

Making a DIFFERENCE Good, Replicable and Innovative Practices

Healthcare systems have experienced a proliferation of innovations aimed at enhancing life expectancy, quality of life, diagnostic and treatment options, as well as the efficiency and cost effectiveness of the healthcare system. Ministry of Health and Family Welfare, Government of India has encouraged piloting and scaling up of innovations and good practices to improve health outcomes which is essential part of National Health Mission. 'Making a Difference: Good Replicable and Innovative *Practices*' is a compilation of eighty five innovations across the States and eight Central Government Initiatives from the different areas of health systems. The innovations are scaled up by the state according to their need and priority. This is an effort to systematically identify innovations which can have a high impact to address health issues of the community and facilitate their prompt scale up through a platform, which would provide repository, learnings, information on enabling milieu and cross-learnings.





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Introdu

inistry of Health and Family Welfare, Government of India has encouraged piloting and scaling up of innovations and good practices to improve health outcomes. It is an essential part of National Health Mission and the states are supported to pilot & field test innovations. These are being encouraged through national consultations to reward good practices and innovations. This summit is an effort to systematically identify innovations which can have a high impact to address morbidity and mortality and facilitate their prompt scale up through a platform, which would provide repository, learnings, information on enabling milieu and cross-learnings.

To convert our phenomenal economic growth, high quality medical care and available technology into social well-being and happiness, one of the most important steps is identification, assessment and progressive uptake of innovations developed and successfully implemented in India.

DEFINITION OF INNOVATION THAT ARE BEING CONSIDERED

Programme Innovations

Several programme innovations are existing or are facilitated at various levels of healthcare delivery as a response to a specific

problem, programme need or to achieve a better level of performance. Such innovations may range from a better referral system, new and efficient ways of treatment compliance, new mechanisms to reduce cost of care or out of pocket expenditure etc. This may also include innovations in service delivery, financing and governance.

Product Innovations

Health Products including Medical Devices, Innovative technologies including Healthcare IT, m-health, and tele-health/e-health form a bulk of product innovations. New Vaccines and Drugs follow other regulatory routes and usually get well identified and incorporated. However, medical technology innovations tend to remain unidentified due to inadequate systems support.

PRINCIPLES OF INNOVATIONS IDENTIFICATION

Given that each category of innovations comes with its own strengths and challenges of identification and assessment, certain guiding principles of for identification of innovations or potential innovations is a must, which could also serve "proxy eligibility criteria".

C t i o n

Exclusion Criteria

The Healthcare Innovation Platform excludes:

- Specific drugs, surgical or medical procedures or practices that need evaluation through Randomized controlled trials or Systematic Reviews.
- Incomplete Documentation of innovation: For any innovation to be reviewed the document should include adequate information on process, human resource and infrastructure need, capacity building strategies, cost, challenges and lessons.

Inclusion Criteria

- The programme or product innovations are relevant to existing health care needs of the population specially those who are disadvantaged and marginalized.
- The programme and or product innovations address locally endemic health problems and or diseases.
- The programme and or product innovation facilitates better health care reach to people in terms of accessibility including its reach to rural areas,

tier II and tier III urban settlements, affordability including potential to reduce cost of care, quality inclusive of safety of a healthcare product or process and equity with special consideration to groups including those identified in (I).

- The programme or product innovations bridge a crucial specialized skill gap required in delivery of health services.
- Innovations, which meet criteria for uniqueness of logic of initiative, system based approach, likely impact on the health status of the population and scalability.

Evaluation of Innovations

Based on i) Strength of evidence; ii) Scale of Coverage; iii) Impact; and iv) Replicability & Contextual fitness - all innovations in this compendium have been categorized as Emerging Innovations OR Established Innovations. While Emerging Innovations call for larger pilots, already established innovations are suggestion for uptake and scale up on priority.

CONCLUSION

Healthcare systems have experienced a proliferation of innovations aimed at enhancing life expectancy, quality of life, diagnostic and treatment options, as well as the efficiency and cost effectiveness of the healthcare system. Information technology has played a vital role in the innovation of healthcare systems. Despite the surge in innovation, theoretical research on the art and science of healthcare innovation has been limited. In order to achieving target goals of National Health Mission and to make health more accessible, affordable, safer and equitable; there is a need to identify, evaluate and scale up innovations. This compendium of innovations is collection of best practices in various states in India and is being shared for the purposes of dissemination and scale up.

Health Stren

Systems gthening

Service delivery reforms are meant to transform conventional healthcare delivery into primary care, optimizing the contribution of health services – local health system, healthcare networks, health districts – to health and equity while responding to the growing expectations for *Putting people at the centre of healthcare, harmonizing mind and body, people and system*

-Primary Health Care Now More Than Ever, The WHO Report 2008

JHARKHAND STRENGTHENING RMNCH+A SUPPORTIVE SUPERVISION



The SRM (State Review Mission teams) covered 26 CHCs across 8 districts covering one-third of the facilities



PROBLEM STATEMENT

Supportive Supervision (SS) mechanisms are regarded as an effective measure to improve and strengthen health systems. Outcomes of multiple public health intervention measures usually get compromised due to inadequate and poorly structured SS mechanisms. Jharkhand has taken many steps to institutionalize and implement various SS mechanisms aimed at Health System Strengthening (HSS) and improving coverage and quality of service delivery of specific programme interventions. This included formation of State Review Mission (SRM) Teams, District Monitoring Teams and designing and implementation of RAPID model of SS for Routine Immunization.

PROGRAMME DESCRIPTION

To strengthen RMNCH+A outcomes the State has institutionalized the recently launched Government of India's SS checklist, which provides an opportunity to harmonize and consolidate SS visits by looking at the critical impact indicators. All the State and District officials use the SS checklist during their field visits.

To further streamline the use and implementation of the checklist the last SRM round conducted in November - December 2014 utilized the checklist to assess the availability of logistics and practices at the health facilities. Prior to the initiation of the round an orientation on the SS checklist

was conducted for all SRM team members and data was analyzed using an excel based tool developed by the technical team of the USAID/Scale up RMNCH+A Project The tool helps analyze data district and facility wise thereby providing an opportunity to the State officials and district officials to identify and address the gaps existing at the health facilities.

PROGRAMME OUTCOMES

The SRM round covered 26 Community Health Centers across 8 districts and accounted for nearly one third of the total facilities in the visited districts. Significant observations during the round were presented in form of information using the data collected through SS checklists. For example, BP was recorded in only 50% of the facilities while Partographs were used to monitor progress of labour in 73% CHCs. Injection Vit K1 was available in 58%, bag and mask in 62% and clean linen/towel for receiving newborns in 54% facilities visited.

IMPLEMENTING PARTNERS

Technical support provided by the USAID/Scale Up RMNCH+A Project (State RMNCH+A Unit).

SCALABILITY

Similar mechanisms can be adopted during future review & monitoring visits. State is in the process of

institutionalizing an external RMNCH+A Monitoring and Evaluation system for the High Priority Districts of the State through Medical Colleges on similar lines.

CONCLUSIONS/LESSONS LEARNT

A limiting factor in earlier SS models in the State had been the lack of a comprehensive data management and analysis system. The data analysis tool developed for the current checklist helps identify critical parameters and components which need to be addressed at the State, district and facility levels. This mechanism should therefore be able to develop an integrated action plan for strengthening service delivery mechanisms in Jharkhand.

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KERALA COMPREHENSIVE HEALTH PLAN





PROBLEM STATEMENT

following the decentralisation process in Kerala, the allocation to all departments, including Health, was decreased proportionally to allocate 25-30% of the State Plan Fund to Local Self Government Institutions as recommended by the Kerala Finance Commission. This resulted in a financial crunch in continuing the various programmes. Lethargy of the departments in liaisoning with Panchayati Raj Institutions resulted in miniscule allocations to the health sector from LSGD plan resources in the earlier three plan period.

PROGRAMME DESCRIPTION

The Comprehensive Health Plan (CHP) initiated by NRHM in the State as a massive Campaign in 2011-12 has succeeded in the first three years of the XIIth Five Year Plan in placing **Public Health Care** firmly on the agenda of Local Self Governments/Panchayati Raj Institutions (PRIs). Decentralized planning is not a new concept in the State, but such an initiative in the Health Sector as a joint initiative of NRHM, Health and other related departments and PRIs was a novel venture. In Kerala, PRIs in the State are sufficiently capacitated and empowered since the last two decades to own and manage all the developmental activities of departments brought under their control, which included the Public Health services. A Comprehensive Health Plan was prepared through a decentralised Plan Preparation process on a pilot basis in Alappuzha district. Considering the success and participatory approach, the process has been extended to all the districts of Kerala. The Comprehensive Health Plan was planned as a Decentralised Plan Campaign involving all the field staff of Health/Health-related departments and NGOs, as a joint initiative of PRIs and NRHM. Health Plans of all wards of Grama Panchayaths were prepared and all such Plans were consolidated at Grama/Block/ District Panchayath level as projects and duly vetted by the District Planning Committee (DPC), a Constitutional body with the District Panchayath President as Chairman and District Collector as Member Secretary. State and district level TOTs and workshops were conducted to roll out the campaign. State/district level workshops were periodically conducted for Medical Officers (Implementation officers of LSGD Health Projects) and health staff to familiarise them with the procedures/techniques of taking up and implementing LSGD projects. To motivate and energise the PRIs to take up more health and health-related projects and also the Medical Officers in charge of PHC/CHC, District Panchayth, Corporation/Municipality Arogya Keralam Puraskaram was institutionalised. NRHM in association with Doordarshan, Kerala has produced a documentary on Health Initiatives of PRIs- covering the State-level "Arogyakeralam Puraskaram" award winners of 2012-13. This was widely acclaimed and noticed by the public at large, resulting in taking up of more health projects by PRIs from their Plan allocation.

FINANCIAL INVESTMENT

Around 15,000 meetings/workshops were conducted in the State as part of the Campaign. Altogether projects worth Rs. 209 crores were included in the Health Sector from the allocation of LSGDs. However, the expense incurred – around Rs. 40 lakhs – is meagre considering the total amount (Rs. 209 crores) of health projects included in the PRI's Annual Action Plan of 2012-13.

CONCLUSIONS/LESSONS LEARNT

A review of the last three years compared to XIth Five Year Plan compared reveals that NRHM in association with Health Service Department has succeeded in diverting the resources from LSGD plan.

