

Case Report

Beyond safe delivery: integrating maternal anaemia management, Janani Suraksha Yojana and girl child promotion – a rural facility experience from Northern India

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ABSTRACT

Maternal and newborn health requires a continuum of care extending from early pregnancy registration to the postnatal period, particularly in rural settings. This case report describes an integrated maternal healthcare experience at Community Health Centre (CHC) Faridpur, Bareilly, Uttar Pradesh, India, combining routine antenatal care, maternal anaemia screening and prevention, Janani Suraksha Yojana (JSY) facilitation, respectful maternity care, skilled institutional delivery, essential newborn care, and postnatal counselling. A 25-year-old pregnant woman from a rural area registered during the first trimester and received multidisciplinary antenatal care, haemoglobin screening, iron-folic acid and calcium supplementation, nutritional counselling, birth-preparedness counselling, and assistance with JSY documentation. On 19 July 2026, she presented at term with spontaneous labour and underwent an uncomplicated normal vaginal delivery. A healthy female infant weighing 2690 g was delivered with immediate spontaneous cry. Evidence-based intrapartum and newborn practices included labour monitoring, delayed cord clamping, skin-to-skin contact, thermal protection, early initiation of breastfeeding, and postpartum counselling. The family positively celebrated the birth of the daughter with the message “Mere Ghar Lakshmi Aayi Hai,” providing an opportunity for gender-equity messaging within routine maternity care. This case illustrates the feasibility of integrating clinical care, maternal nutrition, government maternity schemes, respectful care, newborn practices, and community engagement within an existing rural government facility. Such an approach may provide a practical and replicable framework for strengthening maternal and newborn healthcare while promoting positive attitudes toward the girl child.

Keywords: Maternal health, Safe motherhood, Community health centre, Janani Suraksha Yojana, Maternal anaemia, Respectful maternity care, Rural health, Girl child promotion

INTRODUCTION

Safe motherhood depends not only on institutional delivery but on timely antenatal care, prevention and management of maternal anaemia, skilled birth attendance, respectful maternity care, essential newborn care, and appropriate postnatal follow-up. Maternal and neonatal deaths remain important public health concerns

in low- and middle-income countries, although substantial progress has been made through expansion of antenatal and institutional services.¹⁻⁴

India has strengthened maternal healthcare through the National Health Mission and programmes including JSY, Janani Shishu Suraksha Karyakram (JSSK), Pradhan

Mantri Surakshit Matritva Abhiyan (PMSMA), Anaemia Mukd Bharat (AMB), and LaQshya.⁵⁻⁹

These initiatives address access, financial barriers, anaemia, quality of care, and safe childbirth. Respectful maternity care is also an important component of quality because privacy, dignity, informed communication, and emotional support influence the childbirth experience and trust in health services.^{3,4,10-12}

CHC Faridpur, Bareilly, Uttar Pradesh, functions as a rural secondary-level referral facility providing maternal and newborn services. The centre has integrated antenatal assessment, maternal anaemia screening, nutrition counselling, JSY facilitation, skilled institutional delivery, respectful maternity care, essential newborn care, and postnatal counselling into a continuum of care. This case report describes one illustrative beneficiary journey through this integrated model and highlights how routine maternity care can also provide an opportunity to promote positive attitudes toward the girl child.

CASE REPORT

A 25-year-old pregnant woman (Mrs. X) residing in the rural service area of CHC Faridpur registered her pregnancy during the first trimester. She belonged to a rural family of modest socioeconomic status and had adequate family support. No documented history of hypertension, diabetes mellitus, thyroid disease, epilepsy, cardiac illness, or other chronic medical disorder was reported. At registration, the pregnancy was considered low risk.

The beneficiary received care from a multidisciplinary team comprising Medical Officers, Nursing Officers/Staff Nurses, ANMs, ASHAs, laboratory personnel, pharmacists, and counsellors. Antenatal assessment included obstetric and medical history, physical examination, blood pressure and weight assessment, nutritional assessment, obstetric examination, routine laboratory investigations, and pregnancy risk assessment. Haemoglobin estimation, blood grouping and Rh typing, blood glucose testing, urine examination, and screening for HIV, hepatitis B surface antigen, and syphilis were undertaken according to routine protocols.

During pregnancy, maternal anaemia prevention and monitoring were incorporated into routine antenatal care through the facility's Maternal Anaemia Corner. Severe anaemia was not identified in this beneficiary.

She received iron-folic acid and calcium supplementation, individualized nutrition counselling, advice on locally available iron-rich foods and dietary diversification, counselling regarding adherence to supplementation, and follow-up haemoglobin monitoring. Family members were included in counselling to support dietary and treatment adherence.

During the third trimester, the woman and her family received birth-preparedness and complication-readiness counselling. This included recognition of labour and obstetric danger signs, emergency transportation, institutional delivery, skilled birth attendance, immediate newborn care, and early breastfeeding. JSY counselling and documentation support were also provided before delivery.

