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AOGD BULLETIN

"Women's wellness-From tiny heartbeats to timeless strength"

THEME: FROM ADOLESCENCE TO MOTHERHOOD: STRENGTHENING THE CONTINUUM OF CARE THROUGH NATIONAL PROGRAMMES

AOGD SECRETARIAT
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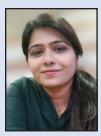

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From the President's desk

Dear AOGD Members,

As President of AOGD, the year 2025–26 has been immensely satisfying in terms of achieving our goals. As a team, we have worked with sincerity, dedication, integrity, and a spirit of mutual support to fulfill our objectives.

I am deeply grateful to all AOGD members for their unwavering support. I take this opportunity to thank each one of you for your continued cooperation and encouragement. I also extend my heartfelt gratitude to our patrons, advisors, and senior members for their invaluable guidance and blessings.

I sincerely appreciate the active participation of all executive members in meetings throughout the year. My thanks also go to the subcommittee chairpersons for their significant contributions in successfully carrying forward AOGD's activities. I would especially like to acknowledge and thank the office bearers of Team AOGD (2025–26) for their constant support and excellent teamwork.

This issue marks the final edition of the AOGD Bulletin for our tenure, focusing on a highly relevant theme—"National Programmes." I commend Dr. Manisha, Dr. Apoorva and the whole team for their efforts in bringing out this important academic issue.

We formally handed over the AOGD office to AIIMS on 30th March 2026. I extend my heartfelt congratulations to Dr. Neena Malhotra, President AOGD (2026–27), and her team, and wish them great success in the coming year.

This is not an end, but a continuation of our shared journey. I am confident that the new team will take AOGD to even greater heights.

With gratitude,

Dr Reena Yadav
President AOGD

From the Secretarial Desk

Dr Ratna Biswas
Honorary Secretary

Dr Sharda Patra
Joint Secretary

Dr Swati Agrawal
Joint Secretary

Dr Anuradha Singh
Joint Secretary

Dear AOGD Members

It is with great pleasure and sense of fulfilment that I pen this last message from the secretarial desk at Lady Hardinge Medical College.

As we wrap up this term I am filled with pleasant memories of our journey from taking over from RML hospital to Handing over to a team of spirited and enthusiastic new office bearers from AIIMS .

The GBM and handing over ceremony held on 30th March 2026 was a memorable event drawing a sizeable crowd of invitees. It was a pleasure to felicitate our patrons, advisors, executive committee members and sub-committee chairpersons whose contributions added much value to our academic and public health endeavours . The annual report and subcommittee reports contained a versatile representation of work done by AOGD all through the year.

Other major activities held in March were a CME on "Decoding Storage LUTS- A Universal Concern" & a CME on "Essentials of Obstetric Critical Care" organized by the AOGD secretariat at Lady Hardinge Medical College on 5th March & 14th March respectively. The programs were very well curated and provided new insights for improving care of women with lower urinary tract disorders and those with critical illness in pregnancy . The events were well attended and much appreciated by the participants.

Amongst the subcommittee activities a CME on "Decoding the Basics of Fetal Health & Genetics" was organized by Fetal Medicine Subcommittee on 7th March and Masterclass on Endometriosis in Adolescents was organized by the Adolescent Health subcommittee on 17th March 2026. The Safe motherhood subcommittee organized a workshop on PPH on 19th March and Community Health & Public Awareness Subcommittee celebrated the International Women's Day on the theme "Give to Gain". All activities were hugely successful.

Our last Bulletin from this office is themed on "**From Adolescence to Motherhood: Strengthening the Continuum of Care through National Programmes**" which is a reflection of our theme "**From Tiny heartbeats to Timeless Strength – Honouring the Journey of Women through Birth & Beyond**"

I congratulate the Editorial team headed by Dr Manisha and well supported by Dr Apoorva as guest editor for bringing forth a collection of articles on National programs which the readers will definitely benefit from and I acknowledge the contribution of all the authors for the useful information they have provided.

AOGD Secretariat

From the Editor's Desk

Dr Pikee Saxena

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Dr Apoorva Kulshreshtha

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Co-editor

It is with great pride that we present this issue of the AOGD Bulletin for April 2026, centred on the theme "From Adolescence to Motherhood: Strengthening the Continuum of Care Through National Programmes."

Women's health is a continuum—spanning adolescence, reproductive years, and motherhood. This edition brings together key national initiatives that collectively strengthen care across these stages, addressing critical gaps along the way.

From adolescent health and menstrual hygiene under RKSK, to anaemia control through the National Iron Plus Initiative and risk identification via PMSMA, early interventions play a pivotal role in shaping maternal outcomes. Quality intrapartum care through LaQshya, complemented by newborn survival strategies under NSSK, reflects the commitment to safe delivery and healthy beginnings. Postpartum family planning further extends this continuum, reinforcing holistic reproductive care.

This bulletin not only highlights programme strengths but also critically explores implementation gaps, offering valuable insights to strengthen both policy and practice.

As this bulletin marks the culmination of our recent academic efforts at Lady Hardinge Medical College, it stands as a testament to the collective dedication of our faculty, residents, and contributors. We extend my sincere appreciation to all authors for their scholarly contributions and to the editorial team for their meticulous work in bringing this issue together.

The Editorial Team

Menstrual Hygiene Promotion Under the Swachh Bharat Mission: Coverage, Behavioural Outcomes, and Implementation Barriers

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Introduction

Menstrual hygiene refers to the safe, dignified, and clean management of menstruation, essential for the health and well-being of women and girls. It involves using clean materials, changing them regularly (every 4–6 hours), washing with water, and safe disposal. Proper hygiene prevents reproductive infections, reduces stigma, and encourages school attendance. Poor hygiene can also lead to toxic shock syndrome and urinary tract infections. The Ministry of Drinking Water and Sanitation under Swachh Bharat Abhiyan has developed National Guidelines on Menstrual Hygiene Management (MHM) for creating awareness in rural areas as part of its overall interventions related to behaviour change in sanitation hygiene aspects. Since 2015-16, the Menstrual Hygiene Scheme is supported by 'National Health Mission' (NHM) through State Programme Implementation Plan (PIP) route based on the proposals received from the States. While Menstrual Hygiene Scheme (MHS) focuses only on sanitary napkin distribution in the age group 10 - 19 years, MHM deals with a broad health concept that covers the entire experience, including education, social stigma reduction, and WASH (Water, Sanitation, and Hygiene) facilities.

Menstrual hygiene scheme (MHS)

Objectives of the scheme

1. To increase awareness among adolescent girls on Menstrual Hygiene.
2. To increase access to and the use of high quality sanitary napkins among adolescent girls in rural areas.
3. To ensure safe disposal of Sanitary Napkins in an environmentally friendly manner.

Provisions under MHS

1. Since inception of MHS (2011 in 107 selected districts in 17 States), the Government of India has subsidized the napkins for rural adolescent girls (10-19 years) at ₹6 per pack of six under the NHM's brand 'Freedays'. They are sold by ASHA.
2. The ASHA receives an incentive @ Rs 1 per pack sold and a free pack of napkins every month for her own personal use.
3. Procurement and State Allocation (Post-PIP)(From 2014 onwards)
   (a) In the first year of a state's proposal under the PIP route, the Centre provided ₹**12 per pack**, inclusive of all taxes and transportation cost etc. Any additional cost beyond Rs. 12 for a pack of six napkins will have to be supported from state funds.
   (b) For subsequent years, this was reduced to ₹8 per pack. The remaining ₹4 gap is intended to be filled by funds recouped from previous sale proceeds.

Menstrual Hygiene Management (MHM)[2]

Menstrual hygiene management and issues related to menstruation is an integral part of the Swachh Bharat Mission Guidelines. The MHM Guideline is issued by the Ministry of Drinking Water and Sanitation to support all adolescent girls and women. Women suffer in the absence of knowledge about safe practices on MHM. MHM guidelines make sure that every household has a toilet, governments and all stakeholders must make sure that every adolescent girl and woman:

1. Must have awareness, knowledge and information to understand menstruation so that it can be managed safely with confidence and dignity. This applies to the other members of the family also.
2. Must have easy access to sufficient, affordable and hygienic menstrual absorbents.
3. Must have access to a separate toilet with private space for cleaning and washing. This includes access to adequate and sustained water supply and soap.
4. Must have access to infrastructure for disposal of used menstrual absorbent, and should know how to use it.

Barriers to implementation of MHM

The barriers are multifaceted. Key challenges include poverty, non-private school/work toilets, limited access to sanitary materials, inadequate education, and stigma that leads to shame and silence. Major Barriers to MHM Implementation are:

1. Inadequate WASH (Water, Sanitation, and Hygiene) Facilities: Lack of private, safe, and clean toilets with scarce water supply in schools, workplaces, and public spaces.
2. Limited access to products: Unavailability of affordable,

comfortable, and sustainable sanitary materials, particularly in rural or humanitarian settings.

3. Sociocultural taboos and stigma: Prevalent shame, silence, and myths surrounding menstruation, which prevent open discussion and hinder proper knowledge sharing.
4. Lack of knowledge/education: Insufficient education on puberty and menstrual hygiene before menarche, leading to fear and embarrassment.
5. Waste disposal issues: Lack of safe and sanitary methods for disposing of used pads or cleaning re-usable materials.
6. Support systems and policy gaps: Weak support from teachers and families, inconsistent policy implementation in schools, and inadequate funding for MHM programs.
7. Special considerations for vulnerable groups3: the MHS does not describe any provision to provide the menstrual products to girls with physical or intellectual disabilities, and those in humanitarian crises (refugee situations). Their needs remain unfairly overlooked in the scheme.
    (a) Adolescent girls with intellectual disabilities often require more counselling and guidance for MHM. These girls may not attend schools for general students, and they may not be able to go to the health centres where the ASHAs are located.
    (b) Girls with severe intellectual disability often face difficulty in communicating and in understanding instructions provided. They may refuse to wear menstrual absorbents, and may on occasion change their menstrual absorbent in front of other people.
    (c) Physical disability imposes barriers in terms of access and effective utilisation of the water, sanitation and hygiene infrastructure and facilities.
    (d) Visually impaired girls may have difficulties positioning their menstrual absorbents, or gauging the proper absorbency of the menstrual blood, unless they have an attendant caretaker. The MHM programme often uses conventional classroom teaching and discussion methods with a chalk board and diagrams for MHM awareness generation programmes, which may not suit a visually or a hearing impaired girl.
    (e) Girls with disabilities may be subjected to forced sterilisation, including hysterectomies.

Van Eijk et al. found that limited access, socioeconomic disparities, and poor WASH infrastructure cause many Indian adolescent girls to use unhygienic menstrual absorbents. Driven by taboos and limited education, this leads to higher rates of urogenital symptoms and school absenteeism, highlighting the need for integrated, stigma-reducing interventions.[4]

Overcoming the barriers

1. Better supply chain management, and better-quality management.
2. Use behavioural change therapies to eliminate "inappropriate actions" in relation to menstrual blood and menstrual absorbents. [5]
    (a) Girls should be able to participate in daily activities during their period without being subjected to stigma or exclusion from peers, parents, teachers, or community leaders.
    (b) Community involvement, including men, traditional and religious leaders, helps change perceptions, practices and ultimately, national policies.
    (c) Boys also need an understanding of the changes related to a girl's body, which is delivered to them in a way that cultivates solidarity and builds social support.
3. Provide a place, both at school and at home
    (a) A private space to change and to wash reusable cloth and sanitary napkins with soap or detergent.
    (b) A small rack to dry clothes.
    (c) A secure place to store sanitary pads in between the menstrual cycles.
4. Availability of sanitary napkins
    (a) Provision of low-cost napkins, which are locally produced by self-help groups, or by girls and women themselves, is a good alternative.
    (b) Availability of a female salesperson so that girls can feel comfortable buying the napkins.
5. More counselling and guidance for MHM.
6. For girls with disabilities, the following steps can be taken 3
    (a) An amended disability-friendly MHS should consider engagement, universal teaching designs, barrier-free technologies, and sensitising and training caregivers and providers. The involvement of non-governmental organisations can also reduce these barriers.
    (b) Awareness programmes should be relevant and comprehensible to all. There could be a consistent inclusion of universal designs of communication, such as sign language and Braille.
    (c) There should be a provision of barrier-free toilets; the manufacture and provision of menstrual hygiene products made with special consideration for the ease of use by the differently-abled; ensuring ease of access to menstrual waste disposal facilities.
    (d) The MHS should impart special sensitisation and

training on MHM to caregivers to the differently-abled.

7. Essential facilities to be made available are
   (a) Separate toilets for girls and boys/ male and female teachers.
   (b) Water supply availability (approximately 500 litres water storage capacity for 100 children)
   (c) Availability of soap for handwashing and space for washing and laundering menstrual absorbent.
   (d) Facilities for safe disposal of used menstrual absorbents.

Impact and behavioral outcomes

1. A study demonstrated that a low-cost, multifaceted health education intervention significantly improved menstrual literacy and hygiene practices among adolescent girls in rural Bangalore. The intervention group showed a 148% increase in knowledge scores and a 204% improvement in adequate MHM practices, leading to a substantial 60% reduction in menstrual-related school absences. 6 To scale the results, there should be a focus on integrating health education into the existing school curriculum and ensuring the availability of private sanitary facilities.
2. A study conducted amongst school girls in Tamil Nadu found that while most adolescent school girls practiced good menstrual hygiene, significant knowledge gaps do exist, with only a quarter receiving prior information about menstrual hygiene, mainly from the family. Challenges like inadequate school sanitation and prevalent cultural taboos hinder effective menstrual hygiene management. The research emphasizes the critical need for improved school-based education and better WASH facilities. 7
3. Analyzing NFHS-5 data, a study in 2024 found that 77% of urban Indian adolescent girls use hygienic menstrual hygiene methods, a figure influenced by education, wealth, and media. However, disparities exist across religion, caste, and regional lines. The study recommends targeted interventions, including subsidized products and school education, to address these inequalities and ensure equitable MHM access. 8
4. A sanitary pad distribution program in Assam and Tripura improved hygiene practices amongst adolescent girls, particularly benefiting those from poor backgrounds and with secondary education. While the initiative successfully removed cost barriers and increased awareness, a concurrent rise in STIs highlights the need for further health awareness. [9]
5. MHS and MHM significantly impact Indian adolescent girls by increasing sanitary product use, reducing school absenteeism, and improving knowledge about menstruation. Enhanced access to products and better sanitation facilities reduce stigma, improve confidence, and decrease fears regarding leakage. But unfortunately the rural areas still face high dropout rates

Conclusion

While initiatives like the MHS have made strides in providing subsidized products and education, persistent shortcomings, such as deep-seated cultural taboos, inadequate school WASH facilities, and "period poverty"—continue to hinder progress. Current steps for improvement focus on a more holistic approach, integrating gender-segregated infrastructure, pre-menarche education, and community-wide awareness to dismantle stigma. Ultimately, the impact of effective MHM is transformative for adolescent girls; it goes beyond preventing infections to significantly reducing school absenteeism, boosting self-confidence, and fostering a sense of dignity that is essential for achieving long-term gender equality.

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PMSMA and High-Risk Pregnancy Screening: Evidence, Impact, and Implementation Challenges in India

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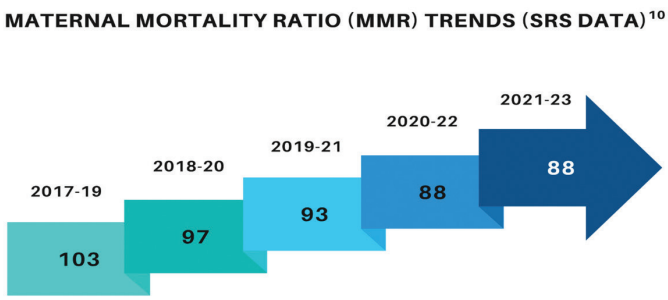
Abstract

The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) is a Government of India initiative aimed at improving maternal health outcomes by ensuring quality antenatal care (ANC), particularly through the identification and management of high-risk pregnancies (HRPs). In India, approximately 20–30% of pregnancies are categorized as high-risk, contributing to nearly 75% of perinatal morbidity and mortality.[1]

This evaluation examines the effectiveness of PMSMA in high-risk pregnancy screening, with respect to early detection, referral, and management of maternal complications. While the program has enhanced antenatal coverage and risk identification, challenges in implementation, follow-up care, and health system capacity limit its overall impact.