Contact

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Through 15,000 meeting/workshop projects worth Rs. 209 crores were included in the Health Sector from the allocation of LSGDs under the intervention



MADHYA PRADESH INTEGRATED REFERRAL TRANSPORT SYSTEM





Under the project, Sanjeevani-108 (Emergency Medical Ambulance Service (EMAS)) has been integrated with a fully functional centralized call center receiving more than 25000 calls per day and handling approx. 1800 emergencies on daily basis

PROGRAMME DESCRIPTION

The Government of Madhya Pradesh has floated a tender to establish an integrated referral transport system in the year of 2013-14. Under the integrated referral transport system the following services have been integrated:

- I. Mobile Medical Units
- **II. Janani Express**

Janani Express vehicles under Janani Shishu Suraksha Yojana (JSSK). Currently 940 such vehicles are being operated through district level call centres. The services are contracted based on a mutually agreed amount. The service provider manages both capital and operational cost of the agreed amount.

III. Sanjeevani-108

An emergency Medical Ambulance Service (EMAS), also popularly known as"108 Ambulance Service". This Emergency Medical Ambulance Service, with a fleet of 554 Basic Life Support (BLS) Ambulances and 50 Advance Life Support (ALS) Ambulances are deployed strategically across the State supported by a fully functional centralised call centre which is receiving more than 25000 calls per day and handling approximately 1800 emergencies on a daily basis.

IV. Doctor Express (Mobility support vehicles)

Doctor Express is a transport service available for the doctors at CHCs to commute to PHCs where doctors are not available. The objective of the service is to improve doctors' availability in health facilities which otherwise is not possible due to poor public transport facility.

V. 104 Health Help Line

"104 Health Help Line" service has recently been introduced and made operational through Private Public Partnership (PPP). Any resident of the M.P. State can dial a 3 digit number '104' and get access to trained paramedics and doctors.

CONCLUSIONS/LESSON LEARNT

All the services will be operated and monitored through one call centre instead of different call centres for different services in districts. This would be beneficial as different services can be availed through one number resulting in reduction in costs that are presently borne by the State and NHM. It would also reduce confusion amongst the users.

- It would help in getting real-time data of beneficiaries, monitoring of movement online through GPS and getting biometric attendance of the concerned staff, resulting in providing quality service to patients and efficient use of existing human resources.
- The complaints relating to quality of service across all health facilities can be registered through 104- Health Help Line.
- It would help in rational distribution of existing resources and increase the coverage of population.
- Mortuary vehicles have also been integrated and monitored through a single centralised call centre.



ODISHA

360-DEGREE COMMUNICATION APPROACH TO DELIVER RMNCH+A OUTCOMES



43,000 villages of Odisha have a functional health wall, 110,000 minutes of contents have been used by ASHAs and ASHA Sathis in Mobile Kunji & 21093 village PLA meetings completed in 5650 villages

PROBLEM STATEMENT

ost of the health programme are not implemented as envisaged due to poor IEC/BCC strategies. A rebust IEC strategy is imperative for success of health programme implementation and achievement of expected outcomes.

PROGRAMME DESCRIPTION

Multiple, distinct, yet complementary channels of communication is used in this approach in the State to compliment the results of RMNCH+A outcomes. The overall strategic thrust of the approach has identified evidence based key priority behaviours with a judicious mix of media and messages. The overall strategy has led its foundation on three pillars i.e. institutional strengthening to deliver and augment the plan, capacity building across all delivery outlets including frontline workers and community and integrated communication interventions intercepting with key messages and channels.

The key elements of the approach are:

- Evidenced based communication strategy.
- Capacity building & institutional strengthening.
- Synergy & convergence between different media & activities.
- Integrated communication calendar and activities.
- Strengthening Interpersonal Communication & community process.

A Centre of Excellence in Communication is established at State Institute of Health and Family Welfare, in partnership with DFID, UNICEF and BBC:

- State of art human resource, infrastructure.
- Integrated health communication.
- Modelling as a Communication Institute.
- Media and Communication management.
- Material Development and Programme management Unit.

- Documentation and Research Cell.
- Web based IEC material and training warehouses.

PROGRAMME OUTCOMES

- CoE has driven evidence based planning by conducting two KAP studies i.e. information need assessment among tribal districts and community need assessment on MCH behaviours and evaluation of Swasthya Kantha BCC approach is ongoing.
- Developed and implemented a 52 week multimedia communication plan and activity calendar on identified 12 key priority behaviours.
- In last one year, designed, developed and implemented a behavior change and information publicity campaign on Malaria, Dengue and Diarrhoea, emergency BCC campaign during cyclone (phailin) and flood, entitlement drive on RBSK, NUHM and ambulance service.
- Trained all 344 communication service providers at block and district level.
- Initiated support in organizing National Communication Workshop on RMNCH+A.
- Successfully launched and support implementation of Mobile Kunji and Shakti Varta (PLA) work in all high priority districts.

Programme Output

- 1. All 43,000 villages of Odisha have a functional health wall maintained and updated by ASHA and AWW.
- 2. 348 communication service providers of district and block are sensitized and trained on Swasthya Kantha implementation.
- 3. More than 40,000 ASHA and GKS are sensitized on Swasthya Kantha messages, maintenance and implementation.

- 4. Out of 6,844 ASHAs, a total of 5,249 (77%) ASHAs have already received training while out of 1,857 HWs a total of 574 HWs have been trained in using Mobile Kunji.
- 5. 110,000 minutes of contents have been used by ASHAs and ASHA Sathis in Mobile Kunji.
- 6. Above 95% FLWs are using BSNL CUG SIMs.
- 7. Out of 21093 villages PLA meetings completed in 5650 villages of 3 high burden districts of Odisha.
- 8. Around 32800 self help group members have participated in these village meetings on HNWASH issue.
- 9. Each meeting has an average of 33 participants including mothers, pregnant, adolescents and elderly women.
- 10. 1218 Shakti Varta facilitators as SHG members have been trained in 2 phases of PLA meetings.
- 11. Web based MIS and Resource center established to track evidences.





RAJASTHAN

MUKHYAMANTRI NISHULK DAVA YOJANA AND STRENGTHENING OF SUPPLY CHAIN MANAGEMENT SYSTEM



Covering a population of 10.68 Cr, it Increased the access and equity of the underserved. Before – 44 lakh pts/month, Later – 62 lakh patient per month

PROBLEM STATEMENT

R ajasthan had its own Essential Drug List 2005 (now 2012 and revised 2013) and Standard Treatment Guidelines- STGs 2006 (now revised 2012) which are supposed to satisfy the priority healthcare needs of the population. These essential medicines and guidelines are selected with due regard to clinical protocols, disease prevalence, evidence on efficacy, safety and comparative cost-effectiveness. The medical practitioners are expected to abide by these guidelines, but still large gaps exist. In spite of such efforts, access to cost-effective, appropriate medicines and their rational use continued to be a challenge in Rajasthan. There remained large gaps in the processes of medicine procurement, quality-checking, distribution and pricing. Alongwith these shortcomings there were problems of inadequate, unkempt storage and lacunae in transportation facilities. In order to strengthen the drug supply chain management system and to provide free generic medicines MNDY was launched in 2011-2012.

PROGRAMME DESCRIPTION

The two major components introduced under this were:

- Free supply of generic medicines under Mukhyamantri Nishulk Dava Yogna.
- Strengthening of supply chain management.
- An autonomous centralised procurement agency Rajasthan Medical Service Corporation (RMSC) was established. The RMSC is responsible for the procurement of generic drugs and medicines, surgical and diagnostic equipment and their distribution to government medical institutions in the State of Rajasthan through the District Drug Warehouses.
- RMSC has also strengthened the process of quality control of drugs; ensured the availability of essential drugs at all times and promoted the rational use of drugs with special emphasis on the use of generic medicines.
- For each of its diverse functions, the Corporation has been organised into *different cells* with specific roles to play for the efficient functioning of RMSC.
- Before the inception of RMSC the District Drug Warehouses were functioning as stores for receiving

all supplies from the central and State level and were under the administrative control of CM and HOs. These Drug Warehouses (27 locations) were provided with additional storage capacity of approximately 3000 sq. ft area and furnished with requisite equipment and infrastructure.

- e-Aushadhi a software for inventory management was launched. It is a web-based application which deals with inventory management of the stock of various drugs, sutures and surgical items at DDWs. The e-Aushadhi software utilises a propriety software. The software covers – Online Demand, Rate Contract Desk, Online PO Generation, Supplier Interface, Stock Ledger, Inter-DDW Transfer, Lab Interface, Quality Control, Supplier Performance Detail Report, NA Hit Report, Expiry Drugs Detail.
- An effort was made to bring about a change in the prescription behaviour of doctors by sensitising doctors about the usage of Essential Drug List and enforcing them to follow State STGs.

PROGRAMME OUTCOMES

- Increase in access and equity of the underserved; and Reaching out to the unreached, Before – 44lakh patients/month, Later – 62 lakh patient per month.
- Source of Youth Employment.
- Increase in the numbers of Girl Child treated.
- Decrease in out-of-pocket expenditure.
- Reduction in retail sale of costly medicines-particularly anti-cancer, immunoglobulins, albumin, factors, sutures, rabies vaccines etc.
- Savings to Government.

FINANCIAL INVESTMENT

Fund	Amount (Rs. in crore)	Per capita expenditure
State Budget	253.07	Rs. 36.87
NRHM	24.83	Rs. 3.61
Total	277.9	Rs. 40.48



SCALABILITY

This scheme has been taken up by other States also for implementation.

CONCLUSIONS/LESSONS LEARNT

This scheme reduced the out- of- pocket expenditure of the patients and has helped effectively in meeting the needs of the patients. This scheme has resulted for in savings in government expenditure too.

Contact

MD, NHM, Rajasthan



RAJASTHAN MUKHYAMANTRI NISHULK JANCH YOJANA



PROBLEM STATEMENT

ealthcare is a basic requirement of all human beings, but ironically large sections of human population are still deprived of this most primary requirement. This is preventable, and with available resources it is possible to provide essential healthcare facilities to every human being. This requires:

- A strong, efficient, well-run health system.
- A system for financing health services.
- Access to essential medicines and technologies.
- A sufficient member of well-trained, motivated health workers.