On 19 July 2026, the beneficiary presented to the 24-hour labour room at CHC Faridpur with spontaneous onset of labour at term. Maternal vital signs were stable, fetal heart rate was normal, and there was no clinical indication for emergency referral. Labour was managed by trained skilled birth attendants with monitoring of maternal pulse and blood pressure, uterine contractions, cervical dilatation, fetal heart rate, and progress of labour using a partograph. Infection-prevention and biomedical-waste-management procedures were maintained.

Respectful maternity care was incorporated throughout labour. Privacy was maintained, communication remained respectful, procedures were explained, emotional reassurance was provided, and the woman's dignity was maintained. Labour progressed normally without maternal or fetal complications.

A normal vaginal delivery was conducted on 19 July 2026. A live female infant weighing 2690 g was delivered with an immediate spontaneous cry. Delayed cord clamping, immediate drying, thermal protection, skin-to-skin contact, active management of the third stage of labour, and prevention of postpartum haemorrhage were undertaken. The placenta was delivered completely and the mother remained clinically stable.

The newborn received essential newborn care, including assessment of breathing, thermal care, skin-to-skin contact, early initiation of breastfeeding within one hour, observation for danger signs, and breastfeeding and immunization counselling. No additional neonatal intervention was required.

Postnatally, the mother received counselling on exclusive breastfeeding for six months, maternal nutrition, continuation of iron-folic acid and calcium supplementation, hygiene, maternal and newborn danger signs, routine immunization, postpartum contraception, and scheduled follow-up. Home-based follow-up through the local ASHA was arranged. Mother and infant were discharged in stable condition.

A notable social aspect of the case was the family's enthusiastic celebration of the birth of their daughter. The family decorated their vehicle and displayed the message "Mere Ghar Lakshmi Aayi Hai" ("Lakshmi has arrived at our home"). Healthcare workers used this positive family response to reinforce messages concerning gender equality, the value of the girl child, and respectful parenting.

Table 1: Summary of the illustrative case.

Variables	Findings
Age (in years)	25
Place of delivery	CHC Faridpur, Bareilly
Date of delivery	19 July 2026
Mode of delivery	Normal vaginal delivery
Newborn	Female
Birth weight	2690 gm
Maternal outcome	Stable
Neonatal outcome	Stable

Table 2: Continuum of maternal care at CHC Faridpur.

Stages	Services provided
Pregnancy registration	Early ANC registration and health records
Antenatal care	Clinical examination, laboratory investigations and nutrition counselling
Maternal anaemia corner	Haemoglobin screening, iron-folic acid supplementation and counselling
Government schemes	JSY, PMSMA and JSSK support
Labour room	Skilled birth attendance, labour monitoring and infection prevention
Delivery	Normal vaginal delivery and active management of third stage
Newborn care	Skin-to-skin contact, delayed cord clamping and early breastfeeding
Postnatal care	Nutrition, contraception counselling and follow-up

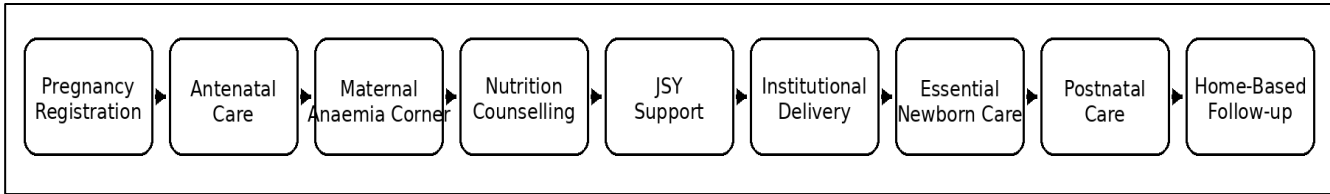


Figure 1: Integrated maternal care pathway.