1. Introduction

Maternal mortality remains a significant public health concern, particularly in developing countries. The following figure illustrates trends in maternal mortality indicators over a ten-year period.



Maternal Mortality Ratio (MMR) Trends (SRS Data)[10]

Early identification of high-risk pregnancies is critical for reducing maternal and neonatal morbidity and mortality. PMSMA, launched on 31 July 2016, provides free and comprehensive antenatal check-ups on the 9th of every month for pregnant women in their second and third trimesters. A key focus of the program is systematic screening for high-risk conditions such as anemia, hypertension, diabetes, and obstetric complications.

Evaluating its effectiveness is essential to assess progress toward improved maternal health outcomes.

2. Design

PMSMA is designed as a nationwide, periodic antenatal care intervention with the following salient features:

Integration with existing maternal health programs is a key component of PMSMA. The program emphasizes early detection, documentation, and referral of high-risk cases to higher-level facilities.[9]

3. Effectiveness of PMSMA on HighRisk screening

A high-risk pregnancy is defined as one in which there are potential complications that may affect the mother, the fetus, or both, and which requires specialized care to ensure optimal outcomes. In India, approximately 20–30% of pregnancies fall into this category and contribute disproportionately to adverse outcomes[1]. Analysis of the impact of PMSMA on various factors are presented as under.

Table 1 - Detection of High-Risk Pregnancies

- Several studies highlight the strong performance of PMSMA in early risk identification:

Study Setting	Proportion of High-Risk Pregnancies Detected	Key Interpretation
Haryana (Hisar district)	26.9%4	• Indicates substantial identification of high-risk cases during PMSMA clinics. • Reflects enhanced detection of previously unrecognized high-risk pregnancies. • Facilitates timely referral and intervention
Uttar Pradesh (Etawah district)	40.5%2	

- The high proportion of high-risk pregnancies detected across different settings underscores the effectiveness of PMSMA as a screening platform. These findings suggest robust early risk identification, enabling timely

referral, closer monitoring, and appropriate clinical intervention.

Table 2 - Coverage and Utilization

Parameter	Key Findings	Programmatic Implication
Antenatal Care Attendance	Improved attendance due to fixed-day (9th of every month) approach	Enhances accessibility and regular utilization of ANC services
Awareness of PMSMA	~41.7% of women aware of PMSMA services (Etawah study)[2]	Indicates significant awareness gaps limiting program reach
Overall Service Utilization	Increased uptake among attendees, but not universal coverage	Not all eligible beneficiaries are being reached

- The fixed-day approach of PMSMA contributes to improved antenatal care attendance and service utilization. However, suboptimal awareness remains a key limitation, restricting the program's reach and overall effectiveness. Addressing these awareness gaps is essential to ensure equitable access and maximize coverage among eligible beneficiaries.

Table 3 - Risk Stratification & Clinical Screening

Component	Key Features	Programmatic Implication
Structured Clinical Screening	Systematic screening for anemia, hypertension, and multiple pregnancies[5]	Enables comprehensive identification of common obstetric risks
Standardized Protocols	Uniform guidelines for screening and diagnosis	Ensures consistency and quality of care across facilities
Risk Stratification (Tagging)	Use of color-coded risk categorization	Facilitates prioritization and focused clinical management

- PMSMA demonstrates strong clinical effectiveness in risk stratification through structured and standardized screening processes. The use of uniform protocols and risk categorization enables early identification and prioritization of high-risk pregnancies, thereby supporting targeted, need-based antenatal care.

Table 4 - Impact on Pregnancy Outcomes (Indirect Evidence)

Study Setting	**Outcome Measure**	**Key Findings**	**Programmatic Implication**
Belagavi, Karnataka (Longitudinal Study)	Outcomes among identified high-risk pregnancies	70.5% favorable outcomes; 29.5% adverse fetal outcomes.[6]	Suggests benefit of early risk identification, but highlights need for strengthened follow-up and management

- Findings from longitudinal data suggest that early identification of high-risk pregnancies under PMSMA is associated with a substantial proportion of favorable outcomes. However, the persistence of adverse outcomes indicates that screening alone is insufficient. Optimal impact requires robust continuum of care, including timely referral, close monitoring, and effective clinical management.

Table 5 - Patient Satisfaction & Service Quality

Domain	Key Findings	Programmatic Implication
Laboratory Services	97.6% of beneficiaries satisfied with investigations.7	Reflects reliability and adequacy of diagnostic services
Privacy during Examination	92.7% satisfaction reported.7	Indicates respectful and patient-centered care practices
Overall Service Quality	High levels of patient satisfaction	Enhances acceptability and promotes continued utilization of services

- The high levels of patient satisfaction reported across multiple domains indicate good quality of care and service delivery under PMSMA. Such positive patient experiences are likely to enhance acceptability, trust in public health services, and sustained utilization of antenatal care services.

Table 6 - Insights from Qualitative & Implementation Studies

Study Setting	**Key Findings**	**Identified Barriers**	**Programmatic Implication**
Tribal Pune (2025–2026)	Effective in high-risk identification and tracking	Poor transport access; limited diagnostic facilities; delayed care-seeking.[8]	Demonstrates functional effectiveness of screening but highlights constraints in real-world implementation

- Qualitative and implementation evidence indicates that while PMSMA is functionally effective in identifying and tracking high-risk pregnancies, system-level and access-related barriers significantly limit its real-world impact. Addressing gaps in transportation, diagnostic infrastructure, and timely care-seeking is essential to strengthen program effectiveness and ensure continuity of care.

Thus,PMSMA is a clinically effective and well-accepted program for identifying high-risk pregnancies. However, its full impact depends on awareness, accessibility, and robust follow-up care systems.

Table 7 - Supporting Evidence from NFHS (COMPARISON OF NFHS-4 AND NFHS-5)[10]

PARAMETER	NFHS-4	NFHS-5
At least 4 ANC visits	51.2%	58.1%
IFA tablets for >180 days in pregnancy	14.4%	26.0%
Institutional Births	78.9%	88.6%
Neonatal mortality rate (per 1,000 livebirth)	29.5	24.9
Infant mortality rate (per 1000 live births)	40.7	35.2

- These improvements likely reflect the cumulative impact of multiple maternal health initiatives, including PMSMA.
- Increased ANC coverage, institutional deliveries, and early registration suggest improved access to maternal healthcare services.

4. Challenges

Despite its strengths, PMSMA faces several implementation challenges as enlisted below:

1. Human Resource Constraints:
   - Many facilities, especially in rural and remote areas, face shortages of trained obstetricians, radiologists, and lab technicians.
   - Even when PMSMA days are organized, the absence of specialists reduces the quality of screening and limits the ability to diagnose complex high-risk conditions accurately.

2. Inadequate Infrastructure and Diagnostics:
   - Many primary and community health centers lack essential diagnostic tools such as ultrasound machines, laboratory facilities for blood and urine tests, and reliable supply chains for reagents.
   - proper diagnostics, screening becomes superficial and less effective.

3. Weak Referral Systems:
   - Although high-risk pregnancies are identified, referral pathways are often poorly coordinated. Issues include lack of transportation, unclear referral protocols, and poor communication between facilities.
   - This can delay timely care and worsen outcomes.

4. Poor Follow-Up Mechanisms:
   - After identification, many high-risk cases are not adequately tracked.
   - There is limited monitoring to ensure that women actually visit referral centers or adhere to treatment plans.
   - This breaks the continuum of care.

5. Data Management and Reporting Issues:
   - Data collection is often inconsistent or incomplete.
   - Manual entry errors, delays in uploading information, and lack of real-time monitoring reduce the effectiveness of decision-making and policy planning.

6. Limited Community Awareness and Participation:
   - In some regions, pregnant women are unaware of PMSMA services or do not perceive the importance of regular antenatal check-ups.
   - Cultural beliefs, low literacy, and gender barriers can further reduce participation.

7. Variable Private Sector Engagement:
   - While the program encourages private doctors to volunteer, participation is uneven.
   - In many districts, private sector involvement remains minimal, limiting access to specialized care.

8. Logistical constraints:
   - Stock-outs of essential medicines (like iron and folic acid), diagnostic kits, and other supplies hinder effective service delivery during PMSMA sessions.

9. Geographical and Socioeconomic Barriers:
   - Women in remote, tribal, or conflict-affected areas face difficulties accessing health facilities due to poor roads, lack of transport, and financial constraints, reducing program reach.

- PMSMA is actually an attempt to introduce structure into ANC by:
  a. Fixed-day services (9th of every month)
  b. Standard protocols
  c. Risk tagging
  d. Specialist involvement

However, it remains largely episodic rather than continuous, highlighting the need for a more comprehensive and structured ANC approach

5. Conclusion

PMSMA has significantly strengthened antenatal care services and improved the identification of high-risk pregnancies in India. Its structured approach and national scale have contributed to enhanced maternal health awareness and service utilization.

However, to maximize its effectiveness, systemic challenges such as inadequate follow-up, infrastructure gaps, and human resource constraints must be addressed. Strengthening referral systems, ensuring continuity of care, and improving monitoring mechanisms are essential for translating screening into improved maternal and neonatal outcomes.

Future strategies should focus on strengthening the continuum of care rather than relying on screening alone.

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Calendar for AOGD Monthly Clinical Meeting 2026-2027

24th April 2026	Hamdard Institute of Medical Science & Research
29th May 2026	BLK Hospital

National Iron Plus Initiative and Anemia Mukt Bharat: Compliance, Coverage, and Haematological Outcomes under Iron Supplementation Strategies

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Background and Evolution of Iron Supplementation Strategies in India:

Anemia remains a major determinant of maternal and perinatal morbidity in India, with NFHS-5 reporting a prevalence of 57% among women of reproductive age and over 52% among pregnant women[1]. India's iron supplementation strategy has evolved over five decades in response to the persistently high burden of nutritional anemia and its limited decline despite early interventions.

The National Nutritional Anemia Prophylaxis Programme (NNAPP), initiated in 1970, represented the first large-scale effort, focusing primarily on pregnant and lactating women with provision of iron–folic acid tablets through antenatal services. However, programmatic limitations—including low coverage, poor compliance, and inadequate monitoring—resulted in minimal impact on population-level anemia prevalence. Recognizing the multifactorial and life-cycle nature of anemia, the strategy was subsequently expanded into the National Iron Plus Initiative (NIPI), which marked a paradigm shift by targeting multiple beneficiary groups, including children and adolescents, in addition to women of reproductive age.

NIPI introduced age-specific dosing schedules, integration with school health programs through Weekly Iron and Folic Acid Supplementation (WIFS), and incorporation of biannual deworming to address parasitic contributors to anemia. Despite these advancements, challenges related to supply chain inefficiencies, weak behavior change communication, and limited real-time monitoring persisted. This led to the launch of Anemia Mukt Bharat (AMB) in 2018 under POSHAN Abhiyaan, which further strengthened the framework through a structured 6×6×6 strategy, digital monitoring via HMIS, and convergence with maternal, child health, and nutrition platforms.

The evolution of these strategies reflects a transition from a narrowly targeted supplementation approach to a comprehensive, systems-based public health model aimed at improving both coverage and hematological outcomes across the population.

National Iron Plus Initiative (NIPI): Framework and Implementation

The National Iron Plus Initiative expanded anemia control across six beneficiary groups, incorporating supplementation, deworming, screening, and behavior change communication[2]. Despite clear operational guidelines, its impact was limited by variability in implementation, particularly with respect to adherence and supply chain continuity. The NIPI framework operationalizes iron supplementation through platform-based delivery mechanisms including Anganwadi centres, schools, and antenatal clinics, ensuring population-level reach. It incorporates the Weekly Iron and Folic Acid Supplementation (WIFS) program for adolescents and leverages Village Health and Nutrition Days (VHNDs) for community-based distribution. Additionally, NIPI integrates biannual deworming (Albendazole) to address parasitic contributors to anemia and promotes testing through point-of-care hemoglobin estimation where feasible.

Anemia Mukt Bharat (AMB): Intensified Strategy and 6×6×6 Framework

AMB, launched in 2018, aims to reduce anemia prevalence by 3 percentage points annually[3]. The framework integrates supplementation with systemic strengthening through monitoring, capacity building, and convergence with existing maternal and child health services.

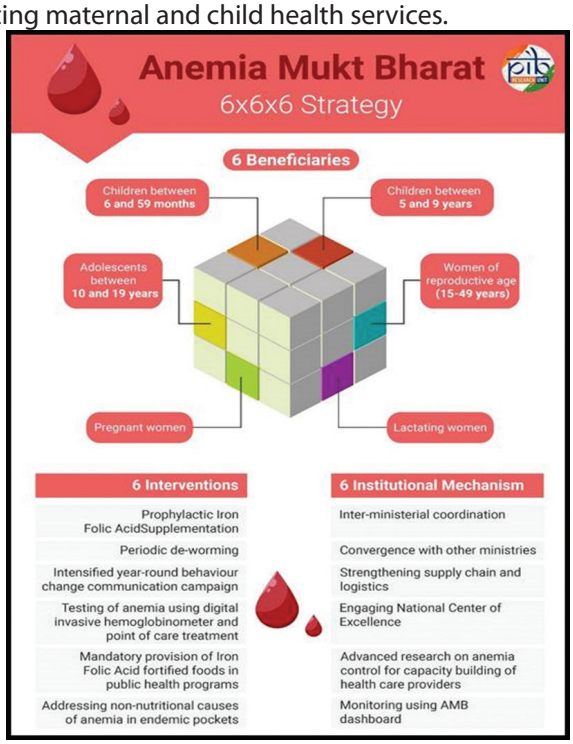

Figure 1. Anemia Mukt Bharat (AMB) 6×6×6 framework depicting target groups, interventions, and implementation mechanisms.

Beneficiary Groups and Supplementation Protocols Under AMB

Beneficiary Group	Supplementation Regimen
Children (6–59 months)	Biweekly IFA syrup (20 mg elemental iron + 100 µg folic acid)
Children (5–9 years)	Weekly IFA tablet (45 mg iron + 400 µg folic acid)
Adolescents (10–19 years)	Weekly IFA tablet (60 mg iron + 500 µg folic acid)
Pregnant women	Daily IFA tablet (60 mg iron + 500 µg folic acid) for ≥180 days
Lactating mothers	Daily IFA tablet for 180 days postpartum
Reproductive age women (20-49 years)	Weekly IFA tablet (60 mg iron + 500 µg folic acid)

This structured life-cycle approach ensures continuity of iron supplementation across critical physiological stages. Such standardization facilitates integration with existing service delivery platforms including antenatal care, school health programs, and community outreach through ASHAs and ANMs.

Coverage and Compliance: Evidence from HMIS and AMB Scorecards

The apparent excess coverage in pregnant women reflects duplication, migration, and denominator estimation errors inherent to HMIS systems[5]. Despite improved distribution systems, true adherence remains significantly lower: Only 30–50% of pregnant women consume ≥100 tablets[6], and discontinuation rates increase after the second trimester. Recent quarterly trends (2024–2025) indicate that while supply-side indicators such as IFA distribution have improved steadily, demand-side uptake continues to lag, particularly in rural and tribal populations. This gap between distribution and ingestion remains the principal limitation of program effectiveness.