While conceptualizing the MNJY it was considered that if diagnostic services were made available at all hospitals without fee charge then it would be a step further (subsequent to implementation of MNDY) towards the "Right to Medical Treatment" under the banner of "Universal Health Coverage" for the people of Rajasthan.

PROGRAMME DESCRIPTION

MNJY was launched in April, 2013 in a phased manner. The scheme has been implemented uniformly across all districts of the State and the benefits extend to the entire population of 7 Crore.

Vision

To provide quality essential diagnostic services in all the government health care institutions and contribute to fundamental right to health.

Mission

To strengthen the existing laboratories and other diagnostic facilities in all the public health institutions so as to provide the essential diagnostic services free of cost to all patients visiting government **FINANCIAL INVESTMENT** hospitals.

To meet gaps and to provide quality diagnostic services adequately equipped diagnostic facilities are proposed as package at various levels of health care.

Implementation

For ensuring success of the intervention and for addressing the gaps, the activities were categorized as short term and long term activities with defined timelines, responsibilities and source of funds. Thereafter the scheme was implemented after issuance of all necessary government orders/circulars for strengthening of four basic components viz- infrastructure, manpower, equipments and reagents and consumables.

Daily Online Reporting of Investigations in e-Aushadhi is done & Non-reporting institutions are informed on daily basis through sms message.

Role of Bio-medical Engineers in MNJY- The success of the scheme is also attributed to establishment of Equipment Maintenance and Repair Workshops (EMRWs) at zonal levels manned by one Bio-medical Engineer each to address the requirements of repair and maintenance of equipments in the zone.

PROGRAMME OUTCOMES

Over the period an increasing trend has been seen in utilization of the services. In the year 2013, number of the test conduct was 2, 30, 00,862. It became 3,27,65,514 In 2014 and 80,40,434 in 2015 (Jan to April).

IMPLEMENTING PARTNERS

Rajasthan Medical Services Corporation in co-ordination with Department of Medical & Health, Department of Medical Education.

The project is supported through NRHM as well as State budget. In the year 2013-14 total State budget was 107.09 Crores while NRHM budget was 20 Crores. For the year 2014-15, it became 119.37 Crores from State and 20 Crores from NRHM. For the year 2015-16 State budget is 117.18 Crores.

SCALABILITY

It has the scope for scaling up to other States with a provision of 100-200 Crore funding depending on the list of investigations to be made free.

CONCLUSIONS/LESSONS LEARNT

Though the period of implementation for MNJY-Free Diagnostics Scheme has been that of two years only i.e 7thApril, 2013-15, it has definitely aided in enhancing access to healthcare and moving the State towards Universal Health. Some of the conclusions/lessons learnt can be enumerated as, such a scheme may first be piloted at some identified institutions, regular supply of reagents and consumables & timely release of funds need to be insured. Strengthening of monitoring by Bio-medical Engineers is required.

REFERENCE

http://www.rmsc.nic.in/mnjy/home.html

Contact

Nodal Officer, MNJY Project Director, MNJY

6,38,06,810 number of tests conducted since inception of scheme





munity Cesses

The community should emerge as active subjects rather than passive objects in the context of the public health system **9** – *NRHM Framework for Implementation, MoHFW, GoI 2005-2012*

CHHATTISGARH

ROLE OF MITANIN IN COMMUNITY MANAGED NUTRITION CUM DAY CARE CENTRES - FULWARI SCHEME



PROBLEM STATEMENT

oor maternal and child nutrition indicators in the State of Chhattisgarh are a result of several factors including gaps in food security, feeding and health care behaviours including care-seeking for infants and young children and a paucity of time for childcare by mothers and caregivers on account of high workloads.

PROGRAMME DESCRIPTION

A Nutrition and Daycare initiative, the Fulwari Scheme was piloted in 2012 in Surguja district in 300 centres with 5000 children and pregnant women. It was a collaborative effort between the Zila Panchayat and the State Health Resource Centre (SHRC). The focus was on the critical age group of under-three, recognized as a neglected group in mainstream nutrition programmes.

The Fulwari functioning relies on community participation. The space for the Fulwari is a voluntary contribution from a community member. The Fulwari provides three, hot, cooked meals daily to children aged 6 months to 3 years. Pregnant and lactating women also get one meal a day at the Fulwari. There is no provision for a paid worker in Fulwari and two mothers volunteer each day to take care of children for 6-7 hours, for no compensation except a meal. This organization of work enables other mothers to go for work, leaving their children at the Fulwari.

Although poor communities are a priority for establishing the Fulwari, community meetings facilitated by Mitanin Trainers are used to gauge the readiness and commitment of parents/mothers to contributing their time. Once there is community agreement, the Gram Panchayat (GP) representatives and community send a demand note to the Block Panchayat. The funds for buying food items are provided by Government through the GP. All purchases for Fulwari are handled by the mothers. They also decide the menu, which includes the addition of eggs, oils and vegetables. Mothers also contribute the Take Home Rations of the ICDS to the Fulwari.

Mitanins and Mitanin trainers play a crucial role in bringing the group together, maintaining accounts and records and overall management. Mitanins promote health related behaviours such as hand washing, proper handling of drinking water, covering foodstuffs, cleanliness and hygiene through demonstration in the Fulwari.



PROGRAMME OUTCOMES

Children who attend Fulwaris regularly showed significant improvements in their health and nutritional status. Fulwaris have enabled Mitanin to undertake closer monitoring of illnesses amongst children and thus reduced the episodes of illnesses and facilitated the reach of the ANM and AWW to these children, leading to improved growth monitoring, de-worming and Iron and Folic Acid (IFA) supplementation. In 2013, the programme was expanded to cover 35,000 children and 17, 000 pregnant/lactating women using the Mitanin network. Currently there are 2850 Fulwari centres in 85 tribal blocks. The initiative recently won the Prime Minister's Award.

IMPLEMENTING PARTNERS

Department of Women and Child Development, Zila Panchayats, Mitanin Programme (National Health Mission) and State Health Resource Centre.

EVALUATION

No formal evaluation has been undertaken, but the programme is being documented by an external agency.

FINANCIAL INVESTMENTS

An annual grant of Rs. 50,000 per Fulwari is routed by the Government through the Panchayat.

Across 85 tribal blocks 35,000 Children & 17,000 pregnant/lactating mothers are covered. The initiative recently won the **Prime Minister's Award**

SCALABILITY

Since the Fulwari is a community led initiative, anchored by the ASHA and her support structure, there is potential for scaling up in other States where the nutrition status among under 3s is poor.

CONCLUSIONS/LESSONS LEARNT

Fulwaris have demonstrated that community managed feeding and care centres, with Panchayat involvement, can be effective in addressing nutritional and health care requirements of children under three and allowing mothers to seek outside employment. Fulwaris also demonstrate that in areas with high malnutrition, an adjunct intervention to the ICDS enables a special focus on children under-3.

JHARKHAND SAHIYA HELP DESK



PROBLEM STATEMENT

Significant proportion of those seeking care in the public health facilities in Jharkhand belong to tribal, rural and poor socio-economic backgrounds. The State identified that the key deterrent to accessing public health facilities is that people often find such facilities, unfriendly and confusing to navigate.

PROGRAMME DESCRIPTION

In 2011, the State established help desks in District Hospitals and Community Health Centers (CHC). Sahiyya Help Desks were set up in district hospitals and Community Health Centers in Left Wing Extremist (LWE) districts in 2011-12 and later scaled up to 24 district hospitals and 188 CHC. The Sahiyya was identified to manage the help desk, given their familiarity with the public health facility and the confidence reposed in them by the community. The key objectives in setting up the Sahiyya Help Desk are to assist the public to navigate the health facilities, with a particular focus on pregnant women from remote areas, register patient grievances and enable appropriate action. A monthly meeting of Sahiyya, District Programme Co-coordinator, Hospital Manager, The Sahiya help desk reinforced the role of helping patients in navigating complex health facilities & has acquired the status of an information corner to visiting patients for queries

Deputy Superintendent and Civil Surgeon enables review and redressal. This help desk also serves as a point for facilitating Sahiyya payments and has a prominent display of the health scheme/incentives of Sahiya. It also provides support to other Sahiyyas who bring patients from remote areas on completing facility related formalities or information on health facilities. In one instance in Simdega district a Sahiyya used the help desk to provide patients with information regarding prevention of Anthrax at the time of an anthrax outbreak.

All services rendered by the Help Desk are free of cost. Sahiyyas are posted on a rotation basis for a maximum of four days in a month and receive an amount of Rs.150 per day. Sahiyyas at the desks are provided with a dedicated phone line and identity cards. The Sahiyyas maintain two registers– one relates to the information and services given and the other for complaints.

PROGRAMME OUTCOMES

Field reports suggest that the help desk has proved to be effective one stop information point, with the Sahiyya Help Desk acquiring the status of an information corner to visiting patients for queries on availability of a doctor, diagnostic facility, and the availability of other facility services. Anecdotal evidence suggests that the feelings of alienation and fear of being misunderstood on account of language and socio-cultural differences are reduced and there is improved awareness about entitlements and services, grievance redressal and feedback regarding services.

FINANCIAL INVESTMENT

The cost of establishing a help desk is Rs. 10,000, the cost of IEC Material and Registers is Rs. 5000, and monthly Sahiyya Payment is Rs. 7200.

SCALABILITY

All health facilities which have inpatient facilities- CHCs and above require help desks. The Sahiyya help desk model thus has significant potential for scale.

CONCLUSIONS/LESSONS LEARNT

The Sahiyya Help desk establishes that there is a specific role for a community health worker in enabling patients to help patients in navigating complex health facilities, often culturally alien and overcome other access barriers to health facilities. Supportive supervision in terms of quarterly reviews and regular orientation of Sahiyas associated with help desks is required to make the SHD more effective. Coordination in work and cooperation between the sahiyas and hospital staff is also essential to ensure the smooth functioning of the help desks.

Contact

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ODISHA STREAMLINING ASHA PAYMENTS



PROBLEM STATEMENT

Solution of ASHA incentives are a deterrent in motivating these activists.

PROGRAMME DESCRIPTION

The State initiated fixed day (10th of each month) monthly payments in 2009, under which payments were made through NEFT transfers directly from the block. The key components of this model were establishing a robust system of claim submission, collection, verification and authentication which resulted in timely payments. The introduction of CPSMS (Central Plan Scheme Monitoring System, now known as the Public Financial Management System) in April 2013, provided a platform for the State to scale this up. Launched as a pilot in Salepur CHC of Cuttack district, the model was scaled up to three more districts (Puri, Sonepur and Bolangir) and is now operational in all 30 districts.