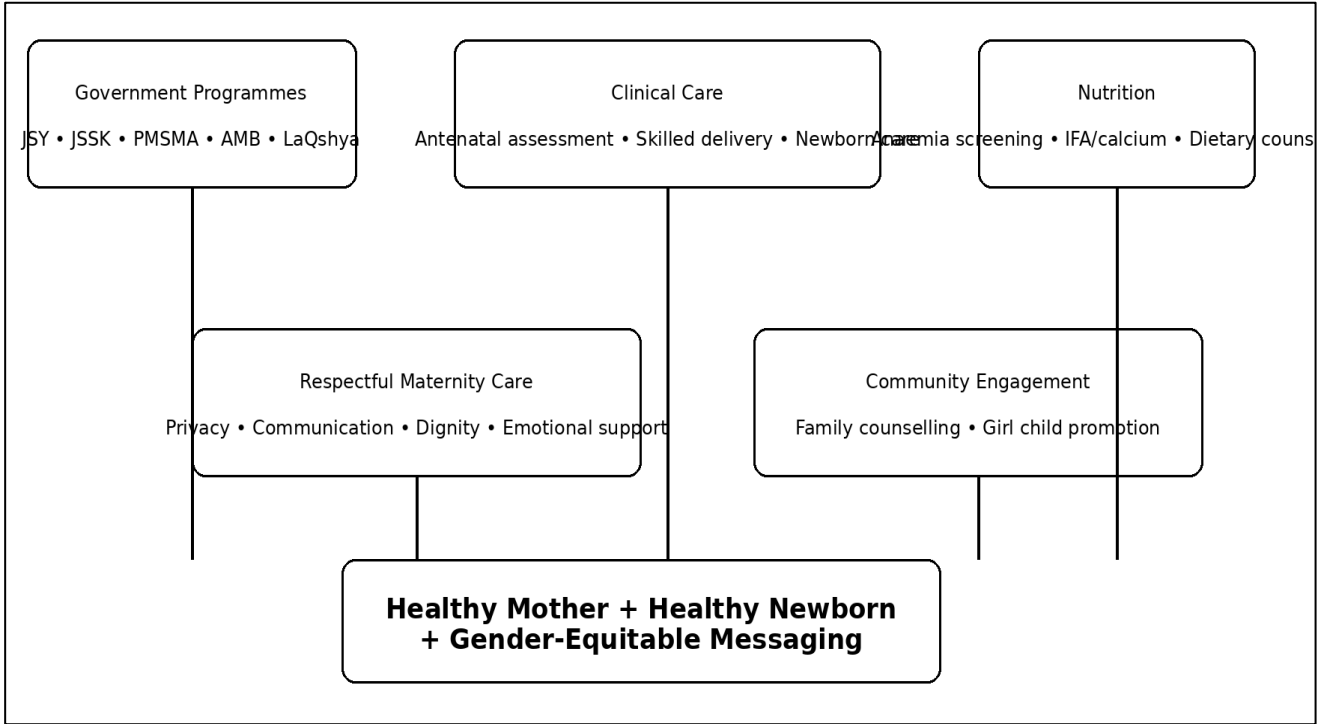


Figure 2: Integrated maternal care model at CHC Faridpur.

DISCUSSION

This case illustrates that safe institutional delivery can be strengthened when antenatal, intrapartum, postnatal, nutritional, financial-entitlement, and community-oriented interventions are linked within one continuum. The experience is particularly relevant to rural facilities where the same beneficiary may depend on the public health system for multiple components of maternity care.

Early antenatal registration provided an opportunity for systematic assessment, identification of risk factors, laboratory screening, nutrition counselling, and preparation for institutional delivery. WHO recommendations emphasize antenatal care as a platform for prevention, early identification of complications, and preparation for a positive pregnancy experience.² In this case, no obstetric complication requiring referral developed during the antenatal period.

Maternal anaemia remains an important public health concern. The Maternal Anaemia Corner at CHC Faridpur provides a facility-level mechanism for routine haemoglobin screening, nutrition counselling, iron-folic acid supplementation, follow-up, and referral when required. In the present case, severe anaemia was not identified, but preventive interventions were continued throughout pregnancy. This demonstrates that anaemia management can be embedded into routine ANC rather than treated as a separate activity.^{8,13}

JSY support was integrated into antenatal counselling and documentation. The purpose was not merely to facilitate a financial entitlement but also to reduce uncertainty about institutional delivery and administrative procedures. Government maternity schemes are most useful when beneficiaries can access them through coordinated facility-level support.^{5,6}

The case also highlights respectful maternity care. Privacy, respectful communication, informed explanation, emotional support, and maintenance of dignity were incorporated during labour. WHO standards identify respectful, evidence-based care as a core component of quality maternal and newborn services.^{3,4} Although patient satisfaction was not formally measured in this case, the care process demonstrates practical implementation of these principles.

Essential newborn practices were provided immediately after birth, including thermal care, skin-to-skin contact, delayed cord clamping, and early breastfeeding. These interventions are consistent with evidence-based newborn care recommendations and are feasible in appropriately equipped first-referral facilities.^{3,4}

An additional feature was the family's positive celebration of the birth of a girl. A single family experience cannot establish a population-level change in gender attitudes, and no formal behavioural outcome was

measured. Nevertheless, the event illustrates how routine maternity services can become an opportunity for health promotion. Recognition of positive family practices can complement broader efforts to encourage equitable value, care, and opportunities for girls.

The case has important limitations. It describes one beneficiary in one facility and therefore cannot demonstrate effectiveness or generalizability. There was no comparison group, no standardized patient-satisfaction assessment, and no longitudinal measurement of maternal or neonatal outcomes. The report should therefore be interpreted as an illustrative practice-based case rather than evidence of causal programme impact. Future multicentre implementation studies could assess the effect of integrated maternal-care models using standardized clinical, utilization, patient-experience, and cost measures.

CONCLUSION

This case demonstrates the feasibility of providing an integrated continuum of maternal and newborn care in a rural government CHC. Early antenatal registration, maternal anaemia prevention and monitoring, nutrition counselling, JSY facilitation, skilled institutional delivery, respectful maternity care, essential newborn care, and postnatal follow-up were delivered as connected components of routine care. The family's positive celebration of the birth of a daughter also created an opportunity to reinforce gender-equitable social messages. The experience provides a practical example for rural facilities seeking to strengthen continuity, quality, and patient-centredness of maternity services using existing public-health systems and resources.

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