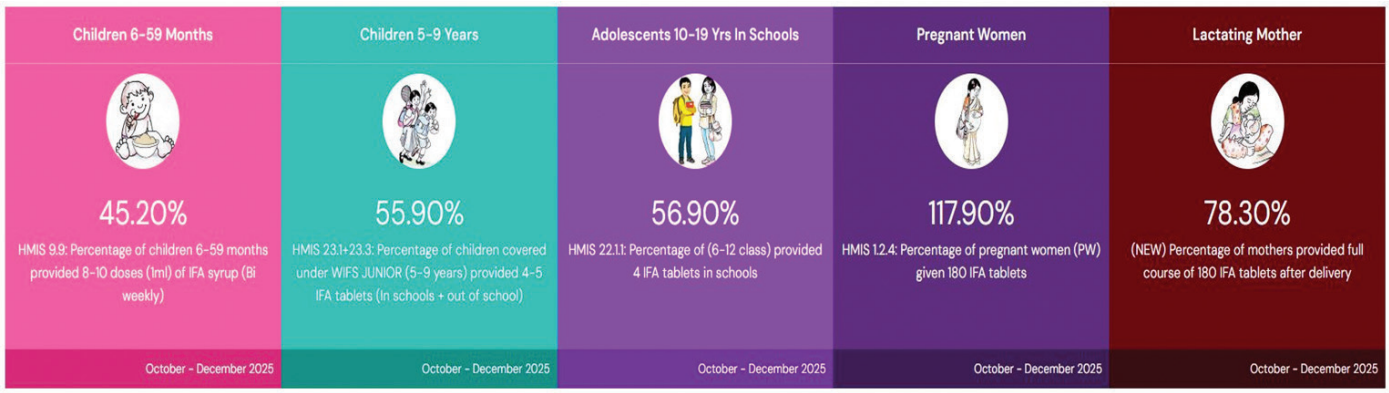

Figure 2. Coverage of IFA supplementation across beneficiary groups (AMB Scorecard, Oct–Dec 2025)

School-based platforms consistently demonstrate higher compliance rates compared to community-based delivery, suggesting the importance of structured delivery environments. Furthermore, repeated stock-outs at sub-centre and Anganwadi levels have been identified as critical bottlenecks affecting sustained coverage. Longitudinal HMIS data also suggest that early antenatal registration (first trimester) is positively associated with higher completion rates of ≥180 IFA tablets, highlighting the role of early health system contact in improving adherence trajectories.

Determinants of Compliance:

Compliance with iron–folic acid supplementation is influenced by a complex interplay of drug-related, health system, and sociocultural factors.

- Gastrointestinal side effects such as nausea, epigastric discomfort, constipation, and altered taste perception remain the most commonly reported barriers, often leading to early discontinuation, particularly in the first trimester.
- Health system constraints, including irregular supply, stock-outs at sub-centre and Anganwadi levels, and inadequate follow-up mechanisms, further compromise sustained adherence.
- From a service delivery perspective, insufficient counseling during antenatal visits and lack of emphasis on the importance of continued supplementation beyond symptomatic improvement contribute significantly to poor compliance.
- Sociocultural beliefs and misconceptions such as fears of excessive fetal growth, difficult labor, or perceived 'heat' from iron tablets continue to influence patient behavior, particularly in rural settings.
- Programmatic gaps are also evident among out-of-school adolescents and marginalized populations, where delivery platforms are less structured and follow-up is limited.
- Additionally, variability in frontline worker engagement, particularly in ASHA and ANM training, motivation, and workloa// directly impacts reinforcement, monitoring, and adherence support.

Collectively, these factors highlight that improving compliance requires not only drug availability but also strengthened counseling, community engagement, and system-level accountability.

State-wise Variations and Program Performance

Southern and western states demonstrate relatively higher AMB indices, while northern and northeastern states continue to lag. These variations reflect differences in health infrastructure, antenatal care coverage, and program monitoring.

Figure 3. State-wise variation in AMB index based on coverage and performance indicators.

Marked inter-state disparities persist.

Haematological Outcomes under Iron Supplementation:

Iron supplementation demonstrates measurable improvements in hematological parameters:

Hemoglobin Response: Mean increase of 0.8–1.2 g/dL within 12–16 weeks[9], up to 1.5–2 g/dL increase in moderate anemia with adequate adherence and 30–40% reduction in anemia at term with daily supplementation[10]. In addition to hemoglobin improvement, an increase in serum ferritin levels by approximately 10–15 µg/L in compliant populations has been seen, indicating replenishment of iron stores. However, the hematological response is often attenuated in the presence of concurrent deficiencies such as vitamin B12 and folate, which are increasingly recognized in Indian populations.

Additionally, inflammation-mediated anemia and infections such as helminthiasis and malaria can significantly blunt hematological response, underscoring the need for integrated interventions.

Improvement in maternal and fetal outcomes has been observed, including:

– Reduction in postpartum hemorrhage risk by 20%

– Reduction in maternal infections by 10–15%

– Reduction in low birth weight by 15–20%

– Reduction in preterm birth by 10–12%12

Program-Level Effectiveness

- Timing of initiation: Early initiation in the first trimester is associated with greater hemoglobin gains compared to late initiation, emphasizing the importance of early antenatal registration.[13]
- Adherence-dependent outcomes: Program impact is directly proportional to adherence, with significantly better hematological outcomes in women consuming ≥100 IFA tablets.
- Integration with deworming: Combined interventions improve iron absorption and enhance hematological response in endemic regions.[11]
- System strengthening: Digital monitoring and scorecards have improved accountability but require refinement for data accuracy.
- Equity gaps: Program effectiveness remains lower in marginalized populations due to access and awareness barriers.

Programmatic Challenges and Limitations

Program monitoring under AMB relies heavily on HMIS-based reporting, where interpretation of coverage indicators is influenced by inherent numerator–denominator limitations. Numerators often reflect the number of IFA doses distributed, while denominators are based on estimated target populations, which may not accurately capture migration, duplication across service points, or private sector utilization. This can lead to apparent over coverage, particularly in pregnant women, where reported values may exceed 100%. Additionally, reporting bias, delayed data entry, and variability in data validation across states further affect reliability. These limitations necessitate cautious interpretation of program performance and highlight the need to complement HMIS data with periodic survey-based assessments. Recognizing these gaps, the government has emphasized strengthening real-time digital tracking systems, improving denominator accuracy through updated population estimates, and enhancing data validation mechanisms at block and district levels. Recent programmatic directions also include greater integration with POSHAN Tracker, expansion of point-of-care hemoglobin testing, targeted strategies for high-burden districts, and intensified behavior change communication to improve adherence. Such measures aim to shift the focus from coverage-based metrics to outcome-oriented indicators, particularly reduction in anemia prevalence and improvement in hemoglobin levels.

Furthermore, compliance remains suboptimal due to the high prevalence of gastrointestinal side effects and inadequate counseling regarding their management, supply chain inefficiencies, sociocultural misconceptions regarding iron supplementation persist, particularly among pregnant women, reducing adherence and inadequate screening for non-nutritional causes of anemia, including hemoglobinopathies and chronic infections, limits the overall effectiveness of supplementation-based strategies.

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Rashtriya Kishor Swasthya Karyakram (RKSK): Gaps and Opportunities in Delivering Adolescent Reproductive Health Services

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Introduction

RKSK is a flagship health program launched by the Government of India under the Ministry of Health and Family Welfare on 7th January 2014. It is aimed at addressing the health needs of adolescents (10–19 years). It primarily focuses on nutrition, sexual and reproductive health, mental health, drug abuse, injury and violence (including gender-based violence), and non-communicable diseases. RKSK aims to ensure holistic health and well-being of over 253 million adolescents. It is in line with the National Reproductive Maternal Newborn Child Health + Adolescent Health (RMNCH +A) Strategy's commitment to a continuum of care approach.[1]

Coverage[2]

The program marked a paradigm shift from a narrow focus on reproductive health to a comprehensive adolescent health strategy encompassing nutrition, mental health, substance abuse, injuries, violence, and non-communicable diseases. It aims to provide universal coverage, i.e., males and females; urban and rural; in-school and out-of-school; married and unmarried; vulnerable and underserved populations.

The vision[2] of this program was to ensure that all adolescents in India should be able to reach their full potential by making informed and responsible decisions about their health and well-being, as well as having access to the services and support they require.

Objectives

1. Improve nutrition – lower the prevalence of malnutrition and iron deficiency anaemia in adolescent girls and boys
2. Improve sexual and reproductive health (SRH)
3. Enhance mental health – address mental health of adolescents
4. Prevent injuries and violence
5. Prevent substance abuse
6. Address non-communicable diseases

Components

This health program consists of:

1. **Adolescent Friendly Health Centres (AFHCs)**

   AFHC entails a whole gamut of clinical and counselling services on diverse adolescent health issues ranging from sexual and reproductive health (SRH) to nutrition, substance abuse, injuries and violence (including gender-based violence), non-communicable diseases, and mental health.

   To establish an AFHC, certain criteria and prerequisites are to be fulfilled, which include:

- The infrastructure should be clean, bright, and colourful, well-lit and ventilated, with clean drinking water and a functional toilet.
- It should be easily accessible to adolescents (distance and convenient working hours).
- It should maintain privacy and confidentiality.
- Educational pamphlets should be displayed and made available for take-away.
- There should be proper signage for the AFHC.
- There should be a system in place for referrals from the community and higher facilities, as well as referral links to special clinics.

2. **Weekly Iron Folic Acid Supplementation (WIFS)**

   WIFS is an evidence-based programmatic response to the prevailing anaemia situation amongst adolescent girls and boys through supervised weekly ingestion of IFA supplementation and biannual helminthic control.

3. **Peer Educator Programme (PE Programme)**

   Under the PE programme, four peer educators (two boys and two girls) are selected per village/1000 population/ ASHA habitation to reach out to adolescents. Saathiya selection is facilitated by ASHA in consultation with the Village Health Sanitation and Nutrition Committee. They educate adolescents about their health and inform them about existing adolescent-friendly health services so that all adolescents can make the best use of them.

4. **Menstrual Hygiene Scheme (MHS)**

   The Ministry of Health and Family Welfare launched the Scheme for Promotion of Menstrual Hygiene among

adolescent girls in the age group of 10–19 years in rural areas as part of the Adolescent Reproductive Sexual Health (ARSH) in RCH II, with specific reference to ensuring health for adolescent girls. In this scheme, awareness on menstrual hygiene, along with distribution of sanitary napkins at subsidized rates, is done by ASHA workers.

5. **Adolescent Health Days (AHD)**

   The quarterly Adolescent Health Days are conducted at village level/anganwadi/other public places to increase awareness among adolescents, parents, families, and stakeholders about issues and needs related to adolescent health.

Despite its comprehensive vision, the effectiveness of the program depends largely on its implementation at its grassroots levels where significant limitations are present.

Drawbacks of the Scheme[3, 4]

1. **Poor reach and awareness** – There is a lack of general awareness among adolescents and other members of the community regarding the availability of this scheme. There is also a failure of this scheme in remote areas and in reaching out-of-school adolescents.
2. **Infrastructure shortfalls** – There is a lack of dedicated private rooms for providing RKSK services so as to maintain privacy of adolescents.
3. **Human resources** – Many centres face a shortage of dedicated trained personnel for providing RKSK services. In addition, there is a lack of refresher training courses, which would encourage continuous medical education and training of personnel.
4. **Limited focus on mental health** – Mental health is a core pillar of RKSK; however, it remains under-addressed. There is a lack of trained professionals with limited screening and counselling services.
5. **Weak monitoring and evaluation systems** – Limited use of data for decision-making, as well as inadequate evaluation of outcomes, hampers evidence-based policy improvements.
6. **Policy gaps** – There are policy gaps that need to be addressed to ensure effective implementation and delivery of RKSK services. These include the need for better funding, resource allocation, and policy support for the program.

Recommendations for strengthening[3, 4]

1. Strengthening AFHC infrastructure, which can significantly improve service utilization
2. Regular training and refresher programs for healthcare professionals
3. Use of digital platforms to increase awareness and accessibility, especially in remote populations
4. Strengthening parental and community involvement to improve program uptake and sustainability
5. Strengthening monitoring and evaluation of data and programs in place

Addressing these gaps and opportunities is crucial for the successful implementation of RKSK and for ensuring that adolescents receive the health services they need to thrive.

Conclusion

Rashtriya Kishor Swasthya Karyakram represents a landmark initiative in India's public health landscape, addressing the diverse needs of adolescents through a comprehensive framework. Investing in adolescent health is not only a public health priority but also a strategic investment in the nation's future. Adolescents often do not have the autonomy or agency to make their own decisions. RKSK takes cognizance of this and involves parents and the community.

Addressing the challenges faced in this program requires a concerted effort from policymakers, healthcare providers, communities, and adolescents themselves. Strengthening RKSK will contribute to improved health outcomes, economic productivity, and social development in India.

The focus should be to reorganize the existing public health system in order to meet the service needs of adolescents. The strength of the program lies in its health promotion approach. It is a paradigm shift from existing clinic-based services to promotion and prevention, reaching adolescents in their own environment such as schools, families, and communities.

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Early identification of Cardiometabolic risk in pregnancy under National NCD Strategy: Programmatic gaps and opportunities.

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Introduction

India is undergoing a rapid health transition, with the burden of non-communicable diseases (NCDs) now surpassing that of communicable diseases. NCDs such as hypertension, cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes account for nearly 60% of all deaths in the country and lead to a substantial loss of productive years of life.[4]

To address this growing challenge, the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was launched in 2010.[1] The programme focuses on strengthening healthcare infrastructure, human resource development, health promotion, early diagnosis, treatment, and referral services.

Under NPCDCS, NCD Cells have been established at national, state, and district levels for programme management, while NCD Clinics at district hospitals and Community Health Centres (CHCs) provide services for early detection, treatment, and follow-up of common NCDs.

Integrating maternal healthcare with NPCDCS ensures comprehensive care for women by addressing both reproductive health and NCDs. This approach supports early detection, prevention, and management of conditions such as hypertension, diabetes, and cardiovascular diseases during pregnancy and beyond.[2,5]

The Importance of Integration

Maternal health and non-communicable diseases (NCDs) are closely linked. Pregnancy can reveal or worsen conditions such as hypertension and gestational diabetes, increasing long-term risks of cardiovascular disease and diabetes.

While NPCDCS focuses on NCD screening, early diagnosis, and management, maternal health services primarily emphasize safe pregnancy and childbirth, often missing systematic chronic disease screening.

Integrating maternal care with NPCDCS enables:

- Early screening for diabetes, hypertension, and cardiovascular disease during antenatal visits.[5,8]
- Continuity of care through postnatal linkage to NCD services.[2]
- Improved health system efficiency by sharing resources
- Reduction of intergenerational risks such as low birth weight and future metabolic disorders.[9,5].

Key implementation strategies include training frontline workers (ASHAs and ANMs) to conduct NCD screening during maternal outreach, strengthening primary health centres to deliver integrated services, linking digital maternal records with NPCDCS registries[2,5] and promoting community awareness on maternal health and NCD prevention.

Major challenges include resource constraints, data system integration, and ensuring equitable access for rural and marginalized populations.[3]

Screening Methods for Hypertension in Pregnancy under India's NCD Strategy

Hypertension in pregnancy, including gestational hypertension and pre-eclampsia, is a major contributor to maternal and perinatal morbidity in India. Recognizing this, the Government of India integrates hypertension screening for pregnant women within the broader National Programme for Prevention and Control of Non-Communicable Diseases (NP-NCD) and the Comprehensive Primary Health Care (CPHC) framework.[2,6]

These efforts align with the national goal of early detection and management of NCDs, including hypertension, across all population groups.

1. Integration with Population-Based Screening (PBS)

India's NCD strategy includes population-based screening for individuals aged ≥30 years, but the system also strengthens screening for vulnerable groups such as pregnant women. Under the NP-NCD, screening is conducted at Ayushman Arogya Mandirs (Health & Wellness Centres), where frontline workers—ASHAs, ANMs, and CHOs—play a central role.

2. Opportunistic Screening during Antenatal Care

Opportunistic screening is a core pillar of the NP-NCD strategy. Pregnant women are screened for hypertension at every ANC visit across all levels of the health system—

sub-centres, PHCs, CHCs, district hospitals, and medical colleges.