The process is initiated by the ASHA submitting vouchers to the ANM for verification during meetings, who verifies and compiles the claims, and submits to the Block Accounts Manager (BAM). The BAM is responsible for beneficiary record creation, monthly data entry and for initiation of payment process. The Block Medical Officer is the first Data Approver (DA)/signatory and second senior medical officer is the second DA and signatory. After completion of data entry, DA approves the payment. The PFMS system provides both online and offline data entry options for ASHA payment. An inbuilt validation system shows error messages in case of any wrong/incomplete data entry and allows for re-uploading by creating a new voucher number. Any data entry error can be rectified in the system till the DA approves the payment.

Payment can be made in one of three ways. In the Print Payment Advice (PPA), payment advice note is generated after approval, printed, signed by both signatories and submitted to the bank. The PPA contains ASHA-wise list of incentives for payments, bank details and account heads from where payment is to be made. Another mechanism uses a digital signature to confirm the payment and the money is transferred immediately to beneficiary accounts. A single approval from DA initiates the payments process from different accounts to various beneficiaries. The State has also initiated Corporate Internet Banking where payments can be made directly to the beneficiary.

After release of payments, details are printed and given to ASHA SATHI (ASHA Facilitator), from where ASHAs can verify their payment details.

PROGRAMME OUTCOMES

Payment of incentives for 36 identified activities related to maternal, newborn and child health and diseases control programmes are made on a fixed day i.e. 10th of each month, significantly eliminating delays and established transparency in ASHA payments.

SCALABILITY

PFMS implementation is through the use of existing human resources at each level and existing technology, including banking platforms with little additional investment. Positive results with regards to timelines and transparency in ASHA payments highlight the strong potential for scaling up payments through PFMS in other States.

CONCLUSIONS/LESSONS LEARNT

Payment of ASHA Incentive through PFMS has proved to be successful for maintaining timeliness, transparency and accuracy in ASHA incentive payment. However successful transfer is largely dependent on strengthening IT systems at block level as poor internet connectivity hampers data entry and timely payment. Generating an automated SMS on CUG numbers of ASHAs with details of payments could facilitate the ASHA's information on specific payments.

Contact

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Payment of ASHA Incentive through PFMS has proved successful for maintaining timeliness, transparency and accuracy in ASHA incentive payment



ODISHA IMPROVED FINANCIAL MANAGEMENT SYSTEM UNDER NHM



Initiated for effective control over timely release of funds to 53850 facilities. Resulted in prompt receipt and release of funds



PROBLEM STATEMENT

Effective control over timely release of funds to 53850 facilities, especially for those at the community level such as Sub-centres, Primary Health Centres and Village Health and Sanitation Committees, where the accounts for expenditure incurred are maintained by non-accounts persons like Pharmacists, ANMs and AWWs.

PROGRAMME DESCRIPTION

The State has taken up the following activities:

- 1. Steps to ensure that the funds are received by SHS through the treasury within an average period of one month, from the date of receipt in treasury from Government of India.
- 2. Implementation of PFMS in the State: Public Financial Management System (PFMS) was initiated and Direct Benefit Transfer was rolled out in all 30 districts and expenditure filing was initiated in the last quarter of 2014-15.
- 3. PIP module in ERP-based accounting software: The State has developed and implemented ERP-based accounting software under NHM with a PIP module built in the same.
- 4. Performance appraisal of accounts personnel using a checklist is implemented at district and sub-district levels to take a judicious decision on further extension of contracts.

- 5. From August 2014 assessment of financial performance and a system of awarding best financially-managed districts in KBK+ and non-KBK areas was initiated. This is based on the performance indicators such as timely release of funds, financial progress, implementation of DBT and PFMS, internal control, submission of FMR and SFP (timeliness and quality), concurrent audit etc.
- 6. From July 2014 to ensure adherence to the financial and programme-related guidelines and proper internal control mechanisms, the concurrent audit system has been kept intact in the system on a monthly basis.

PROGRAMME OUTCOMES

The major achievements of the above system strengthening initiatives are given below:

- 1. Prompt receipt and release of funds to districts enabling them to take up the approved activities in time.
- 2. Better maintenance of financial records, adherence to financial and programme guidelines, ensuring transparency in the system.
- 3. Early liquidation of advances leading to better absorption of funds.
- 4. Cash-/paper-less transactions leading to better internal control in the system.

- 5. PIP-based reporting leading to better monitoring of the implementation of activities.
- 6. Corrective measures have been taken on a monthly basis through concurrent audit.

IMPLEMENTING PARTNERS

PFMS Team GoI.

SCALABILITY

Across the State and for all programmes.

CONCLUSIONS/LESSONS LEARNT

All the above-mentioned interventions will not only contribute in strengthening the financial management system but also will contribute in programme implementation in a better and effective way.

REFERENCE

Finance manual, Fund flow system, PFMS guideline.

Contact

State Finance Manager, Email: fmio.nrhmorissa@gmail.com



RAJASTHAN

ASHA SOFT- ONLINE PAYMENT AND MONITORING SYSTEM FOR ASHAs



ASHA Soft has been successful in streamlining payment of ASHA incentives (47000 ASHA Sahyoginis)

PROBLEM STATEMENT

omplex fund flows for ASHA payment from multiple budget heads leading to delays and lack of transparency in payments.

PROGRAMME DESCRIPTION

ASHA Soft is web-based software launched on December 26th 2014 in the State with key objectives of ensuring timely and transparent online payment to ASHAs and to improve the system of monitoring. ASHA Soft was developed by the State health Mission in collaboration with National Informatics Center, Rajasthan State Unit. It has been implemented across all 38 districts except urban areas where required infrastructure for data entry is not available.

The ASHA fills in the Monthly Claim Form for submission to the ANM on the 26th of every month. The ANM is expected to verify the claim forms and submit to the PHC level. Here, the PHC ASHA supervisor undertakes verification and entry of data. Then the payment is sanctioned by the PHC MOIC with assistance of Accountant/LHV by the 4th of every month. Final sanction of payment requires the digital signature of the CM&HO by the 7th of every month. The Payment is then transferred into the ASHA's Bank Account directly from State headquarters, where a separate account has been opened for ASHA incentives. After release of payments a SMS alert is sent to ASHAs regarding the transfer of payment.

ASHA Soft also captures beneficiary wise details of services given by ASHA to the community and generates various reports to monitor the progress of the program.

PROGRAMME OUTCOMES

ASHA soft has led to fixed day payment of ASHA incentives, reducing delays and establishing transparency in the payment process. It has also improved entry of beneficiaries in PCTS as both data bases are interlinked for payment verification. This software has also enabled programme managers to capture the performance of ASHAs based on incentives earned for a range of activities and maintain detailed data base of ASHAs.

IMPLEMENTING PARTNERS

NIC Rajasthan, National Health Mission, Rajasthan and Bank of Baroda.



FINANCIAL INVESTMENT

No additional cost was involved in designing and implementing ASHA Soft.

SCALABILITY

Streamlining of payments in Rajasthan through ASHA Soft with no additional HR and financial investments highlights the potential of scale up in other States where adequate HR for data entry is available at PHC level.

CONCLUSIONS/LESSONS LEARNT

Initial findings indicate that ASHA Soft has been successful in streamlining payment of ASHA incentives and generating interest State Demographer, Consultant ASHA, NHM

among programme managers at all levels in monitoring the ASHA programme. A major objective of achieving transparency in ASHA payments has been achieved. Some hurdles that have been identified include shortages of human resources for data entry and the skills to effectively use such reports. ASHA Soft data could also be used to generate reports to improve programme functionality but this potential of the software is yet to be fully developed and utilized.

REFERENCE

ASHA Soft results - http://ashasoft.raj.nic.in/

Contact

SIKKIM

ROLE OF VHSNC MEMBERS FOR IMPROVING HEALTH SEEKING BEHAVIOUR OF THE COMMUNITY


Overall institutional deliveries in the state reached to 97.3% in 2014-15. The maternal deaths in the state also showed a decline from 25 in 2011-12 to 12 in 2014-15



PROBLEM STATEMENT

Representation problem of non communicable diseases in the State.

PROGRAMME DESCRIPTION

A cause of death analysis in 2012 by the State showed that over half of deaths were on account of complications of non communicable diseases (NCD). Given that life styles are a key contributor in the etiology of several NCDs, the State undertook training of members of the Village Health, Sanitation and Nutrition Committees (VHSNC) in the year 2014 in order to improve the community's health seeking behavior through community participation. VHSNC members including the PRI representative, ASHAs, AWWs, NGO members, representatives from Self Help Group, teachers and religious leaders were trained at the PHC level. This effort builds on an existing initiative in the State, namely the CATCH scheme.

The State already has in place a CATCH scheme (Chief Minister's Comprehensive Annual and Total Checkup for Healthy Sikkim). The scheme involves community mobilization of the population sub group by the ASHA and the administration of a screening tool by the ANM. This is followed by an examination conducted by the Medical officer, who then prescribes the requisite medication or enables referral. The State assures treatment for all patients requiring services at no cost, either within or outside the State. The CATCH survey is conducted annually. The survey includes questions related to Family History, lifestyle related (diet, tobacco and alcohol consumption), insurance coverage, Reproductive history, and includes all family members including infants. Diagnostic screening tests include: Hb, Random Blood glucose, Serum Cholesterol/ Triglycerides, and Creatinine. Electronic Health Records (HER) cards have also been issued.

During the training the roles and responsibilities of VHSNC using the ward wise/sub center wise presentation on findings of the CATCH scheme and other health indicators were discussed. The trainees were presented with the data on home delivery, major diseases according to CATCH and causes of death. This enabled the development of action plans with the ASHA and PRI member taking ownership for the actions that were decided by the group.

PROGRAMME OUTCOMES

Increased community participation led by ASHAs resulted in increase in institutional deliveries and improved reporting and detection of NCDs. There is some evidence to show that secondary prevention measures are working as well.

FINANCIAL INVESTMENT

No additional costs were incurred as members were trained during VHNSC training.

SCALABILITY

The State has utilized the existing resources of VHSNC members by training and planning using existing data. Therefore training of VHSNC members in addressing an identified local problem using existing resources can be scaled up across other States.