Key components include[5,8]:

- Blood pressure measurement using validated digital or manual sphygmomanometers
- Urine protein testing to detect pre-eclampsia
- Risk assessment using standardized checklists and digital tools
- Referral pathways for high-risk pregnancies

This approach ensures early detection even if women do not fall within the age bracket of population-based NCD screening.

3. Use of Community-Based Assessment Checklist (CBAC)

While CBAC is designed for adults aged ≥30 years, its deployment strengthens community-level screening systems. The same ASHA workforce trained under NP-NCD applies similar skills during home visits and ANC mobilization, improving early identification of hypertensive symptoms in pregnancy.[7]

4. Strengthening Primary Care through Ayushman Bharat.[6]

The Ayushman Bharat Health and Wellness Centres (AB-HWCs) provide comprehensive primary care, including maternal health and NCD services. This integration ensures:

- Routine BP checks during ANC
- Follow-up for high-risk pregnancies
- Teleconsultation support via eSanjeevani for remote management
- Digital tracking through the National NCD Portal and Reproductive and Child Health (RCH) portal

5. Digital Monitoring and NCD Portal

The National NCD Portal, originally designed for adult NCD screening, also strengthens maternal health by:

- Tracking hypertension cases
- Ensuring follow-up and continuity of care
- Supporting data-driven decision-making at district and state levels

6. Referral and Secondary/Tertiary Care Linkages

NP-NCD guidelines emphasize clear referral pathways for complications. Pregnant women with severe hypertension or pre-eclampsia are referred to higher facilities equipped with:

- Obstetric ICUs
- Cardiac and stroke care units
- Specialist obstetricians and physicians

7. Awareness and Behaviour Change Communication (BCC)[6]

The NCD strategy includes community-level awareness campaigns on:

- Early ANC registration
- Warning signs of hypertension
- Importance of regular BP monitoring
- Lifestyle modifications (salt reduction, physical activity)

Screening Performance for Diabetes in Pregnancy under India's NCD Strategy

India's National Programme for Prevention and Control of Non-Communicable Diseases (NP-NCD) provides the framework for integrating diabetes screening across all levels of the public health system, with growing emphasis on gestational diabetes mellitus (GDM) due to its high prevalence and long-term intergenerational impact.

The NP-NCD Operational Guidelines (2023–2030) promote population-based and opportunistic screening with clear linkages to RMNCH+A services, enabling routine GDM screening during antenatal care at Ayushman Arogya Mandirs, PHCs, CHCs, and district hospitals.

Standardized protocols, free diagnostics, strengthened referral pathways, district- and CHC-level NCD clinics, and teleconsultation platforms together support early detection, confirmatory testing, follow-up, and improved access to specialist care.

GDM is a unique intersection of maternal health and NCD prevention. Women with GDM face a significantly higher lifetime risk of type 2 diabetes, and their children have increased risks of obesity and metabolic disease. Thus, screening in pregnancy is not only a maternal health intervention but also a strategic NCD prevention opportunity.

India's NCD strategy recognizes this intergenerational dimension. By embedding GDM screening within routine antenatal care and linking it to NCD follow-up pathways, the system aims to reduce long-term diabetes incidence.

Screening Strategies and Implementation

India follows a universal screening approach for GDM, typically using DIPSI testing at the first ANC visit and again at 24–28 weeks [5]. Under the NP-NCD framework, screening is supported through:

- Population-based screening (PBS): Although PBS targets adults ≥30 years, its infrastructure—digital registries, community mobilization, and ASHA-led outreach—indirectly strengthens ANC-linked diabetes

screening.

- Opportunistic screening: Conducted at all healthcare delivery points, ensuring pregnant women presenting for ANC are screened regardless of visit timing.
- Digital monitoring: The National NCD Portal enables real-time tracking of screening coverage, follow-up, and treatment adherence.
- NCD Screening Campaign (Feb–Mar 2025): Aimed for 100% screening of individuals ≥30 years, indirectly boosting ANC-linked screening through increased community awareness, mobilization, and facility readiness [2].

India's NCD strategy has significantly strengthened the ecosystem for diabetes screening, including for pregnant women. Continued improvements in workforce capacity, laboratory infrastructure, and data systems are essential to achieving equitable, high-quality screening for all pregnant women.

Early Identification of Cardiometabolic and Cardiovascular Risk in Pregnancy

India's NP-NCD programme has expanded substantially in recent years, strengthening the country's capacity for cardiovascular and metabolic risk detection through population-based screening, opportunistic assessments, and digital registries.

Although these advances are not pregnancy-specific, they provide a stronger foundation for identifying women with chronic hypertension, pre-existing cardiovascular disease (CVD), and metabolic risk factors before or during pregnancy.

Current Performance and Emerging Cardio-Obstetric Models

National programme reports demonstrate large-scale improvements in hypertension screening and treatment initiation under NP-NCD. These system-level gains enhance the baseline ability to detect chronic hypertension and known heart disease among women entering pregnancy.

Parallel research initiatives are also shaping India's cardio-obstetric ecosystem. The National Pregnancy and Cardiac Diseases (NPAC-INDIA) study is developing protocolized care pathways and risk stratification tools for pregnant women with heart disease across multiple centres.

Gaps and Challenges

Programme and Monitoring Limitations

- NP-NCD lacks pregnancy-specific indicators for CVD or metabolic risk
- Maternal health HMIS and the NCD digital portal operate in parallel, resulting in fragmented data and limited longitudinal tracking

Clinical Detection Constraints

- Non-hypertensive cardiac conditions (congenital, rheumatic, cardiomyopathies, arrhythmias) remain under-recognized at primary care levels [10}
- Laboratory limitations, particularly for lipid profiling and HbA1c, restrict early detection
- Frontline providers are proficient in BP measurement but less confident in identifying cardiac red flags and metabolic syndrome

Care Continuity and Referral Gaps

- Linkages between ANC and NCD clinics are inconsistent
- Referral pathways vary widely across states

Opportunities for Strengthening Pregnancy-Specific Cardiometabolic Surveillance

- Leveraging Ayushman Arogya Mandirs for early screening
- Integrating pregnancy-specific indicators into NP-NCD digital systems
- Strengthening cardio-obstetric referral networks
- Targeted capacity building for frontline providers

Conclusion

India's NCD strategy has significantly strengthened the national platform for cardiovascular and metabolic risk detection. For pregnant women, these gains translate into improved identification of chronic hypertension and known heart disease.

However, systematic, pregnancy-specific CVD and cardiometabolic surveillance remains underdeveloped.

Integrating maternal health with NP-NCD/NPCDCS represents a strategic shift toward holistic, life-course care, with the potential to improve maternal and neonatal outcomes, enhance continuity of care, and reduce long-term NCD burden and premature mortality.

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Events Conducted in April

10.04.2026 - Webinar on Decoding Vulval Lesions - Benign to Pre-invasive by Dept. of Obst. & Gynae Oncology , Amrita Hospital in association with Oncology committee AOGD.

18.04.2026 - CME on Co-Morbidities in Maternal Health by Safe-motherhood Committee AOGD at MEU, Hall, SJ Auditorium, LHMC.

Forthcoming Events

09.05.2026 - Hands-on workshop by Endoscopy Committee at skill centre at Sir Ganga Ram Hospital

16.05.2026 - CME by Fetal medicine and genetic subcommittee of AOGD

Effect of LaQshya and MAA Implementation on Maternal Morbidity and Early Breastfeeding Practices

A Review of Evidence and Program Outcomes

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Abstract

India's maternal and neonatal health landscape has witnessed transformative policy shifts over the past decade. Two flagship government initiatives — LaQshya (Labour Room Quality Improvement Initiative) and MAA (Mothers' Absolute Affection) — represent targeted efforts to reduce maternal morbidity and improve early newborn care, including breastfeeding practices. LaQshya, launched in 2017[1], focuses on upgrading the quality of care in labour rooms and maternity operation theatres, while MAA, introduced in 2016[2], is a comprehensive programme to promote breastfeeding across health facilities and communities. Together, these programmes have created structural, behavioural, and systemic changes that have produced measurable improvements in maternal outcomes and breastfeeding initiation rates.[3,4,6,1] This article critically reviews the design, implementation strategies, and documented effects of LaQshya and MAA on maternal morbidity and early breastfeeding practices, drawing on available national data, programme evaluations, and peer-reviewed literature.

1. Introduction

Maternal morbidity — the burden of acute and chronic health conditions arising from pregnancy and childbirth — remains a pressing public health challenge in India5,12. While India has achieved significant reductions in its maternal mortality ratio (MMR) over the past two decades, declining from 254 per 100,000 live births in 2004–06 to 97 per 100,000 live births by 2018–205, the burden of maternal morbidity continues to far exceed mortality in absolute numbers. Conditions such as obstetric haemorrhage, sepsis, eclampsia, and complications from obstructed labour continue to afflict millions of women annually, many of whom survive but with lasting health consequences.[12,18]

Concurrently, suboptimal breastfeeding practices remain a critical concern. Despite global recommendations that breastfeeding should begin within one hour of birth and be continued exclusively for six months[9,13], early initiation rates in India have historically remained low3,4, particularly in institutional settings. Barriers including lack of skilled support, routine separation of mother and newborn, use of pre-lacteal feeds, and inadequate counselling have long undermined breastfeeding success at the population level.[10,19]

Recognising these twin challenges, the Government of India launched LaQshya and MAA as part of broader efforts under the National Health Mission (NHM). This article examines how these two programmes have been designed and delivered, and evaluates their documented impact on maternal morbidity outcomes and early breastfeeding practices across different tiers of the Indian health system.[12,14]

2. The LaQshya Programme: Design and Implementation

LaQshya — an acronym for 'Labour Room Quality Improvement Initiative' — was launched in December 2017 by the Ministry of Health and Family Welfare1 (MoHFW). The name itself, meaning 'goal' or 'target' in Hindi, underscores its purpose: to reduce preventable maternal and newborn mortality, morbidity, and stillbirths by improving the quality of care in labour rooms and maternity operation theatres.

The programme employs a certification-based model, whereby facilities are evaluated against a comprehensive set of standards across five domains: infrastructure and equipment, human resources, service delivery protocols, infection prevention and control, and patient rights. Facilities are assessed and awarded certification at three levels: Platinum, Gold, and Silver, reflecting their level of compliance with prescribed standards.

Key interventions under LaQshya include the adoption of evidence-based clinical protocols such as active management of the third stage of labour (AMTSL), use of partographs, respectful maternity care (RMC) practices, availability of skilled birth attendants around the clock, functional infrastructure for obstetric emergencies, and structured quality improvement teams at the facility level. The programme also emphasises infection prevention1,18 through the five moments of hand hygiene, appropriate use of antibiotics, and proper management of sharps and biomedical waste.

By 2022, thousands of health facilities across India had undergone LaQshya assessments, with hundreds achieving certification. States such as Rajasthan, Uttar Pradesh, Madhya Pradesh, and Chhattisgarh — high-priority states with high disease burden — were among the early adopters of the programme.[6,14]

3. The MAA Programme: Design and Implementation

The MAA (Mothers' Absolute Affection) programme was launched in August 20162 under the NHM as India's flagship breastfeeding promotion initiative. The programme targets healthcare providers, programme managers, community health workers, and families with a three-pronged strategy: awareness generation through interpersonal communication (IPC), strengthening the capacity of healthcare providers to support breastfeeding, and creating enabling health system environments for breastfeeding.[2,11]

The MAA programme operates through a structured cascade training model.[9,11] Trainers at national and state levels build the capacity of district-level master trainers, who in turn train facility-level healthcare providers including doctors, nurses, auxiliary nurse midwives (ANMs), and ASHAs. Training content covers evidence-based breastfeeding support including counselling on the benefits of colostrum, techniques for correct positioning and attachment, management of breastfeeding difficulties, and exclusive breastfeeding for six months.

A key feature of the MAA programme is its integration with existing maternal and child health platforms, including Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA), Janani Suraksha Yojana (JSY), and Village Health and Nutrition Days (VHNDs).[14] This integration ensures that breastfeeding promotion is embedded in routine maternal and neonatal care rather than delivered in isolation.

The programme also introduced a facility-level recognition framework — the MAA facility recognition — to incentivise health facilities to adopt breastfeeding-supportive practices. Facilities earning recognition are expected to achieve minimum thresholds in early breastfeeding initiation within one hour of birth, exclusive breastfeeding counselling, and documentation of breastfeeding outcomes.[2]

4. Effect on Maternal Morbidity

4.1 Reductions in Preventable Complications

LaQshya's emphasis on evidence-based obstetric care has been associated with reductions in key indicators of maternal morbidity at accredited facilities.[6,18] Studies conducted in LaQshya-certified facilities have reported improvements in the administration of uterotonics for the prevention of postpartum haemorrhage, more consistent use of partographs for monitoring labour progress, and greater adherence to infection control protocols.[5,12] These improvements are clinically significant, as postpartum haemorrhage and sepsis together account for nearly half of all direct maternal deaths in India.

An assessment of LaQshya implementation in Rajasthan found improvements in the proportion of deliveries conducted under skilled supervision, a reduction in the rate of intrapartum complications, and enhanced capacity for emergency obstetric care. Similar improvements in obstetric care quality were documented in Uttar Pradesh and Madhya Pradesh following LaQshya roll-out.[6,14]

4.2 Respectful Maternity Care and its Role in Outcomes

One of LaQshya's distinguishing features is its explicit focus on respectful maternity care (RMC), defined as care that maintains the dignity, privacy, and confidentiality of women, ensures freedom from harm and mistreatment, and promotes informed choice. Evidence from global and Indian contexts suggests that RMC not only improves women's experience of childbirth but is also associated with improved care-seeking behaviour and adherence to postnatal care, which in turn reduces morbidity.[8]

In the LaQshya framework, RMC standards include: presence of a birth companion, written informed consent before procedures, privacy during examination and delivery, and freedom from verbal and physical abuse. Facilities with higher RMC compliance scores have reported improved rates of postnatal care attendance and greater family participation in newborn care — both factors that contribute to reduced maternal and neonatal morbidity16.

4.3 Infection Control and Sepsis Prevention

Maternal sepsis, arising from genital tract infections during labour and the puerperium, remains a major contributor to maternal morbidity in India.[1] LaQshya's infection prevention and control standards — including hand hygiene compliance, proper sterilisation of instruments, and appropriate antibiotic prophylaxis — have contributed to reductions in healthcare-associated infections in certified facilities.[18] Audits of LaQshya-certified labour rooms have found significantly lower rates of postpartum fever and wound infections compared to pre-implementation baselines.[1]

5. Effect on Early Breastfeeding Practices

5.1 Trends in Early Initiation of Breastfeeding

The National Family Health Survey (NFHS) data provide important benchmarks for evaluating breastfeeding trends in India. NFHS-4 (2015–16) reported that early initiation of breastfeeding within one hour of birth stood at 41.6% nationally. NFHS-5 (2019–21), conducted after the full-scale roll-out of the MAA programme, reported an improvement to 51.9% — a gain of more than 10 percentage points in five years. While multiple factors contributed to this improvement, the MAA programme's targeted interventions are considered a significant driver.[3]

States with high MAA programme coverage and strong implementation fidelity, such as Odisha, Sikkim, and

Himachal Pradesh, demonstrated some of the sharpest improvements in early breastfeeding initiation rates. In Odisha, early breastfeeding initiation rose from 64.4% (NFHS-4) to 79.7% (NFHS-5) — among the highest in the country. These gains have been attributed to the strong integration of MAA training within the state's facility-based maternity services, reinforced by community-level IPC by ASHAs.[14]

5.2 Provider Training and Attitude Change

One of the most consistently documented effects of the MAA programme has been its impact on the knowledge, attitudes, and practices of healthcare providers. Pre-post evaluations of MAA training programmes have shown significant improvements in provider knowledge of breastfeeding physiology, correct positioning and attachment techniques, and management of common breastfeeding difficulties such as engorgement and sore nipples9. Attitude change has been equally important: providers trained under MAA have reported greater confidence in breastfeeding counselling and a more positive attitude toward supporting mothers in the immediate postpartum period.[11]

5.3 Reduction in Use of Pre-Lacteal Feeds

Pre-lacteal feeds — the practice of giving newborns foods or liquids other than breast milk before breastfeeding is established — have historically been common in many parts of India.[3] These practices, which include giving water, honey, sugar solution, or formula, undermine the establishment of breastfeeding and expose newborns to infection risk4. NFHS-5 data show a decline in pre-lacteal feeding practices nationally, from around 38% (NFHS-4) to 21% (NFHS-5), a trend that has been linked in part to MAA's community IPC strategies and facility-level counselling.[10,13]

5.4 Colostrum Feeding

Colostrum — the thick, yellowish first milk produced by mothers — is rich in immunoglobulins and has critical immune-protective properties for the newborn.[13] In many communities, colostrum is discarded due to cultural beliefs, and pre-lacteal substitutes are given instead. The MAA programme has specifically targeted this practice through community counselling by ASHAs and healthcare providers.[9] Studies from MAA-implementing states have shown significant improvements in colostrum feeding rates following programme implementation, with some districts reporting near-universal colostrum feeding among facility-delivered newborns.[11]

6. Synergistic Effects of LaQshya and MAA

While LaQshya and MAA address distinct dimensions of maternal and newborn health, their combined implementation within facility settings has produced synergistic effects.[12,18] LaQshya's focus on quality labour room care creates the structural and procedural environment in which early breastfeeding support — as promoted by MAA — can be effectively delivered. For instance, LaQshya mandates immediate skin-to-skin contact and early breastfeeding initiation as part of its essential newborn care standards, directly reinforcing MAA's objectives.[1,18] The co-certification of facilities under both programmes has helped create coherent, breastfeeding-supportive maternity environments.

Evidence from states where both programmes have been jointly implemented suggests that the combination of quality obstetric care (LaQshya) with strong breastfeeding support (MAA) is associated with better outcomes than either programme alone.[14] Facilities that have achieved LaQshya certification alongside MAA recognition show higher rates of both respectful care and early breastfeeding initiation, reflecting the additive value of integrated programme delivery.[11]

7. Challenges, Gaps, and the Way Forward

Despite documented progress, both programmes face significant implementation challenges.[7] Human resource shortages remain a critical barrier — many primary health centres (PHCs) and community health centres (CHCs) lack the minimum skilled birth attendant workforce necessary to sustain LaQshya standards. High staff turnover in frontline health workers also undermines the durability of MAA training gains, necessitating continuous re-training.[1]

Equity gaps also persist. Rural, remote, and tribal populations continue to have lower access to LaQshya-certified facilities and MAA-trained providers. Health system strengthening efforts must prioritise these underserved populations to realise the full potential of both programmes. Furthermore, data quality issues in facility-level reporting limit the ability to accurately monitor programme coverage and outcomes at scale.[4]

Looking ahead, deeper integration of LaQshya and MAA standards within India's digital health architecture — including the Ayushman Bharat Digital Mission — and stronger linkage with community-level maternal and newborn health platforms will be essential. Investing in independent, rigorous evaluations using quasi-experimental designs will also be critical to building the evidence base on programme impact.[7]

8. Conclusion

The LaQshya and MAA programmes represent important and complementary milestones in India's journey toward quality maternal and newborn care. LaQshya has contributed to measurable improvements in the quality of obstetric care in institutional settings, reducing the risk of preventable maternal morbidity through evidence-based protocols, infection control, and respectful care.[16,18] MAA has catalysed a national shift in breastfeeding culture,

producing improvements in early breastfeeding initiation, colostrum feeding, and reductions in pre-lacteal feeds.[13] Together, these programmes have created a stronger platform for achieving India's maternal and newborn health goals under the Sustainable Development Goals (SDGs) and the National Health Policy 2017. Sustained political commitment, adequate resource allocation, and rigorous monitoring will be essential to consolidating and expanding these gains across all states and union territories.[14]

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Strengthening Newborn Survival: An Assessment of NSSK (Navjat Shishu Suraksha Karyakram) and Facility-Based Newborn Care Outcomes

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India accounts for one of the highest numbers of neonatal deaths globally, with a significant proportion occurring within the first 24 hours of life. Prior to the introduction of structured neonatal care training, many deliveries, especially in rural and resource-poor settings were attended by birth attendants without adequate resuscitation or newborn management skills. (Figure 1)

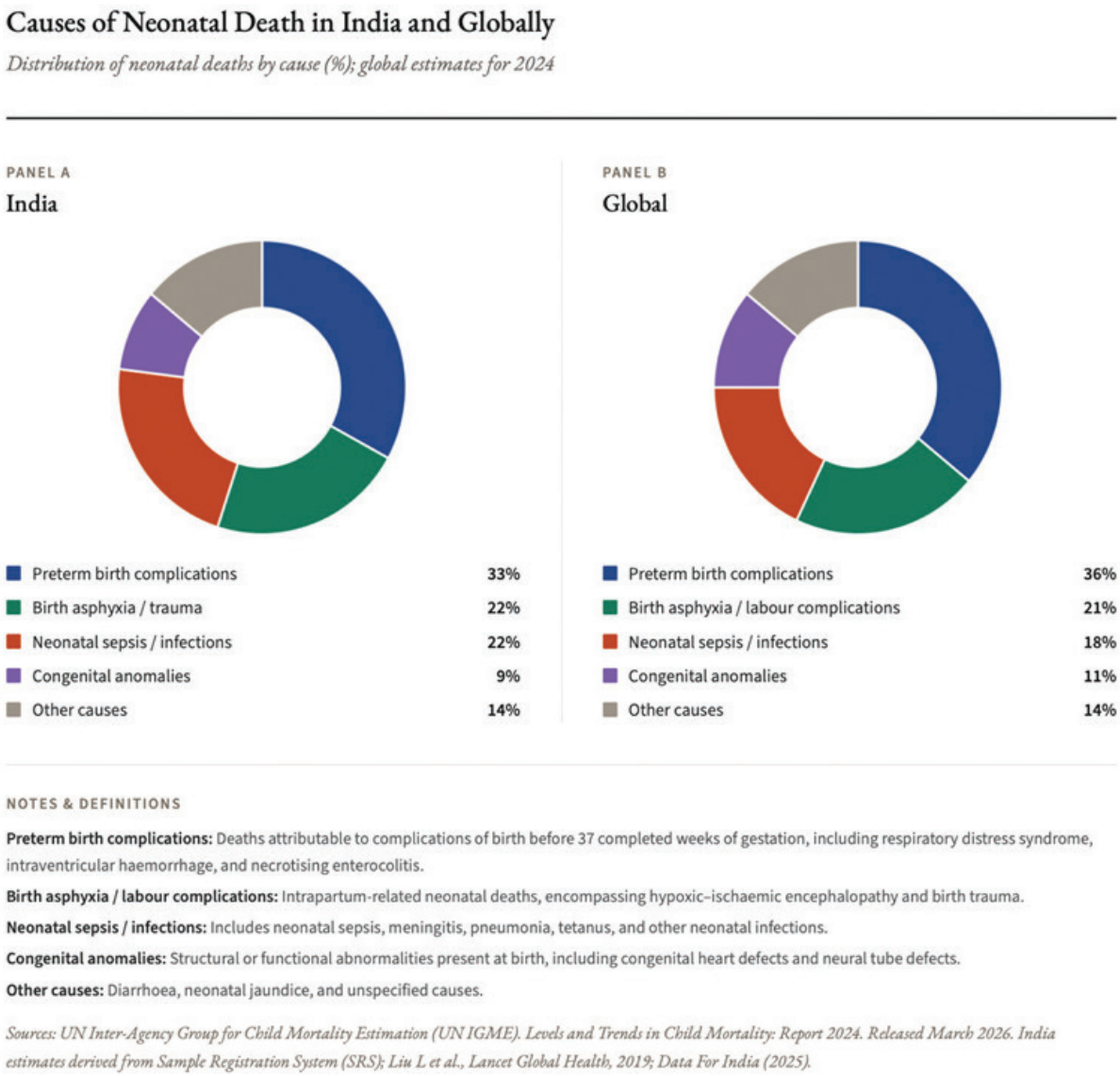

Fig 1. Causes of Neonatal mortality

To address this, the Ministry of Health and Family Welfare launched Navjat Shishu Suraksha Karyakram (NSSK) and developed a simple, scalable training module specifically designed for newborns and their resuscitation in urgent situations, focusing on evidence-based knowledge to improve medical assistance immediately after birth.

The Government of India has been implementing the NSSK since 2009 to build the capacity of doctors and nurses to provide essential newborn care around birth.

Programme Structure of NSSK and its Core Pillars

NSSK is a programme aimed to train health personnel in basic newborn care and resuscitation, addressing care-at-birth issues: Prevention of Hypothermia, Prevention of Infection, Early Initiation of Breastfeeding, and Basic Newborn Resuscitation. The objective is to have a trained health professional in basic newborn care and resuscitation **at every delivery point.** The program focuses on four primary interventions at birth to ensure immediate survival and long-term health:

(i) Basic Newborn Resuscitation: Training doctors, nurses, and ANMs to manage birth asphyxia using standardised protocols.

(ii) Prevention of Hypothermia: Ensuring warmth through immediate drying and skin-to-skin contact.

(iii) Prevention of Infection: Maintaining strict hygiene protocols during and after delivery.

(iv) Early Initiation of Breastfeeding: Facilitating breastfeeding within the first hour of life to improve nutrition and immunity.

The evidence behind the core pillars is summarised in Table 1.

Table 1: The core pillars of NSSK and the evidence level

Pillar	Intervention	Key outcome indicator	Evidence level
1. Resuscitation	Bag-mask ventilation within "Golden Minute"	Asphyxia-related NMR	WHO evidence-based
2. Hypothermia prevention	Immediate drying, skin-to-skin, wrapping	Thermal protection coverage	High (RCT evidence)
3. Infection prevention	Hand hygiene, cord care, clean delivery	Neonatal sepsis / pneumonia rate	High (RCT evidence)
4. Early breastfeeding	Initiation within 1 hour of birth	Early BF initiation rate	High (observational + RCT)

Training structure

The programme is designed as a two-day skill-based training course focusing on hands-on learning and practical demonstrations — using simulation-based teaching with neonatal manikins, stepwise demonstration of Essential Newborn Care (ENC) and Newborn Resuscitation, and focused sessions on infection prevention, thermal protection, and breastfeeding support.

The "Golden Minute" Doctrine

NSSK is a training initiative for healthcare workers to improve newborn care, especially during the critical "Golden Minute" after birth, training healthcare providers in essential newborn care and resuscitation to reduce neonatal mortality. **The Golden Minute Doctrine** aims at initiating the positive pressure ventilation within the first minute after birth, in neonates who have not cried after birth

The Neonatal Resuscitation Program (NRP) was initiated in 1987 to address the need for an educational program focusing on the initial management of newborns immediately after birth, offering a comprehensive and systematic training program that teaches psychomotor and teamwork skills. The program has been adopted in 130 countries worldwide.

NSSK has incorporated Basic Newborn Resuscitation including ventilation (Day 1) and essential newborn care including breastfeeding, Kangaroo Mother Care, prevention of hypothermia, and hand hygiene (Day 2).

Target Cadres

NSSK trains medical officers, paediatricians, and staff nurses; Auxiliary Nurse Midwives (ANMs), Lady Health Visitors (LHVs), and Skilled Birth Attendants (SBAs); and paramedical staff involved in delivery care. Training is implemented through State Institutes of Health and Family Welfare, District Training Centres, Medical Colleges, and District Hospitals.

NSSK is essential at all the levels of neonatal care

Levels of Neonatal Health care under Facility Based Newborn Care (FBNC) are the Newborn Care Corner (NBCC), Newborn Stabilisation unit (NBSU), Special Newborn Care Unit (SNCU) and Neonatal Intensive Care Units(NICUs). The level of care and the key functions are summarised in Table 1. It is to be noted that the nurses and the health care providers should be skilled in basic resuscitation at all the levels of neonatal care.

Table 1: Levels of neonatal care as per FBNC (Facility Based Newborn Care)

Facility / Unit	Level of Care	Location / Setting	Bed Capacity	Key Functions	Staffing Requirements
Newborn Care Corner (NBCC)	Essential / Primary	Labour Room & Obstetric OT; all facilities	Designated space (not bed-based)	Essential newborn care (ENC): skin-to-skin contact, airway maintenance, resuscitation support, early initiation of exclusive breastfeeding	Trained staff available round the clock
Newborn Stabilization Unit (NBSU)	First Level	Sub-district level: Community Health Centres (CHC) / First Referral Units (FRU)	4–6 beds (may include mother beds in MNSU configuration)	Basic care for sick and small newborns; first-level referral management; option for Mother–Newborn Stabilization Unit (MNSU) co-location	Basic nursing and medical staff; networked with referral units
Special Newborn Care Unit (SNCU)	Secondary Level	District hospitals, high-delivery load sub-district hospitals, medical colleges	Minimum 12 beds (may be larger)	Comprehensive secondary newborn care; 24×7 services for small and sick neonates not requiring surgical intervention or mechanical ventilation; training hub for MOs and nurses	Dedicated doctors, staff nurses, and support staff; adequately trained
Mother Newborn Care Unit (MNCU)	Secondary Level (integrated)	Within or alongside SNCU; NBSU beds may be converted	Co-located with SNCU / NBSU beds	Zero separation of mother and newborn; mother empowered in developmentally supportive care; mother's bed adjacent to radiant warmer	Same as SNCU / NBSU; emphasis on mother participation
Neonatal Intensive Care Unit (NICU)	Tertiary Level	Teaching hospitals (medical colleges) and district hospitals attached to medical colleges	Variable (as per tertiary centre capacity); includes intermediate nursery / step-down unit	Care for medically unstable or critically ill neonates; constant nursing; complex surgical procedures; continued respiratory support; intensive monitoring; also provides intermediate-level care	Continuously available neonatologists, neonatal nurses, respiratory therapists, and life-support equipment

In addition, referral linkage is an important component of the neonatal care provision and the core pillars of NSSK also apply during the transportation of sick neonates.

The mentoring and quality assurance checklists for NSSK trainings

Special Newborn Care Units (SNCU) and Newborn Stabilization Units (NBSU) are standardized under the National Health Mission (NHM) to ensure that the training provided in NSSK translates into high-quality clinical care.

I. SNCU Quality Assurance Checklist (The "Red" Drill)

Mentors and district officials use this checklist to assess the unit's readiness to handle critical neonates.

1. Infrastructure & Environment:
    i. Is the ambient temperature of the unit maintained between 26°C – 28°C?
    ii. Are there separate areas for "Clean" and "Sepsis" (infected) babies?
    iii. Is there a dedicated Kangaroo Mother Care (KMC) zone with comfortable chairs?

2. Equipment Readiness:
    i. Radiant Warmers: Are they functional with skin probes attached?
    ii. Phototherapy Units: Are the blue lights functioning (checked with a flux meter)?
    iii. Oxygen Sources: Are oxygen concentrators or cylinders available with functional flow meters?
    iv. Self-Inflating Bags: Are two sizes (250ml and 500ml) available with appropriate mask sizes (0 and 1)?
3. Clinical Protocols:
    i. Are Standard Treatment Guidelines (STGs) for Sepsis, Asphyxia, and Jaundice displayed on the walls?
    ii. Is the "Safe Injection Practice" followed (e.g., no multi-dose vials for different babies)?
    iii. Are hand-washing steps displayed at every hand-wash station?

II. NBSU Stabilization Checklist

Since NBSUs are at the Community Health Centre (CHC) level, the focus is on pre-referral stabilization.