CONCLUSIONS/LESSONS LEARNT

The positive results of the intervention have demonstrated that it is feasible to address local challenges faced by the community by strengthening community participation. Joint training facilitated better coordination between PRI members, Health workers, ASHA, NGO representatives and other community members. While currently available evidence cannot definitively State that this is directly attributable, change in health behaviors fostered by such community action and planning, could lead to positive impact.

Contact

Mission Director, Sikkim



In 2030, when we look back on our progress on meeting the sustainable development goals, a key measures of our success will be the health and well-being of women, children and adolescents everywhere

– Ban Ki-moon

GUJARAT MOBILE MAMTA DIWAS





Information generated by the software has influenced policy decisions. Nearly 245052 newborn admission, 189373 discharges, 29376 deaths & 330752 follow up visits captured in software

PROBLEM STATEMENT

The territory of Gujarat State has wide variation in terms of its geography – ranging from the desert area of Kutch district in the north to dense forest areas of district Valsad in the south. The State officials look for geography-specific approaches to render effective health services to all the beneficiaries. Valsad with a population of over 17 lakhs of which 54.8% is tribal (census 2011),has adopted the concept of "Mobile Mamta Diwas" to ensure maternal and child health services provision in identified Hard to Reach (H2R) areas of the district.

PROGRAMME DESCRIPTION

Administratively, district Valsad has five talukas. Of all the talukas, Kaparada home to 258888 tribal people (census 2011), has a hilly terrain covered with dense forests and very scattered population living in small, distantly located hamlets. This makes it extremely difficult to provide continuous, regular health services to all, despite the best planning, dedication and efforts of the health department. To reach out to the under-served population in left out hamlets and conduct VHND sessions (Mamta Diwas), Mobile Mamta Diwas, the flagship scheme was inaugurated by Hon'. Minister, Mr. Ganpatbhai Vasava on 31st August 2013 in the district. Under this, provision for two additional vehicles was made to cover the unreached areas according to a predefined route map and time schedule in consultation with field level workers, Medical Officers and Taluka Health Staff.

FINANCIAL INVESTMENTS

The budgetary requirements were proposed and approved under NRHM District Health Action Plan for the financial year 2013-14.

CONCLUSIONS/LESSONS LEARNT

Mobile Mamta Diwas as an innovation has proved essentially useful in addressing issues like beneficiaries travelling long distances for receiving health services, health staff not being able to travel to hard-to-reach and far-flung hamlets and beneficiaries left-out/dropped-out from essential health services.

MCH SERVICES PROVIDED DURING THE PERIOD (CUMULATIVE)									
Period	ANC 4	PNC (Up to 14th day)	Vaccination					TV shows	Mike
			TT 2+Booster	BCG	Pentavalent 3	Measles 1st dose	Measles 2nd dose		prachar
April to Nov. 2014	538	341	1117	696	922	1020	1028	944	943



MADHYA PRADESH

USING DATA FOR ACTION: FACILITY BASED NEWBORN CARE DATABASE



adhya Pradesh developed its first SNCU in 2007 and universal coverage of units across the districts was achieved in 2013. It was an achievement for the State that SNCUs were established with a rapid pace but State lacked strong data management and monitoring system. With manual reports, chances of errors were very common.

The lack of credible data made it difficult to justify the continued investments on establishing SNCUs amongst other competing priorities and interest in health sector. Additionally, newborns discharged from the SNCU were untraceable after the discharge, due to absence of follow up and feedback system. There was no follow up system for these newborns leading to nearly 10% newborns deaths after discharge within first year of life.

To address these gaps Government of MP and UNICEF took a lead to develop an online data management and follow up tracking system, which can be used in SNCUs across the State and country.

PROGRAMME DESCRIPTION

UNICEF has piloted desktop version of SNCU database management system in 2011 in Guna and Shivpuri. Government of MP and UNICEF developed an online data management and follow up tracking system, which can be used in SNCUs for data entry and analysis at a click.

Description of intervention

SNCU online data management and monitoring system was scaled up in all the SNCUs in 2012. The

application consists of two main utilities, one of which is a repository for facility based newborn care and contains prototypes for designs of SNCU, training material, operational guidelines on facility based newborn care, government circulars, data recording formats and teaching aids.

The second utility is the online data application, which permits generation of reports and graphs on various parameters stratified by gender, caste, admission weight, maturity, cause of death and other critical parameters.

Other implementing partners

Technical support and initial funding from UNICEF were vital for development and scale up of software across the SNCUs of the State.

PROGRAMME OUTCOMES

- Each unit is monitored online from the State and National level.
- The follow up tracking has been integrated in the system with system generated SMS being sent to the community worker and family and the follow up status is entered at the end of the visit.
- Software has influenced policy decisions such as introduction of SNCU follow-up, both community and facility, introduction of antenatal steroids, C-PAP and ventilators.
- Software is helping the State to improve quality by providing performance of different districts on several parameters.

EVALUATION

Based on the capability of the database in providing quality data with ease, FBNC database is declared winner in "Best use of ICT for e-Governance" category of MAP-IT award.

FINANCIAL INVESTMENT

Initial commissioning was supported by the UNICEF, which was followed by NHM funding to support the FBNC database. Every year Rs. 50,000/- is sanctioned in programme implementation plan of the State to support the successful functioning of the database with its utility.

SCALABILITY

Policy decision for scale up of database has already been taken up by the Government of India based on efficiency of the database to support informed decision-making.

CONCLUSIONS/LESSONS LEARNT

The rapid scale up of SNCUs highlighted the inadequacy of data, which highlighted the need of online data management.

Contact

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Information generated by the software has influenced policy decisions. Nearly 245052 newborn admission, 189373 discharges, 29376 deaths & 330752 follow up visits captured in software



MADHYA PRADESH DAKSH SKILL LABS



PROBLEM STATEMENT

The need of time is to expedite the pace of decline in MMR and IMR with special focus on quality parameters. This requires capacity building of health care providers so as to make them proficient in technical skills and knowledge entailed for key intervention to ensure desired outcome.

In spite of various types of training imparted to the service care providers, it is observed that the providers are less confident in applying skills.

PROGRAMME DESCRIPTION

Comprehensive Skill Lab with skill stations is designed with the aim for up-grading and acquisition skills of health care providers to enhance their capacity to provide quality RMNCH services leading to the improved health outcomes.

The objective of Skill lab is to facilitate reinforcement of key standardized technical skills and knowledge to health care providers for RMNCH services thus ensuring availability of trained skilled personnel at health facilities.

PROGRAMME OUTCOMES

In Madhya Pradesh, two Skill labs (Bhopal and Gwalior) are providing training to the health care providers posted at Delivery points since March 2014. Till April 2015, a total of 40 batches of staff were trained involving 494 health care providers of districts of Sagar and Rewa division; where MMR is highest among the State. There are 39 skills

that are imparted to the trainees, which include plotting and interpreting Partograph, managing normal delivery, preparation and method of using injection MgSo4 in prevention and management of eclampsia, active management of third stage of labor, initial management of PPH and shock by using Inj. Oxytocin, putting IV line and CAB approach, New born resuscitation and essential new born care.

After each batch the trainees have to provide feedback about the training content and their confidence level to practice the Skill acquired. 100% of the participants felt that the course content was sufficient and was helpful in upgrading Skill. 100% of the participants were confident in using the Skill acquired. 12 % of the participants were less confident about executing standard precautions in infection prevention and use of personal protective equipments.



SCALABILITY

In Madhya Pradesh with support of DFID- MPTAST, Skill labs are being established at divisional level in Indore and Rewa.

The skill lab can be used for skill assessment of newly recruited staff (ANM, SN, MOs) and their induction training and providing proficiency certification to master trainers of different trainings

CONCLUSIONS/LESSONS LEARNT

on simulation or on mannequin which won't be possible

on actual client. During the mentoring visits by trainers of Skill lab, skills provided to SN and ANM are assessed and it was found that the trained staff is now confident and secure in executing and managing various RMNCH skills.

REFERENCES

- 1. Skill lab Operational Guidelines and Skill lab training manual.
- 2. Partner in implementing (if any).
- Comprehensive Skill lab provides opportunity to practice 3. Established with technical and financial support of DFID-MPTAST.

Contact

MD NHM and Deputy Director Maternal Health, National Health Mission, Madhya Pradesh

A total of 40 batches of staff were trained involving 494 health care providers. 100% of the trained staff is now confident in various RMNCH skills



TAMIL NADU BIRTH COMPANION PROGRAMME



PROBLEM STATEMENT

In ancient times, women experienced childbirth surrounded by companions who are usually women from their own family or community. Birth companions are women who have undergone the process of labour and provide continuous one-to-one support. The presence of a female relative during labour is a low cost intervention that has been proved to be beneficial to the labouring mother.

PROGRAMME DESCRIPTION

Birth Companions provide emotional support (continuous reassurance), information about labour progress and advice regarding coping techniques, comfort measures (comforting touch, massages, promoting adequate fluid intake and output), and advocacy (helping the woman articulate her wishes to others). Studies and reviews show that continuous support leads to slightly shorter labour, greater likelihood of spontaneous vaginal birth and reduced need for intra-partum analgesia. In addition, women who receive continuous support are less likely to report dissatisfaction with their childbirth experience.

The Birth Companion programme was launched by the Honourable Minister of Health and Family Welfare, Tamil Nadu on 25th August 2004, at Chennai. It is being implemented in all the public healthcare facilities in the State.

Pre requisites for a birth companion

- Only female companions are allowed.
- She should have undergone the process of labour.
- She should not suffer from any communicable diseases.
- She should wear clean clothes.
- She should be willing to stay with the mother throughout the process of labour.
- She should not interfere in the work of hospital staff and the treatment procedures.

• She should not attend to other women in the labour room.

PROGRAMME OUTCOMES

During the eleven years since the introduction of the programme:

- There were no adverse effects of allowing a companion during labour.
- All the mothers who have had a birth companion were very much contented and welcomed the opportunity of someone known to them being there in an alien atmosphere during the period of stress.
- The companions are able to understand the efforts put in by the medical professional at all times and more so during an emergency situation.
- Even in the event of any adverse outcome to the mother or child, they act as a witness to the efforts put in by the healthcare providers and help in making the relatives understand the situation.



It is a no cost intervention with immense benefits to the mother, relatives and the service providers

SCALABILITY

It is scalable at all facilities as evidenced in Tamil Nadu where all Government healthcare facilities from PHCs upwards to Medical College Hospitals (Nearly 2000 facilities) allow Birth Companions.

CONCLUSIONS/LESSONS LEARNT

Strong positive effects were noted when:

- Other sources of support were not available.
- Epidural anaesthesia was not routinely used.

- was not an employee of the hospital.
- The support started early in labour.

The Birth Companion programme is a no-cost intervention with immense benefits to the mother, relatives and the service providers.

REFERENCES

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TELANGANA

BIRTH PREPAREDNESS AND PARENTAL EDUCATION FOR BETTER MATERNOFETAL OUTCOMES



Improved set up L.Rs, organized A.N. clinics and parental education gradually increased the number of deliveries in 24x7 PHCs

PROBLEM STATEMENT

oor and inadequate preparation of the mother and family is one of the major causes of all preventable maternal and infant deaths (as observed during project period Medak district) including female infanticides in the Indian situation.

PROGRAMME DESCRIPTION

- a. Start date- month and year: March 2007 May 2009.
- b. Project description.

Background

It is a series of planned and structured informative sessions given according to the trimester, on specific, set days to all expectant mothers and their important family members, like mother-in-law/mother and husband, so that they become partners with the providers to help the mother enjoy a healthy pregnancy, pleasant childbirth and a healthy child, ultimately leading to a reduction in MMR and IMR.

Methodology

- A specific day (Friday) was allotted exclusively for conducting antenatal clinic – the second Friday and third Friday of every month were allotted for second trimester and third trimester mothers consecutively.
- A series of informative sessions were planned and prepared according to the trimester of pregnancy. Thus every mother who attends the antenatal clinic receives uniform information through group-teaching/ discussion and demonstration, and posters.
- Birth preparedness and Parental Education was conducted for ten to fifteen minutes and mothers were taken to already improved and set Labour Rooms and shown the facilities that are available for them when they come to PHC for safe delivery.
- Feedback from mothers in reference to Birth preparedness and Parental education comments and

feedback to be written in the parental education book that had to be maintained by the staff nurse or Head Quarters ANM.

- Initiation of Birth preparedness and Parental Education Sessions.
- Training of master trainers at Sweden, Karolinska institute.
- Piloted in one district as one of the components of Medak Modal Project.
- Five levels of interventions were implemented Facility level, Provider level, Community level, Programme level, Policy level.
- Operationalising Midwifery services in 36 round the clock PHCs, and 10 FRUs.
- Parental education was taught in "Midwifery Skill Enhancement Trainings" (a three-day training programme for staff nurses and Head Quarters/OP ANMs).
- Parental education was initiated at the provider level through PHC/Head quarters sub-centre at PHC Kondapur in July 2007.
- Champions identified, rewarded and programme disseminated to other PHCs 18 out of 36 24x7 PHCs in Medak districts.

Population Covered: Since 2007, 1119 mothers attended the birth preparedness sessions.

PROGRAMME OUTCOMES

Impact on the district during project period: Improved set up L.Rs, Organized A.N. clinics and parental education gradually increased the number of deliveries in round the clock PHCs.

IMPLEMENTING PARTNERS

Sida through IIM Ahmadabad and ANSWERS, MITRI, Peddapur, Medak District.

EVALUATION

Indian Institute of Public Health (IIPH, Hyderabad), 2010. "A cross sectional survey of the PHCs."

FINANCIAL MANAGEMENT

The financial expenditure for a two-year period for Medak district was 18-20 lakhs which included all five interventions.

SCALABILITY

For future scalability this intervention can be taken as a pilot study in three to five PHCs at different geographical situations.

CONCLUSIONS/LESSONS LEARNT

Dedicating a separate day (other than UIP) for organising antenatal clinics helps service providers to give focused antenatal care, Birth preparedness and Parental education sessions according to the trimester uniformly throughout district.

REFERENCES

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TRIPURA

EVALUATION AND TREATMENT OF BIRTH DEFECTS THROUGH CAMP APPROACH UNDER RBSK



During April to November 2014 (09 month) total 92,482 children were screened from rural Tripura and out of that 23.14% were found with some minor or major health problem



PROBLEM STATEMENT

Tripura is a small State of India located in North Eastern Zone; its 65% of total area is hilly terrain & 03 sides of the State is having international boundary with Bangladesh and remaining with Mizoram and Assam. The State is connected with the rest of India by only one National Highway. Health service of the State is totally depends on government sector. Tertiary care of Government setup is available in 02 Medical College and 01 State Hospital. Private health institutions are very negligible; only one hospital is functional. State has a better Primary health setup, where Institutional delivery is 86% (HMIS-2014) and Infant Mortality Rate (IMR) is 26.

On an average 12,000 children are being screened every month throughout the State. Therefore, burden of curative services has increased day by day. In Tripura tertiary care facility is very limited either in government or private sector. In absence of adequate tertiary care services to identified cases, State National Health Mission (NHM) decided to opt for camp approach of service provision under RBSK in collaboration with Nationally recognised service providers for specialist treatment.

PROGRAMME DESCRIPTION

Child health screening under Rashtriya Bal Swasthya Karyakram (RBSK) was started in Tripura from April 2014 through 12 Mobile Health teams covering all 08 districts. Camp approach under RBSK initially began in November'2014 with Cleft Lip and Palate Operation camp at Tripura Medical College & Hospital, Agartala.

PROGRAMME OUTCOMES

To provide surgical intervention partnership was done with 'Tripura Medical College' for infrastructure and logistic and 'Operation Smile' for specialist service provider. Partner NGOs has support this camp voluntarily. 42 children were identified as cases of cleft lip& palate.

During last ten month RBSK team identified 59 cases with CHD. A total 61 cases were evaluated free of cost, out of

which 29 cases were suggested for surgical procedure. Nearly 50 clubfoot cases were identified in last ten months. A camp was organised at Agartala Government Medical College (AGMC) in partnership with Cure International. Similarly 61 children were identified as cases of congenital cataract & Retinopathy of Prematurity at a camp organized for the same.

During April to November 2014 (09 month) total 92,482 children were screened from rural Tripura and out of that 23.14% were found with some minor or major health problem.

IMPLEMENTING PARTNER

Different local and National Level NGOs.

SCALABILITY

According to the prevalence rate there is large number of child with different birth defect is in the community, this is RBSK which make an opportunity to find out all these children for treatment. Camp based approach is a small initiative; which reduce at burden of large number of backlog, and so far has been a successful approach.

CONCLUSIONS/LESSONS LEARNT

Camp based approach under RBSK has made a practical understanding of the expectation of the stake holders and community about RBSK programme. This approach of service provision has also helped in generating community awareness, capacity development of service providers and willingness on effective and efficient functioning of RBSK in the coming days and necessity of setting-up of DEIC in every district at the earliest.

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EDICINE

The most exciting breakthrough of the 21st century will not occur because of technology, but because of an expanding concept of what it means to be human

– Jhon Nais Bitt

ANDHRA PRADESH MOTHER AND CHILD TRACKING SYSTEM (MCTS)



anual data collection/reporting from all the health facilities is not systematic & timely which leading to huge backlog of data. As an outcome, analysis of the data & corrective actions could not be taken up timely and effecting the service delivery.

PROGRAMME DESCRIPTION

(MCTS) is an initiative of the Ministry of Health and Family Welfare for ensuring delivery of full spectrum of healthcare and immunisation services to pregnant women and children up to 5 years of age. It is an innovative, webbased application to facilitate and monitor service delivery as well as to establish a two-way communication between the health service provider and the beneficiary. The State has implemented the MCTS in an innovative way by involving all the stakeholders and fixing responsibilities for each. A predefined schedule is fixed for each stakeholder. Also special attention is given for the local community involvement (Gram Panchayat etc). ASHA is responsible for identification of new cases in the field and informs ANM about the status of existing beneficiaries. ANM provides the required services and updates the MCH register. ANM visits the PHC on the allocated date and the data entry is done in the MCTS portal by a Data Entry Operator. Each beneficiary is issued a MCH card and a MCTS ID. Once data entry/service update is completed in the MCTS portal, a print out of the Work-Plan from the MCTS portal is handed over to the ANM for to facilitate services delivery. A print out of the Line Listing of the Expected Deliveries for the month is also given to the ANM at the beginning of each month. The Medical Officer at the PHC downloads the HIGH RISK cases report from MCTS portal and in case of requirement suggests to ANM to accompany the beneficiary. The BMO reviews the performance and the implementation of the MCTS through various reports available in the MCTS portal. The MIS manager identifies the gaps and informs the respective officials for necessary action. The key interventions for successful implementation of



the MCTS in the State are – community involvement at different levels for review of the MCTS service delivery status, convergence with W&CW Department and SERP for Tracking of High Risk Mothers and Children during JANMABHOOMI MANA VOORU PROGRAMME, regular review of MCTS at different levels, extensive utilisation of the MCTS reports by the departmental programme officers and utilisation of the MCTS portal for service delivery assurance.

PROGRAMME OUTCOMES

Near real-time data upload ensures real-time work plan generation for ANMs, thereby ensuring timely delivery of services to all pregnant women and infants/ children.

Near real time data upload ensures real time work plan generation for ANMs, timely delivery of services to all pregnant women and infants/children

FINANCIAL INVESTMENTS

The cost burden is borne entirely by the Ministry of Health and Family Welfare, Government of India.

SCALABILITY

The process for MCTS implementation and review has been established State-wide.

CONCLUSIONS/LESSONS LEARNT

A Tablet-based application is being developed for Statewide roll-out for ensuring more robustness and utilisation of data for immediate necessary action and programme interventions.



HIMACHAL PRADESH TELE- HEALTH SERVICES PROGRAMME



On 21st of April 2015, highest altitude tele consultation OP on Earth (Next only to NASA space station) became functional at Kaza, Himachal Pradesh. Till May 2015 there has been a total of 254 Tele-consultations

PROBLEM STATEMENT

The Department of Health and Family Welfare, GoHP has taken cognisance of the unique challenges faced by the State in relation to the terrain, climatic conditions and remoteness of the community settlements, particularly the eastern districts of the State at the foothills of the Himalayas. Providing essential services in these districts poses challenges which are unique to the State and attributed to the mountainous nature of the area.