1. Triage Assessment:
    i. Does the staff check for "Danger Signs" (e.g., grunting, convulsions, lethargy) within 5 minutes of arrival?
    ii. Is the Blood Glucose checked immediately for any baby with lethargy or poor feeding?
2. Emergency Interventions:
    i. Is the Vitamin K1 injection (1mg IM) administered to all out-born babies who haven't received it?
    ii. Is loading dose of Caffeine Citrate available for babies with apnea of prematurity?
    iii. For babies needing referral, is the "STABLE" mnemonic followed? (Sugar, Temperature, Airway, Blood Pressure, Lab Work, Emotional Support).

NSSK Curriculum Revision (2020)

With advances in evidence-based critical care, the NSSK package was updated in 2020 with a revised algorithm and improved training methodology. The revised NSSK curriculum is anticipated to enable healthcare providers in improving their clinical skills and practices and contribute to newborn survival. An NSSK Resource Manual and Flip Chart in pictorial format was also developed as a job-aid.

Mentorship & Skill Retention (NSSK 2020 Focus)

The revised guidelines emphasize that training is not a one-time event.

Mentors use a Skill Competency Checklist:

Table 2: Skill competency checklist for NSSK

Skill Area	Key Assessment Point
Bag & Mask	Can the provider achieve a visible chest rise within 3 breaths?
Suctioning	Does the provider suction the Mouth first, then the Nose?
KMC	Does the provider ensure the baby is in a "frog-like" position on the mother?
Thermoregulation	Does the provider use the "Foot vs. Abdomen" touch method to check for cold stress?

Impact on Neonatal Resuscitation Outcomes

1. Knowledge and Practice Improvement: Participants who underwent NRP/NSSK training were more likely to follow correct practices regarding meconium-stained liquor management (80% vs 53.1%, P=0.002) compared to those without training, demonstrating statistically significant improvement in one of the most critical intrapartum resuscitation scenarios.
2. Decline in Neonatal Mortality: India's Neonatal Mortality Rate (NMR) has declined steadily from 39 per 1,000 live births in 2005 to around 24 per 1,000 live births by 2023, partly attributable to initiatives like NSSK. Delivery room practices have improved, resulting in better management of asphyxia and prevention of hypothermia, and enhanced institutional deliveries and skilled birth attendance have contributed to declining neonatal mortality rates.
3. Reduction in Asphyxia and Infection Deaths: The Million Death Study (Lancet) showed a marked reduction in neonatal deaths due to infections (66% reduction) and asphyxia (76% reduction) from 2000 to 2015, saving approximately one million neonates. Repeated basic resuscitation training under NSSK has been credited with contributing to much lower mortality among outborn neonates.
4. Health Systems Perspective
    (i) Capacity Building at Scale: Since its inception, NSSK has led to significant improvements in newborn care practices across India, with hundreds of thousands of healthcare providers trained nationwide in essential newborn care and resuscitation. The programme has raised awareness about the importance of immediate care and breastfeeding within the golden hour after birth.
    (ii) Integration with the RMNCH+A Strategy: NSSK operates as part of the Reproductive,

Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategy, integrating newborn care through complementary programmes like Janani Shishu Suraksha Karyakram (JSSK), Facility-Based Newborn Care (FBNC) with Newborn Care Corners and SNCUs, and the LaQshya Programme for improving quality in labour rooms.

(iii) Post-Training Outcomes in Facilities: Following NSSK training, healthcare providers are equipped to provide essential care to newborns, identify and manage common complications, stabilise when necessary, and refer or transfer newborns requiring additional interventions.

Table 3 and Table 4 summarise the key impact of NSSK on practice and Neonatal mortality as a whole in the country.

Table 3: Practice Improvement outcomes post-NSSK training

Practice indicator	Trained providers	Untrained providers	Difference	Significance
Correct meconium-stained liquor management	80.0%	53.1%	+26.9 pp	p = 0.002
Bag-mask ventilation technique (correct)	~74%	~41%	+33 pp	Significant
Thermal wrap for ELBW neonates	~38%	~32%	+6 pp	Not significant
Correct cord clamping timing	~61%	~56%	+5 pp	Not significant
Breastfeeding within 1 hour initiation	~69%	~48%	+21 pp	Significant

TABLE 4: INDIA NMR & IMR trend (SRS DATA, 1990–2023)

Year	Programme milestone	NMR (per 1,000 LB)	IMR (per 1,000 LB)	U5MR (per 1,000 LB)
1990	Pre-NHM era	52	80	126
2000	Pre-NHM era	44	68	93
2005	NRHM launched (mid-year)	39	58	74
2009	NSSK launched	34	50	64
2013	NSSK scaled nationally	28	40	49
2014	NHM consolidated	26	39	45
2020	Revised NSSK launched	20	28	32
2021	Post-pandemic recovery	19	27	31
2023	Latest SRS estimate	19	25	—

Challenges and Gaps in implementation of NSSK (Table 5)

1. Inconsistent Implementation: An evaluation of NSSK implementation in Uttar Pradesh revealed gaps including inconsistent knowledge transfer and limited practical exposure. The program was subsequently revised to integrate adult learning principles, hands-on training, and better facilitator-to-participant ratios to ensure uniform skill acquisition.
2. Skill Attrition: Challenges to sustained impact include a shortage of trained personnel in rural and remote regions, inconsistent follow-up and refresher training leading to skill attrition, and insufficient supply chains for resuscitation and newborn care equipment.
3. Residual Gaps in Practice: Despite training, no significant difference was found between trained and untrained providers in areas such as application of thermal wraps for extremely low birth weight babies and timing of umbilical cord cutting — suggesting that certain practices require more reinforced, hands-on skill development beyond a two-day course.

Table 5: Key gaps and challenges in neonatal resuscitation that are covered under NSSK

Challenge domain	Specific gap	Impact	Recommendation
Skill retention	No structured refresher training cycle	High	Mandatory 6-month refresher via e-NSSK
Geographic equity	Rural/remote coverage gaps	High	Mobile simulation units for block-level training
Equipment supply	Resuscitation tools absent at PHC level	High	Mandatory Newborn Care Corner (NBCC) at all PHCs
Trainer quality	Facilitator-to-participant ratios inconsistent	Medium	National Master Trainer cadre with annual certification
Data feedback	HMIS lacks delivery-room outcome granularity	Medium	Real-time NSSK outcome capture via HMIS module
Community linkage	Postnatal follow-up by ASHAs inadequate	Medium	ASHA home visit checklist linked to NSSK outcomes

Sources: SRS Statistical Reports (RGI India); MoHFW Child Health Division; NHM HMIS; WHO IGME 2024; SRS CoD Statistics 2020–22; PMC/PubMed clinical studies on NSSK training outcomes. LB = live births; NMR = neonatal mortality rate; IMR = infant mortality rate; pp = percentage points.

Way Forward

To strengthen NSSK and sustain progress, future efforts must focus on universal training coverage to ensure all birth attendants are skilled in newborn care; digital learning and e-training platforms for continuous capacity-building; periodic skill assessments and refresher courses to maintain proficiency; improved supply chains for resuscitation equipment; enhanced data monitoring and real-time feedback systems; and community-level interventions through ASHAs for postnatal follow-up.

Further targeted intervention to tackle preventable causes, particularly perinatal asphyxia, sepsis, better antenatal care, and better management of preterm neonates, is needed urgently if India is to meet the SDG 3.2 target of reducing neonatal mortality to single digits by 2030. Additionally, region specific prioritisation should be done as per the state specific NMR.

Table 6: State-Wise NMR Disparity & NSSK Priority

State	NMR (per 1,000 LB)	Burden category	% of National Neonatal deaths	Priority
Kerala	5	SDG achieved	<1%	Maintenance
Tamil Nadu	12	SDG achieved	~2%	Maintenance
Punjab	18	Near target	~2%	Moderate
Rajasthan	23	High burden	~8%	High priority
Bihar	27	Very high burden	~12%	High priority
Madhya Pradesh	30	Very high burden	~13%	High priority
Uttar Pradesh	30	Very high burden	~22%	Highest priority

Source: srs 2019-202

Further Reading

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Quality of Postpartum Family Planning Services Under NHM: Provider Perspectives and Service Utilisation Patterns in India

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Introduction

Postpartum Family Planning (PPFP) is a crucial public health intervention aimed at preventing unintended and closely spaced pregnancies during the first year after childbirth. In India, where maternal health indicators have improved but still face challenges in reaching international standards, PPFP plays a vital role in reducing maternal mortality and supporting reproductive rights.

Under the National Health Mission (NHM), India has prioritized integrating family planning services into maternal and child healthcare. Despite progress, gaps in service quality, provider readiness, and utilization persist. The use of contraception choices in postpartum and postabortal period can have a incredible impact on material morbidity. PPFP is being defined as Post Pregnancy Family Planning to include both these periods. There is an emergent need for curative services in our country. The dire desire of women to avoid unintended pregnancy during these periods assures a significant possibility for acceptance of contraception.

Status of Contraceptive Use in India

A variety of sociodemographic and birth factors are found to be linked with postpartum contraceptive optimal utilization, and the patterns of use alter amongst adolescent and first-time mothers. Understanding the broader contraceptive landscape helps contextualize PPFP services.

The Contraceptive Prevalence Rate (CPR) in India increased to 65.7% (NFHS-5, 2019–21).[1] However, 33% of women still do not use any contraception. Female sterilization dominates (approximately 36%) permanent methods. Use of reversible methods remains low (around 2%). Postpartum contraceptive use is even lower. Only 45.6% of women adopt contraception within 12 months postpartum. Around 27% of births occur within 24 months, below recommended spacing.[2]

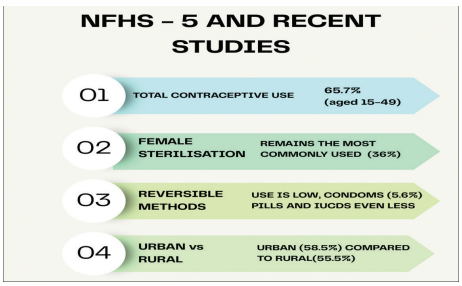

Figure 1. Depicting trends of contraceptive usage as per NFHS-5[1]

We find that 59% of Indian women used a method of contraception within the first year postpartum, that condoms and female sterilization were the most used methods, and that patterns of postpartum contraceptive use differed substantially by month, method, and subpopulation. Among postpartum contraceptive users, 9% switched methods, 19% stopped using contraception entirely, and 5% had another pregnancy within the first year postpartum.[3] These trends highlight the importance of strengthening PPFP under NHM.

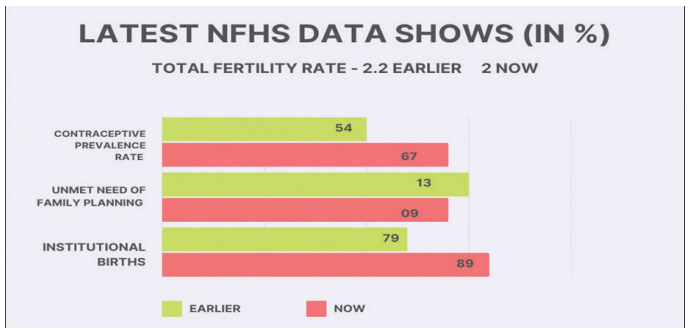

Figure 2. showing latest data changes as per NFHS-5[1]

NHM Framework

The Government of India has strengthened PPFP through NHM using a multi-pronged strategy:

- Integration with Maternal Health Services: PPFP counseling is provided during Antenatal care (ANC), while delivering in institution and during Postnatal care (PNC).
- Focused Initiatives like Mission Parivar Vikas for high fertility districts and ASHA-led community outreach
- Expanded Contraceptive Basket which includes Condoms, Oral pills, IUCDs (including PPIUCD), Injectable contraceptives (Antara), Centchroman (Chhaya), Implants

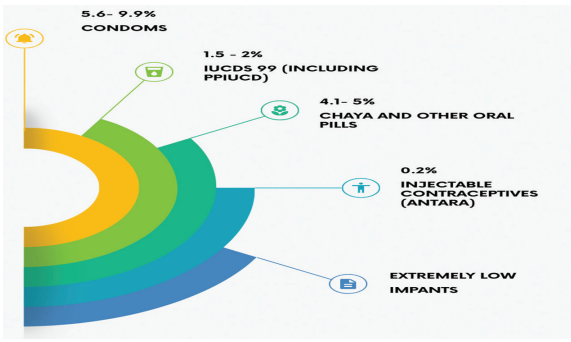

Figure 3. showing utilization of Expanded contraceptive basket.

Provider Perspectives

Healthcare providers are central to ensuring quality and uptake of PPFP services but there are certain constraints such as:

- Training and Skill Gaps: Although NHM provides training, it is inconsistent, with limited exposure to newer methods. Providers often feel the need for continuous professional development.
- Workload Constraints: High patient load in public facilities leads to shorter consultation time, reduced counseling quality and limited follow-up.
- Infrastructure Challenges: Providers face lack of space for individual counseling space, irregular contraceptive supply and limited equipment for PPIUCD services

Figure 4. Algorithm for PPFP service delivery under NHM.

Service Utilization Patterns[4]

- Timing of Adoption: Only 18% initiate contraception within 2 months postpartum. Around 45% adopt by 12 months postpartum. Delays increase the risk of unintended pregnancies.
- Method Preference: Low uptake of reversible spacing methods and increasing but limited use of injectables leads to irregular utilization of resources.
- Socioeconomic Inequalities: Utilization is higher among educated women, urban populations, higher income groups. Lower usage is seen among marginalized populations.
- Role of ASHA Workers: ASHAs contribute significantly by promoting awareness, ensuring follow-up, and facilitating access. However, their effectiveness depends on training and incentives.

Quality of PPFP Services

- Counseling Quality: Challenges faced liked limited time, method-specific bias and lack of client-centered approach
- Informed Choice: Women are often not informed about all options and hence consent may not be fully informed
- Follow-Up Care: Weak tracking systems lead to poor continuity of care and high discontinuation rates
- Respectful Care is often neglected in contraception services. Issues include lack of privacy, poor communication and provider bias. These reduce service trust and uptake.

Figure 5. Key challenges faced by health care providers.

Strengthening PPFP

CAPACITY BUILDING	IMPROVED COUNSELLING	INFRASTRUCTURE STRENGTHENING	TECHNOLOGY INTEGRATION	COMMUNITY ENGAGEMENT
REGULAR TRAINING	DIGITAL TOOLS	ENSURE PRIVACY	MOBILE TRACKING SYSTEMS	MALE PARTICIPATION
SKILL CERTIFICATION	VISUAL AIDS	IMPROVE LOGISTICS	TELE HEALTH FOLLOW UPS	AWARENESS CAMPAIGNS
MENTORSHIP PROGRAMS	STANDARDISED PROTOCOLS	MAINTAIN SUPPLY CHAINS		ADDRESS MYTHS

Figure 6. Tools for strengthening PPFP services.

Discussion

Studies show that pregnancies taking place within 2 years of a previous birth have a higher risk of adverse outcomes like abortions, premature labor, postpartum hemorrhage, low birth weight babies, fetal loss and maternal death. According to the AHS 2012-13 data, only 43.7% births in U.P. were born after a birth interval of more than 36 months which implies that more than half of the pregnancies are high risk pregnancies highlighting the urgent need for post-partum family planning.[5]

India has made substantial progress in family planning, as reflected in declining fertility rates (TFR 2.0) and increased contraceptive use. However, postpartum family planning remains underutilized compared to overall contraceptive prevalence. The dominance of sterilization highlights a skewed method mix, indicating the need for greater emphasis on spacing methods. Provider behavior, system readiness, and socio-cultural factors collectively influence PPFP uptake. Strengthening PPFP requires a continuum-of-care approach, integrating services from pregnancy to postnatal stages, supported by community-level interventions.

Therefore, counselling and provision of family planning methods during the postpartum period is critical to ensure the health of both the mother and child. Recent studies estimate that the prevention of unplanned and unwanted pregnancies could help avert 20-35% of maternal deaths.[6]

Evidence also indicates that the provision of postnatal family planning counselling increases contraceptive awareness and use. The presence of health staff bias and lack of knowlegde, skills and support remain a major matter of concern. Our clients possess limited concerns and knowledge about method use. Moreover, sociocultural and gender norms predispose to the available problem.