PROGRAMME DESCRIPTION

The Himachal Pradesh Tele-Health Services programme has been conceptualised, designed and developed by Apollo Hospitals Tele Health Services (ATHS) on a PPP framework.

The project began in January 2015 and is to continue for a term of 15 months. ATHS will focus on eliminating distance barriers and improve access to quality multispecialty health services virtually, provide information that will assist the community in reducing the travel to distant locations, enable the community to access seamless healthcare, play an invaluable role in emergencies, facilitate patient and government doctors in rural areas to have access to specialist health information, services and support, reduce rural health practice isolation by enhancing access of physicians, nurses and allied health professionals to colleagues, specialists and education.

IMPLEMENTING PARTNERS

The programme was designed, developed and implemented in collaborative partnership between the National Health Mission, Department of Health and Family Welfare, Government of Himachal Pradesh and Apollo Hospitals – Telemedicine Department.

EVALUATION

Till May 31st 2015, there has been a total of 254 Tele-consultations and 13 Emergency consultations for patient stabilisation. As per the plan a structured preand post-impact analysis is planned during the 12-month period of service delivery in the programme.



FINANCIAL MANAGEMENT

The total project cost is funded by the State for meeting the direct expenses of capital and operating expenses. Apollo hospitals has subsidised the cost of consultation charges for Primary, Speciality and Emergency support on a minimum retainer fee with unlimited consultation support to the project locations.

SCALABILITY

The project since deployment has proved to be a perfect solution for making healthcare accessible through the PPP framework. The Government of Himachal Pradesh is aggressively working on scaling-up the learnings from this programme to the rest of the distant and difficult terrains covered by the State health facilities.

CONCLUSIONS/LESSONS LEARNT

The project has helped to provide an innovative solution for healthcare delivery even in remote, difficult and rural locations. In less than 3 months the demand for tele-consultations has gone up significantly.

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TAMIL NADU

PRENATAL SCREENING OF ANTENATAL MOTHERS FOR DETECTING CONGENITAL FOETAL ANOMALIES





There was no prenatal screening for birth anomalies especially in the government sector in this country with few exceptions. Ultrasound is a non-invasive technique of identifying some of the common birth defects during antenatal visits by the pregnant mother but is not used for identification of birth defects routinely.

PROGRAMME DESCRIPTION

Started

First Phase: 2010-2013 and Second Phase: Since April 2014.

Area and population covered in

- Phase 1: 2010-2013: in 30 districts, 504 doctors of 256 PHCs screened 149600 cases approximately and detected 1648 anomalies.
- Phase 2: April 2014: planned for 105 CEmONC centres, 16 Medical college hospitals and 154 Block PHCs at 30 districts.

The following activities were done under the intervention

- a. Establishing the hardware: Computers/laptops are provided at the centre with net connectivity.
- b. Installing a dedicated software which will ensure auditing of all the images.

- c. Orientation of the doctors, online theoretical course and mentoring of each doctor for the next 18 months to validate their findings.
- d. Software monitoring the number of scans done, quality of scans and finally the diagnosis of each of the trained doctors and a rating is done for each trainee.
- e. Tracking of the positive cases and their outcome through software.

The training objectives of this project are to train the participants in Pregnancy dating, to identify most common malformations, to diagnose IUGR, identify Placenta previa, assess Liquor abnormalities, know when to refer to higher centre and absorbing and tracking the outcome.

PROGRAMME OUTCOMES

- Increase the skills of the Obstetricians to detect fetal abnormalities and to identify other gestational problems.
- Increase the skills of the Medical Officers from PHC in the usage of ultrasound during the screening of antenatal mothers so as to detect high-risk pregnancies and fetal abnormalities.
- Preventing and managing birth defects.
- Identification of high-risk pregnancies for appropriate and early referral.

IMPLEMENTING PARTNERS

Mediscan System, Medall Health care Pvt. Ltd. and Government of Tamil Nadu.

FINANCIAL INVESTMENT

Approximately the cost of training each medical officer is Rs. 46,500/- for a period of 18 months. The required funds are provided through the State plan as well as NHM.

SCALABILITY

This programme can be implemented in any of the States. It can be linked with a genetic lab service facilities and RBSK.

CONCLUSIONS/LESSONS LEARNT

The scientific technology of Ultrasound could be used for improving the outcome of pregnancy in respect to both mother and child. This would also reduce the burden of birth defects.

In Phase-1, across 30 districts 504 doctors of 256 PHCs screened 149600 cases and detected 1648 anomalies



TRIPURA USE OF TELEMEDICINE FOR IMPROVED HEALTHCARE OUTCOMES



Telemedicine-55000 patients of remote areas have been treated/ consulted/referred so far and won e-North East award in 2013



PROBLEM STATEMENT

Tripura is a small State in NE Zone with 65% of its area in hilly terrain and difficult to reach. For health services, dependency is completely on government sector. But due to difficult geographic terrain, health accessibility is poor.

PROGRAMME DESCRIPTION

In the first Tele-medicine Projects at Tripura (Phase I), facilities have been set up at 3 referral Centres (GBP Hospital, Cancer Hospital, IGM Hospital, Agartala) and 5 Nodal Centres in remote/hilly areas (Gandacherra, Kanchanpur, Chailengta, Amarpur SDH and Kathalia PHC) using 2 Mbps/512 Kbps leased line. In the 2nd Project (Phase II) the facilities have been setup for various diseases at 6 more Nodal Centres (Melaghar, Sabroom, Belonia SDH, Kumarghat CHC, Kulai and Natunbazar PHC) The same has been extended to another 6 Nodal centres in Phase III (Khowai SDH, Takarjala CHC, Ompinagar CHC, Hrishyamukh PHC, Damcherra PHC and Chawmanu PHC. So far 55000 patients of these remote areas have been treated/consulted/referred. Medical services have been provided for different types of diseases that include Leprosy, Tropical diseases, Paediatrics, Orthopaedics, Cardiology, Medicine, Dermatology, Neurology, Radiology, Oncology etc.

FINANCIAL INVESTMENT

Setting up of Telemedicine Facility in Tripura (SUTF).

Project Cost: 287 lakh, **Deployment of Telemedicine in Tripura, Project II (DOTP) Project** Cost: 282 lakh, **Deployment of Telemedicine at remote CHC/PHC in Tripura,** Project Cost: 296 lakh were funded by DeitY and GoI.

Deployment of Telemedicine at remote DH/SDH in Tripura.

Project Cost: 85.65 lakh was funded by **NHM**, Government of Tripura.

SCALABILITY

The Technology developed is continuously being upgraded and customised to satisfy the requirements of the doctors on the basis of the feedback received. It has been observed that most of the doctors are interested in Tele-medicine.

By implementing Telemedicine Projects in the Government the journey towards e-Governance, the benefits of Information and Communication technology in general and tele-medicine in particular, have reached different parts of Tripura. The tele-medicine facility, particularly the videoconferencing systems, will henceforth also be used for continuing medical education for the isolated health practitioners of these remote areas who do not have access to professional discourses or educational opportunities. It will also be used to educate or to provide necessary training to paramedical personnel serving in the vast and densely populated rural areas in discharging their duties i.e. to administer immunisation, educate people on mother-child health programmes, and render advice on family planning and collect data on the rural population's growth, birth and immunisation rates. The comprehensive database of patients - offline as well as real-time created at the centres will be gainfully used for the significant improvement in medication management.

REFERENCES

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- 2. eNorth East award 2013.

Contact

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TRIPURA TRIPURA VISION CENTRE PROJECT



Tripura has been facing acute shortage of modern ophthalmic infrastructure and Ophthalmologists. There is only one public sector civil hospital, the Indira Gandhi Memorial (IGM) Hospital (base hospital) in the capital of the State that serves the need for all the primary, secondary and tertiary eye-care support. Seventy-four percent of the population that resides in the rural areas has to spend a considerable amount on transportation and accommodation to avail of these services. At present, a total of 19 Ophthalmologists and 26 Ophthalmic Assistants/ Optometrists are catering to the needs of 37 lakhs of residents. By 2016, the numbers are estimated to reduce further as out of the 20 Ophthalmologists, 10 will retire from service, implying that only 8 or 9 Ophthalmologists will be providing eye-care to a projected population of 40 lakhs.

PROGRAMME DESCRIPTION

The model of **Vision Centre** was envisaged in the year **April**, **2007** through the "Vision 2020" global initiative for elimination of avoidable blindness, a joint programme of the World Health Organization (WHO) and the International Agency for Prevention of Blindness (IAPB). The project currently serves a rural population size of approximately 3.7 million people in remote areas, spread across 44 blocks of 8 districts in the State of Tripura. The establishment of 44 Tele-ophthalmology Centres was done in a phased manner.

Phase I: One Centre started on 7th April, 2007 at Melaghar R.D Block on pilot basis.

Phase II: Ten Centres started on 30th September 2008.

Phase III: Twenty nine Centres started on 1st October 2009.

Phase IV:

- a. Once Centre started on December, 2014.
- b. hree Centres started on 1st January, 2015.

FINANCIAL INVESTMENT

Total Fund Received from GoI – Rs. 534.07 lakhs.

SCALABILITY

The model is definitely scalable and is evident in the way the current pr oject has been able to serve the entire State of Tripura, starting with just a pilot at one block. The phased implementation of the project over a period of time has tested the potential to scale-up and sustain the field requirements.

CONCLUSIONS/LESSONS LEARNT

The model of Vision Centre was envisaged in the year April, 2007 through the "Vision 2020" global initiative for elimination of avoidable blindness, a joint programme of the World Health Organization (WHO) and the International Agency for Prevention of Blindness (IAPB). The project currently serves a rural population size of approximately 3.7 million people in remote areas, spread across 44 blocks of 8 districts in the State of Tripura. The establishment of 44 Tele-ophthalmology Centres was done in a phased manner.

REFERENCE

http://indiagovernance.gov.in/bestpractices.php?id=932.

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Teleopthalmology-The project currently serves a rural population size of approx 3.7 million people in remote areas spread across 44 blocks of 8 districts in the state of Tripura

WEST BENGAL

IMPLEMENTATION AND USE OF USSD SERVICE FOR SERVICE DATA UPDATE ON MCTS



arlier MCTS data was being updated by DEOs posted at the block level. Uploading the data from the farthest blocks with poor internet connectivity is a major challenge resulting in huge backlog of data. As a result, the work plan generated by the MCTS system was outdated and not relevant.