Conclusion

Postpartum Family Planning is a critical yet underutilized component of reproductive healthcare in India. Under NHM, significant progress has been made in expanding access and integrating services. However, challenges related to quality, provider capacity, and utilization patterns remain. Provider perspectives highlight the need for improved training, infrastructure, and supportive supervision. Utilization patterns reveal persistent inequalities and delays in adoption.

To achieve better maternal health outcomes, we must:

- Strengthen service quality
- Promote spacing methods
- Ensure informed choice
- Address socio-cultural barriers

A comprehensive and client-centered approach to PPFP can significantly enhance reproductive health outcomes and contribute to sustainable development goals.

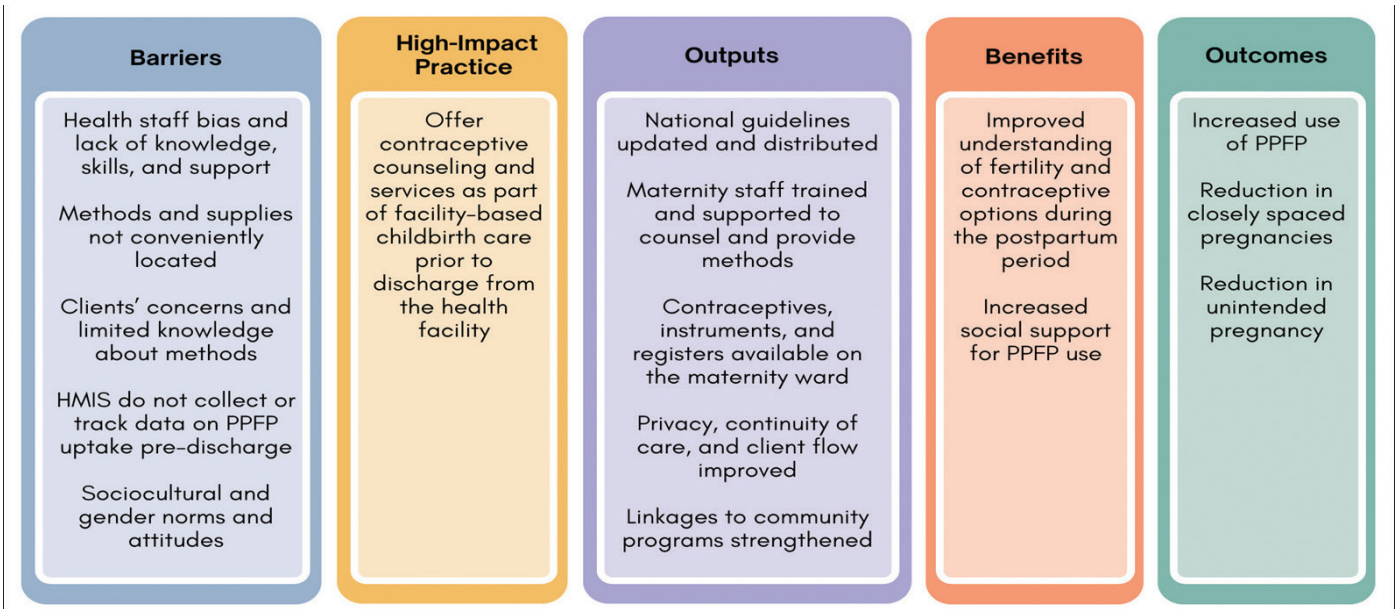

Figure 7. Summarising PPFP structure services.

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Match the Mission: Decode India's Health Programs

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	LOGO	NATIONAL PROGRAMME
1.		A. PMSMA
2.		B. Mid-Day Meal Scheme
3.		C. Ayushman Bharat
4.		D. Janani Suraksha Yojana
5.		E. Family Planning Mission
6.		F. National Rural Health Mission
7.		G. Beti Bachao Beti Padhao
8.		H. Anaemia Mukt Bharat
9.		I. LaQshya
10.		J. Swachh Bharat Mission
11.		K. Poshan Abhiyaan
12.		L. Mission Indradhanush

ANSWERS

1 - E; 2 - J; 3 - D; 4 - I; 5 - C; 6 - H; 7 - B; 8 - L; 9 - G; 10 - A; 11 - F; 12 - K

AOGD Clinical Meet from LHMC & SSK Hospital held on 27th March 2026

Genetic Predisposition Meets A Rare Malignancy- A case report

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Background

Cowden syndrome is a rare autosomal dominant disorder a variant of PTEN Hamartoma syndrome characterized by germline PTEN mutations, conferring increased risk of multiple malignancies, particularly endometrial carcinoma. Association with uterine carcinosarcoma is exceedingly rare and sparsely reported.We report a 30-year-old nulligravida presenting with abnormal uterine bleeding and vaginal discharge. Examination revealed a large polypoidal mass arising from the endocervical canal. Imaging suggested a uterine malignancy, and the patient underwent comprehensive surgical staging. Histopathology confirmed high-grade uterine carcinosarcoma with deep myometrial invasion, cervical stromal involvement, and metastatic deposits in the ovaries and sigmoid colon. Immunohistochemistry showed ER/PR negativity, intact mismatch repair proteins, and wild-type p53. The presence of macrocephaly prompted genetic evaluation, leading to a diagnosis of Cowden syndrome.

Discussion

Cowden syndrome is strongly associated with endometrioid endometrial carcinoma; however, its association with carcinosarcoma is extremely rare. PTEN loss activates the PI3K/AKT/mTOR pathway, contributing to aggressive tumor biology and epithelial–mesenchymal transition. Literature review reveals only isolated reports of gynecological malignancies beyond endometrioid histology, highlighting the uniqueness of this case.

Conclusion

This case underscores the importance of recognizing syndromic clues such as macrocephaly in young patients with aggressive gynecologic malignancies. Early identification of hereditary cancer syndromes enables personalized management, targeted therapy, and familial risk assessment, shifting the paradigm toward preventive oncology.

"Scar That Conceals: Experience Unveils"

Ratna Bisawas, Swati Agrawal, Deepika, Reetu Yadav

Background

Caesarean scar pregnancy (CSP) is a rare type of ectopic pregnancy in which implantation occurs on previous caesarean scar, with an incidence of approximately 1:1800–1:2200 pregnancies. It is associated with serious complications such as uterine rupture, massive hemorrhage, hysterectomy, and future placenta accreta spectrum disorders if pregnancy continues. Early diagnosis and timely management are crucial to prevent morbidity and preserve fertility.

Objectives

To evaluate the management strategies, efficacy, and safety of different treatment modalities in patients diagnosed with CSP.

Methods

A retrospective observational study was conducted at the Department of Obstetrics and Gynaecology, LHMC, over a period of 4 years (March 2022–February 2026). A total of 23 cases diagnosed with CSP on ultrasonography were included. Diagnosis was based on standard ultrasound criteria including empty uterine cavity and cervical canal, gestational sac embedded in the caesarean scar, thin or absent myometrium (1–3 mm), and increased vascularity.

Results

Out of 23 cases, 12 were managed medically and 11 underwent surgical or combined interventions.

- Medical management included intra-sac methotrexate (6 cases, 100% success), systemic methotrexate, and combined regimens (I/C KCl with IM methotrexate) failures were noted in 3 cases subsequent intervention done.
- Surgical approaches included hysteroscopic evacuation (3), laparotomy excision (3), laparoscopic excision (2), uterine artery embolization (1), USG-guided evacuation (1), and hysterectomy (1)
- Surgical approaches with / without preceding medical intervention had a success rate of 91 % as compared to 75 % in only medical group with complications rate of 9.1% & 16.6 % respectively.

Conclusion

Medical management is effective in early CSP (gestation <8 weeks, β-hCG <100,000), while surgical intervention is preferred in advanced gestation, presence of fetal cardiac activity, high β-hCG levels >1,00,000 or hemodynamic instability. A combined surgical approach with haemostatic measures (intra-myometrial vasopressin, uterine/ internal

iliac artery ligation) enhanced efficacy and minimized complications such as massive hemorrhage.

Images:

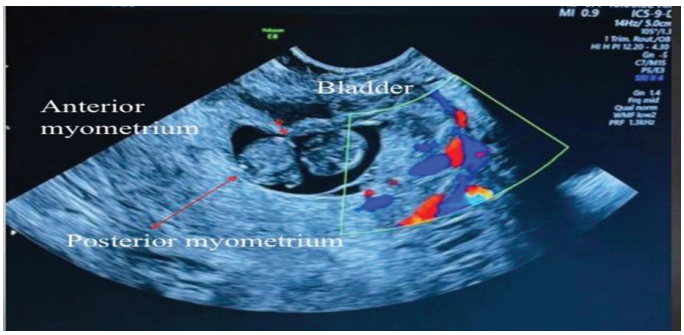


Figure 1: ultrasound imaging of caesarean scar pregnancy

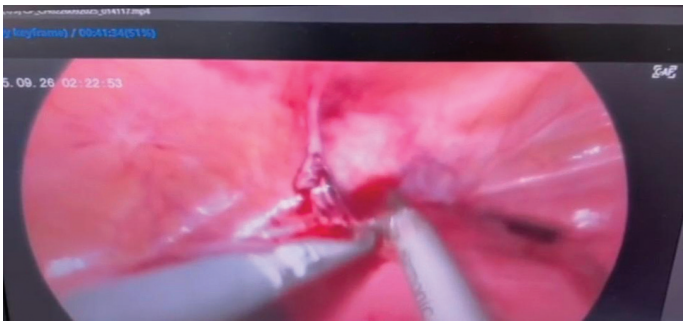


Fig 2: Per-op uterovesical fold has been dissected

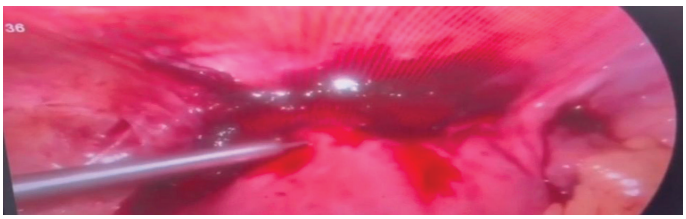


Figure 3: Vasopressin is being injected for devascularization

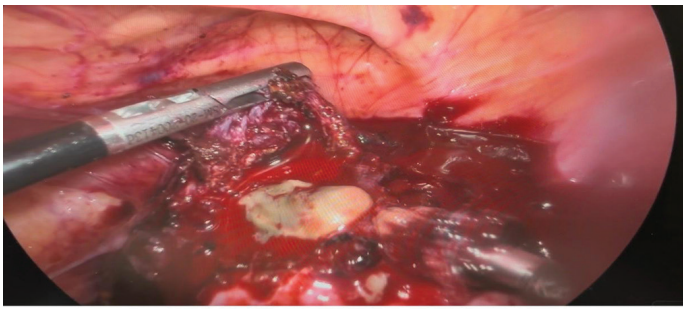


Figure 4 : Fetus is seen after resection

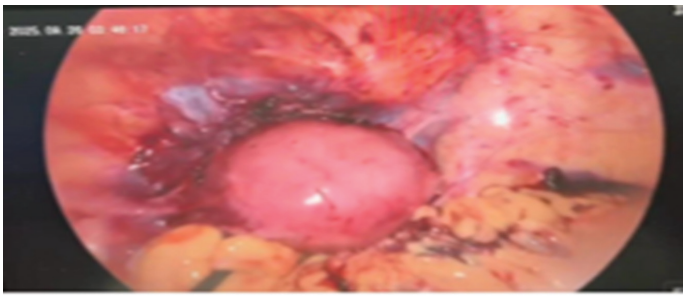


Figure 5 : Post surgery view of repaired uterus

Analysis of fetal short femur: factors that influence clinical decision pathways

Fetal Medicine team, Lady Hardinge Medical College

Introduction

The skeletal dysplasias pose a particular diagnostic challenge due to their rarity, phenotypic overlap, and the dynamic evolution of sonographic features across gestation.

Objective

To evaluate the relative prevalence of skeletal dysplasia (SD) and delineation of antenatal ultrasound markers aiding diagnosis of SD in cases with short femur.

Method

The records of targeted ultrasound of fetuses with suspected SD from 2021–2025 were reviewed. Femur length was expressed as standard deviations below mean and associated visceral and skeletal abnormalities were recorded among diagnosed and undiagnosed cases.

Results

A total of 76 cases were fully followed; the mean gestational age was 28.2±6.6 weeks. Majority of the cases were detected in the late second or early third trimester. More than two-third of them were suspected to have SD, whereas the rest were either FGR or constitutionally small fetus. The ultrasound findings guided us to distinguish FGR and constitutionally small fetuses from SD cases. It was a valuable tool in determining lethality. The molecular testing could be done in only one third of the suspected SD cases. Apart from ultrasound findings such as severely short femur, polydactyly, poor mineralization and fractures, the bending of femur, narrow thorax, micrognathia, visceral anomalies helped in pinning the clinical diagnosis of SD in many cases. The FL/AC and TC/AC ratio individually had less sensitivity and high specificity for the prediction of lethality, but had 100% sensitivity for lethality prediction if both were abnormal.

Fetal growth restriction was diagnosed in 17/76 (22.4%), familial short stature in 4/76 (5.3%). SD was suspected in 55/76 (72.3%). Among them, the genetically diagnosed, clinically suspected, and undiagnosed cases were 19/55 (34.5%), 24/55 (43.6%), and 12/55 (21.8%). Bent femur was most common anomaly (29/55, 52.7%), followed by narrow thorax (20/55, 36.4%). Renal anomaly was the commonest visceral anomaly (5/55, 9.1%). The diagnosis of SD subtype was made in 40/76 (52.6%). Ciliopathies were the largest group (12/40, 40%), followed by osteogenesis imperfecta (11/40, 27.5%).

Conclusion

The study highlights the importance of structured ultrasound assessment and pattern recognition in skeletal dysplasia along with genetic testing for improved clinical decision-making and parental counselling.

Congratulations

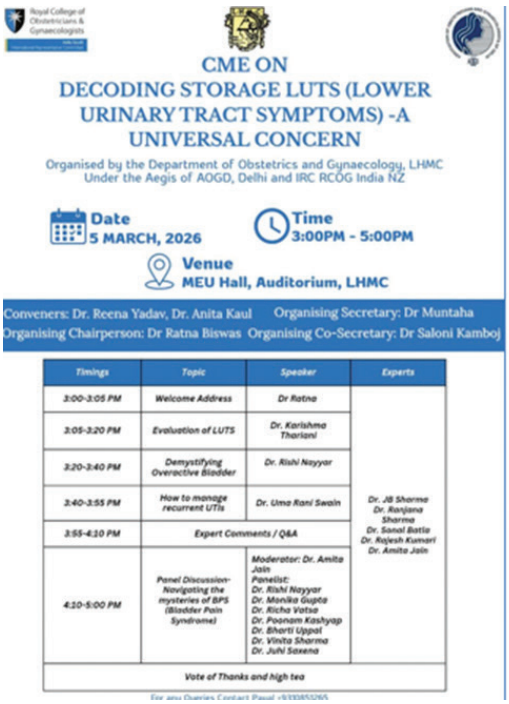
Newly elected AOGD Sub - Committee Chairpersons (2026-28)

2026-2028			
Sub-Committee	**Chairperson**	**Contact No.**	**Email**
Menopause & Geriatrics Subcommittee (New)	Dr Meenakshi Ahuja	9810264890	atulmeenakshi@gmail.com
Infertility & Reproductive Endocrinology sub-committee	Dr Bindu Bajaj	9711067661	Bindubajaj15@gmail.com
Community Health & Public Awareness sub-committee	Dr Divya Singhal	9810414914	drdivyasinghal@gmail.com
Safe Motherhood sub-committee	Dr Ratna Biswas	9971372695	drratnabiswaspaul@yahoo.co.in
Medico-legal sub-committee	Dr Susheela Gupta	9312234911	drsusheelagupta@gmail.com

2025-2027			
Sub-Committee	**Chairperson**	**Contact No.**	**Email**
Adolescent Health sub-committee	Dr Dipti Nabh	9810212166	diptinabh@gmail.com
Endometriosis sub-committee	Dr Rita Bakshi	9810143703	ritabakshi.ifc@gmail.com
Endoscopy sub-committee	Dr Kanika Jain	9811022255	drkanika@gmail.com
Fetal Medicine and Genetics sub-committee	Dr Upma Saxena	9910829017	upma_saxena@hotmail.com
Oncology sub-committee	Dr Bindiya Gupta	9810719002	dr_bindiya_gupta@yahoo.co.in
QI Obst & Gynae Practice sub-committee	Dr Surveen Ghumman	9810475476	surveen12@gmail.com
Urogynaecology sub-committee	Dr Sonal Bhatla	9811444563	drsonalbathla11@gmail.com

Events Held March 2026

CME on "Decoding Storage LUTS– A Universal Concern" conducted by Dept. of Obst. & Gynae, LHMC & SSK Hospital under the aegis of AOGD and IRC RCOG India NZ on 5th March, 2026 at LHMC



CME ON
DECODING STORAGE LUTS (LOWER URINARY TRACT SYMPTOMS) -A UNIVERSAL CONCERN

Organised by the Department of Obstetrics and Gynaecology, LHMC
Under the Aegis of AOGD, Delhi and IRC RCOG India NZ

Date
5 MARCH, 2026

Time
3:00PM - 5:00PM

Venue
MEU Hall, Auditorium, LHMC

Conveners: Dr. Reena Yadav, Dr. Anita Kaul Organising Secretary: Dr Muntaha
Organising Chairperson: Dr Ratna Biswas Organising Co-Secretary: Dr Saloni Kamboj

Timings	Topic	Speaker	Experts
3:00-3:05 PM	Welcome Address	Dr Ratna	Dr. JB Sharma Dr. Ranjana Sharma Dr. Sonal Batla Dr. Rajesh Kumari Dr. Amita Jain
3:05-3:20 PM	Evaluation of LUTS	Dr. Karishma Thariani	
3:20-3:40 PM	Demystifying Overactive Bladder	Dr. Rishi Nayyar	
3:40-3:55 PM	How to manage recurrent UTIs	Dr. Uma Rani Swain	
3:55-4:10 PM	Expert Comments / Q&A		
4:10-5:00 PM	Panel Discussion- Navigating the mysteries of BPS (Bladder Pain Syndrome)	Moderator: Dr. Amita Jain Panelist: Dr. Rishi Nayyar Dr. Monika Gupta Dr. Richa Vatsa Dr. Poonam Kashyap Dr. Bharti Uppal Dr. Vinita Sharma Dr. Juhi Saxena	
Vote of Thanks and high tea			

CME on Decoding the Fetus Basics of Fetal Health & Genetics Through Real-Life Cases" conducted by Fetal Medicine & Genetics Subcommittee AOGD, in association with the SFM on 07th March 2026 at Safdarjung Hospital

SCIENTIFIC PROGRAMME

Decoding the Fetus: Basics of Fetal Health & Genetics Through Real-Life Cases

Date: Saturday, 7th March 2026 | Time: 9:00 AM – 5:00 PM

Venue: Old LT, Behind OPD Block, VMMC & Safdarjung Hospital, New Delhi – 110029

Organized by:
Department of Obstetrics & Gynaecology, VMMC & Safdarjung Hospital
Fetal Medicine & Genetics Subcommittee
Under the aegis of: Association of Obstetricians & Gynaecologists of Delhi (AOGD)
In association with: Society of Fetal Medicine (SFM)

Dr. Bindu Bajaj
Dr. Upma Saxena
Dr. Sumita Bachani
Dr. Dipika Logarwy
Dr. Abhishek Lachyan

MOC: Dr. Anita Kumar / Dr. Sugandha Dev

Guest of Honour
- Dr. Sandeep Bansal (Director, VMMC & SJH)
- Dr. Geetika Khanna (Principal, VMMC)
- Dr. Charu Bamba (MS, Safdarjung Hospital)
- Dr. Reena Yadav (President-AOGD)

Dr. Ashok Khurana

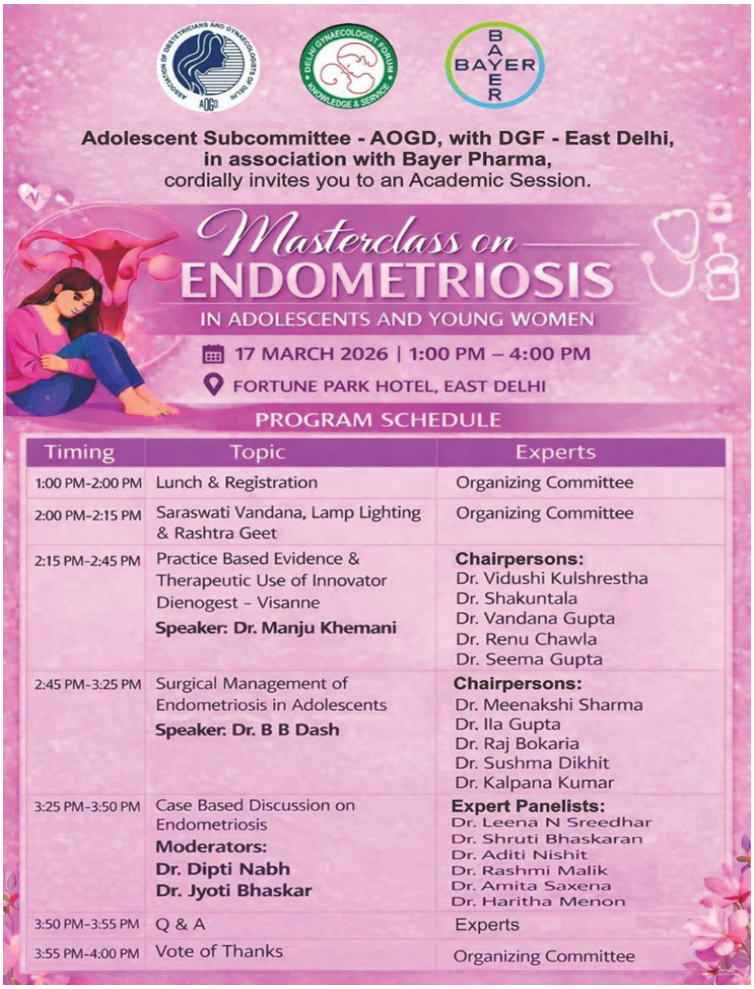
Community Health & Public Awareness Subcommittee celebrated the International Women's Day on the theme "Give to Gain" on 9th March 2026 at DGD , Vasundhara enclave

CME on "Essentials of Obstetric Critical Care " conducted by Dept. of Obst. & Gynae, LHMC & SSK Hospital under the aegis of AOGD on 14th March 2026 at LHMC


CME CUM WORKSHOP ON
Essentials of Obstetric Critical Care 2026
Organized by
Department of Obstetrics and Gynaecology, LHMC, New Delhi
Under the aegis of AOGD, Delhi
Date: 14 March 2026
Venue: Mini auditorium, 5th Floor, New Academic Block, LHMC
Dr Reena Yadav, Convener
Dr Ratna Biswas, Convener
Dr Aishwarya Kapur, Co-Convener
Dr Kanika Chopra, Co-Convener
Chief guest: Dr Sarita Beri
Guest of Honour: Dr Kamal Bukshee, Dr Anju Seth
MOC: Dr Reetu Yadav, Dr Saloni Kamboj
Register via the link below

TIME	TOPIC	SPEAKER	CHAIRPERSON
09:30AM - 10:00 AM	Registration		
10:00AM - 10:05 AM	Introduction to CME	Dr Ratna Biswas	
SESSION 1			
10:05AM - 10:15AM	Obstetric Early Warning Scores- Rationale and Implication	Dr Kanika Chopra	Dr Asmita Rathore Dr Sonal Bhatla Dr Anuradha Singh Dr Vidhi Chaudhary
10:15AM - 10:30AM	Basics of ABG and its Clinical application in Obstetric Emergencies	Dr Rekha Bharti	Dr Ashok Kumar Dr Sharda Patra Dr Rachna Aggarwal Dr Meenakshi Singh
10:30AM - 10:45AM	Fluid MANAGEMENT- Including Goal Directed Therapy	Dr Ratna Biswas	Dr S S Trivedi Dr Achla Batra Dr Shilpi Nam Dr Aishwarya Kapur
10:45AM - 11:00AM	Understanding Oxygen Therapy in Management of Acute Dyspnea in Pregnancy	Dr Ranju Singh	Dr Rinku Sen Gupta Dr Bindu Bajaj Dr Swati Agrawal Dr Archana Singh
11:00AM - 11:10AM	DISCUSSION		
11:10AM - 11:25AM	Inauguration		
11:25AM - 11:45AM	TEA BREAK		
SESSION 2			
11:45AM - 12:00PM	Massive Transfusion Protocol and Viscoelastic Tests in Massive Obstetric Hemorrhage	Dr Nishant Kumar	Dr Kiran Aggarwal Dr Geeta Mendiratta Dr Manisha Kumar Dr Aruna Nigam
12:00PM - 12:15PM	Maternal Safety Bundle for Sepsis in Pregnancy	Dr Reena Yadav	Dr Kiran Guleria Dr Pikee Saxena Dr Deepa Gupta Dr Apoorva Kulshreshtha
12:15PM - 12:30PM	Cardiogenic Shock: Evaluation and Management	Dr Nalini Bala Pandey	Dr Deepti Goswami Dr Taru Gupta Dr Vidushi Kulshreshtha Dr Mumtaha Khan
12:30PM - 12:40PM	DISCUSSION		
SESSION 3			
12:40PM - 01:30PM	Live Demonstration Workshop 1) POCUS -IVC, Cardiac evaluation 2) Maternal CPR on Mannequin	Dr Ratna Biswas/ Dr Nalini/ Dr Kanika Chopra/ Dr Shivangini Sinha/ Dr Neha Sharma Dr Nishant	
01.30PM Onwards	LUNCH		

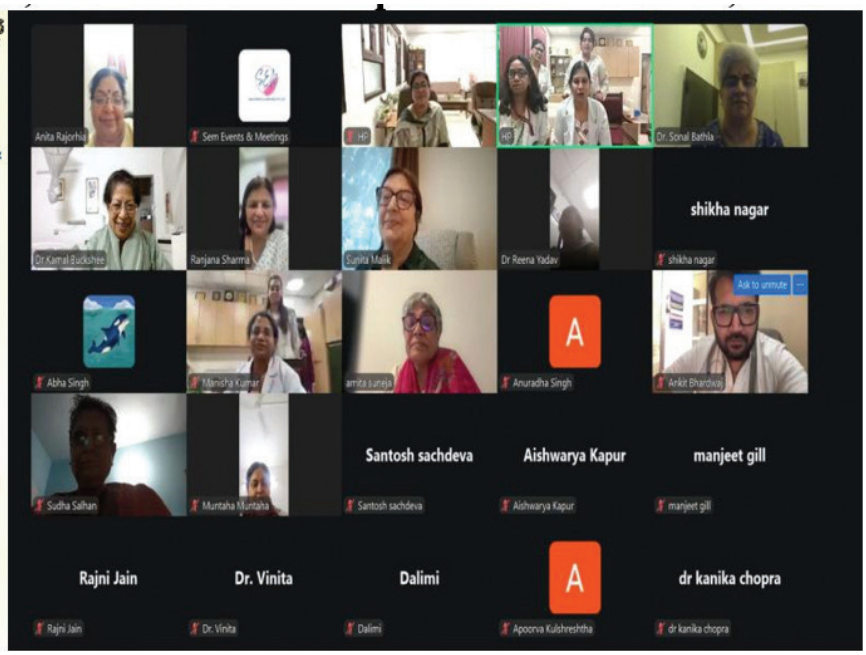
Master class on Endometriosis in Adolescent & young women conducted by Adolescent Subcommittee AOGD in association with DGF on 17th March 2026



Timing	Topic	Experts
1:00 PM-2:00 PM	Lunch & Registration	Organizing Committee
2:00 PM-2:15 PM	Saraswati Vandana, Lamp Lighting & Rashtra Geet	Organizing Committee
2:15 PM-2:45 PM	Practice Based Evidence & Therapeutic Use of Innovator Dienogest - Visanne **Speaker: Dr. Manju Khemani**	**Chairpersons:** Dr. Vidushi Kulshrestha Dr. Shakuntala Dr. Vandana Gupta Dr. Renu Chawla Dr. Seema Gupta
2:45 PM-3:25 PM	Surgical Management of Endometriosis in Adolescents **Speaker: Dr. B B Dash**	**Chairpersons:** Dr. Meenakshi Sharma Dr. Ila Gupta Dr. Raj Bokaria Dr. Sushma Dikhit Dr. Kalpana Kumar
3:25 PM-3:50 PM	Case Based Discussion on Endometriosis **Moderators:** **Dr. Dipti Nabh** **Dr. Jyoti Bhaskar**	**Expert Panelists:** Dr. Leena N Sreedhar Dr. Shruti Bhaskaran Dr. Aditi Nishit Dr. Rashmi Malik Dr. Amita Saxena Dr. Haritha Menon
3:50 PM-3:55 PM	Q & A	Experts
3:55 PM-4:00 PM	Vote of Thanks	Organizing Committee

Workshop on PPH conducted by Safe Motherhood Subcommittee on 19th March 2026 at Shalimar Bagh

The AOGD Monthly Clinical Meeting (virtual) conducted by the Department of Obst & Gynae, LHMC & SSK Hospital on 27th March, 2026



General Body Meeting and Handing over Ceremony organized by Department of Obst. & Gynae., LHMC & SSK Hospital on 30th March, 2026 at MEU Hall, LHMC





Association of Obstetricians & Gynaecologists of Delhi

MEMBERSHIP FORM

Name:.....

Surname: .....

Qualification (year): .....

Postal Address: .....

City:..... **State:** ..... **Pin code:** .....

PHOTO

Place of Working: .....

Residence Ph. No. ..... **Clinical / Hospital Ph. No.** .....

Mobile No:..... **Email:** .....

Gender: Male:..... **Female:**.....

Date of Birth: Date.....**Month** ..... **Year**.....

Member of Any Society:.....

Proposed by .....

Cheque/DD / No: .....

Cheque/Demand Draft should be drawn in favour of: **Association of Obstetricians and Gynaecologists of Delhi**

FOR ONLINE TRANSFER THROUGH NEFT/RTGS

Name of Account: Association of Obstetricians and Gynaecologists of Delhi
Account no: 5786412323
Name of Bank: Central Bank of India
Branch: LHMC & SSK Hospital
IFSC code: CBIN0283462
MICR code: 110016067

ASSOCIATION OF OBSTETR

12418708@cbin

BHIM UPI

For Life Membership	: Rs. 11,000 + Rs. 1,980 (18% GST applicable) = Rs. 12,980
For New Annual Membership*	: Rs. 2,000 + Rs. 360 (18% GST applicable) = Rs. 2,360
For Old Renewal Membership+	: Rs. 1,200 + Rs. 216 (18% GST applicable) = Rs. 1,416

Encl.: Attach Two Photocopies of All Degrees, DMC Certificate and Two Photographs (Self attested)

*** Annual Membership is for the calendar year January to December.**

*** In case of renewal, mention old membership number.**

Note: 18% GST will be applicable as FOGSI requires it.

Send Complete Membership Form Along With Cheque / DD and Photocopy of required documents to the secretariat.
For online transaction send scan copy of all documents with payment slip on given mail id

Secretariat
Department of Obstetrics and Gynaecology
Lady Hardinge Medical College & SSK Hospital, New Delhi-110001
Tel.: 011-23408297, (M): 9717392924 | Email Id: aogdlhmc2025@gmail.com

AOGD SECRETARIAT
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