PROGRAMME DESCRIPTION

USSD (Unstructured Supplementary Service Data) is a GSM technology that makes communication interactive and easy to use. It can be accessed from any simple GSM mobile phone, with no special application requirements on the handset. USSD messages are up to 160 alphanumeric characters in length in English and about 70 characters in length in the local language.

The USSD application designed for MCTS is user-friendly. The application can be easily handled by any healthworkers (ANMs)/users having basic functional knowledge of mobile and registered on MCTS Portal and USSD gateway of NIC. Also no internet connectivity is required for the data updation through USSD.

Area and population covered

As per Census 2011, USSD services have been implemented in rural areas of West Bengal with a population coverage of 6,21,83,113. Service delivery details of the registered beneficiaries (pregnant women and children) are being updated on the MCTS portal through USSD platform on near real-time basis by registered health service providers (ANMs).

The benefits of USSD are as follows:

 Reduces time lag/delay in data updates on MCTS Portal.

- Improves data quality and ownership.
- Ensures better monitoring and micro-planning.
- Meaningful, readily available work plan for the ANMs.

PROGRAMME OUTCOMES

Since September, 2014, 97.7% of the registered ANMs have been subscribed on the USSD gateway. Till date 76.4% maternal services and 69% child services have been updated by ANMs.

IMPLEMENTING PARTNERS

Ministry of Health and Family Welfare, (GoI).

FINANCIAL INVESTMENT

There is no cost implication for the State. The cost is borne entirely by the Ministry of Health and Family Welfare, Government of India.

SCALABILITY

Structured monitoring and hand-holding of ANMs alongwith motivation is the key to success. In this regard a few more monitoring reports for blocks and districts may be developed to scale-up the utilisation of USSD service by ANMs. Nationwide 100% USSD implementation would ensure to improve service delivery coverage and quality services to mothers and children.

CONCLUSIONS/LESSONS LEARNT

It helps in real time data upload which will ensure real-time work plan generation for ANMs, thereby ensuring timely follow up and delivery of services. The State is facing the following issues regarding USSD implementation:

- Works currently only on AIRTEL/TATA(GSM)/BSNL/ Idea/Vodafone SIM (prepaid or post- paid).
- ANMs with BSNL connections are having difficulty in updating of data through USSD.

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97.7% of the registered ANMs have been subscribed on USSD gateway. 76.4% maternal services and 69% child services have been updated by ANMs





• Health service providers are the personification of a system's core values – they heal and care for people, ease pain and suffering, prevent disease and mitigate risk – the human link that connects knowledge to health action 9

– Working Together for Health, The World Health Report 2006

ANDHRA PRADESH & TELANGANA GRIEVANCE REDRESSAL MECHANISM



During period of 2006-15 total of 97,57,642 beneficiaries utilised the service

64 | MAKING A **DIFFERENCE** : Good, Replicable and Innovative Practices

Parious types of information related to health was not accessible to majority of the population particularly those living in rural areas. No mechanism to register and track the grievances related to various schemes and services. So there was a requirement for an effective health information system, which ensures a two-way flow. Such a system will effectively address the felt needs of people especially the poor.

PROGRAMME DESCRIPTION

The centre 104 Sevakendram was started in 2006-07, however the 104 Health information Helpline started working from Oct 2011. Currently same center is working as 104 Sevakendram, for both for A.P & Telangana). The Project was initiated in PPP mode in the combined State of Andhra Pradesh as a Health information helpline so that people living in the remotest villages can obtain advice and information on various health problems the families are suffering from; with a focus on - Receiving of any grievances from public health institutions, giving home based remedies to stabilize the patient's condition, Information on Government and private medical facilities and Counseling services to the needy callers.

This was scaled up for:

- Information and Monitoring of major schemes.
- Information on various services.
- Information to the pensioners and employees on EHS.

PROGRAMME OUTCOMES

A system of internal quality and monitoring mechanism is inbuilt in the 104 Sevakendra. From 2006 to 2011total number of beneficiaries for the both State (Tamil Nadu and Tillengana is 49, 54,627. From 2011 to 2015 the number of beneficiaries for A.P is 48, 03,015.

Training and IEC

Trainings on Medical terminology, disease summaries and Algorithms. Orientation Trainings of 12 categories of health personnel, which includes various schemes of the State, national programmes, Soft Skills including communication and counseling.

FINANCIAL INVESTMENT

Total capital cost since 2006-07 is Rs.8.35 crores Operation cost increased from Rs.3.12 crores to Rs.3.45 crores from 2011-15.

CONCLUSIONS/LESSONS LEARNT

Innovative, emerging and scalable initiative. Good quality training and IEC are essential components.

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BIHAR NURSE MOBILE MENTORING PROGRAMME



In the context of the maternity-benefits-driven rapid increase in the utilization of public facilities for childbirth in Bihar (current estimate ~65% of all deliveries), these facilities must sustain minimum standards of quality of care for safe birth outcomes to be ensured. Most deliveries in public facilities are conducted by ANM and GNM nurses. Pre-service training and SBA training have proven insufficient in improving the quality of intra-partum care to desirable standards, obstetric skill deficits of nurses are identified as serious and the numbers of nurses in position are too small to permit drawing them out of their places of work for prolonged offsite training. The likelihood of recruiting skilled nurses in sufficient numbers in the foreseeable future is small, and without in-service training of available nurses, intra-partum care is unlikely to result in reducing preventable perinatal deaths.

PROGRAMME DESCRIPTION

This programme is an in-service, onsite mentoring of available nurses in public facilities by qualified mobile nurse mentors has been implemented in three phases:

Phase 1: Pilot in 32 designated BEmONC level facilities in 8 districts (2012-2013).

Phase 2: 48 more facilities (including 8 CEmONC level facilities) in the same districts (2013-2014).

Phase 3: (Ongoing) 320 more BEmONC facilities and 56 more CEmONC level facilities (2015-2017).

All nurse mentoring is embedded in the Quality Improvement process of the State and is implemented by the Bihar Technical Support Program (BTSP). The current model exposes 6-8 selected staff nurses in each facility (typically, a combination of all available GNMs and additional ANMs to make up this number, selected by the concerned block/district hospital) to a pair of mobile nurse mentors (typically, BSc nurses, with some experience in obstetric nursing) for one week a month for a total of 6-8 months. A carefully planned but flexibly implemented curriculum defines learning goals for each week and month, and seeks to incrementally improve functionality every month until desired functionality is achieved in the facility. The mobile nurse mentors are overseen by master nurse mentors (typically, one MSc in obstetric nursing oversees 2 pairs of nurse mentors).

The nurse mentors use a combination of bedside teaching (in the labor room on actual delivery cases), simulations (using inexpensive equipment, for teaching complex skills such as managing maternal and neonatal emergencies), and theory to emphasize the rationale for each protocol and process. The mentoring intervention seeks to ensure that all basic practices - infection control, intra-partum and postpartum maternal and neonatal care services, as well as quality of FP procedures provided at these facilities conform to acceptable standards of quality, and result in consistently predictable and positive clinical outcomes. The progress of facilities and individual student nurses is measured and monitored regularly.

EVALUATION

Although no third party evaluation has been carried out, programme data showed significant improvement in practices. For instance, Oxytocin for AMTSL improved from 8.6% to 58.5%, initiation of Kangaroo Mother Care increased from 30.9% to 62.5% and use of sterile instruments increased from 13% to 43.5%.

FINANCIAL INVESTMENT

Besides routine Government of Bihar finances and PIP support from NHM for infrastructure and supplies, only

the direct costs of recruiting, deploying and managing the nurse mentors have been borne by CARE/SRU budgets and is estimated to cost Rs. 1300* per trainee per day.

SCALABILITY

This programme has already gone to scale in Bihar starting from 80 facilities and to complete 320 facilities by next year. The GOI has also accepted as a programme and allocated a FMR A9.1.4 for Onsite Mentoring at Delivery Points under the Skill Labs component within the PIPs for the National Health Mission.

CONCLUSIONS/LESSONS LEARNT

Sustaining and diffusing quality of care is inbuilt in the current model through identifying and training 2-3 staff nurses in each facility to be mentors for others, and through a separate programme for doctor mentoring. The model is effective in improving all aspects of quality of care, but needs complete ownership by the leadership at the block and district level to sustain.

REFERENCE

BTSP is a programme conceptualized by State Quality Assurance Committee and NHSRC, planned and implemented by CARE India with financial support from the Bill and Melinda Gates Foundation (BMGF).

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*Assuming 8 trainees per facility and 7 weeks training per trainee.

Programme has been scaled up from 80 facilities to 320 facilities. Oxytocin for AMTSL improved from 8.6% to 58.5%, initiation of Kangaroo Mother Care increased from 30.9% to 62.5% and use of sterile instruments increased from 13% to 43.5%



MAHARASHTRA PUBLIC HEALTH CADRE





At present, a total of 271 public health professionals are working within the Public Health cadre in the State


PROBLEM STATEMENT

A need for establishing a separate cadre for public health professionals to investigate and control the increased prevalence of communicable diseases such as diarrhea, cholera and small pox in Maharashtra.

PROGRAMME DESCRIPTION

The PH Cadre came into existence in 1976, whereby doctors, usually with Diploma in Public health, MD (PSM), MPH from any institution recognized by the MCI are part of the cadre. The positions for these public health professionals are available at State and district level and training centers and are responsible for managing National Health Programmes and facilitating and/or conducting trainings. They also manage the 11 bureau created for all disease control programs. At present, a total of 271 public health professionals are working within the Public Health Cadre in the State.

PROGRAMME OUTCOMES

The State has developed well-defined roles and responsibilities for each position working within the PH cadre, which has led to functional clarity. While the doctors from medical and Civil Surgeon cadre focus primarily on patient centric care and treatment of diseases; the public health professionals oversee programme management. This has led to effective utilization of specialized skills of doctors from each of these cadres resulting in better understanding of community needs and improvement in planning and implementation of health programmes for better management.

FINANCIAL INVESTMENT

At the time of establishment, sanctioning of new posts for public health positions required financial support. Some of the positions were shifted from the existing workforce, hence required no financial investment.

CONCLUSIONS/LESSONS LEARNT

Lack of adequate candidates with necessary skills for all the sanctioned posts in PH cadre. Ambiguity in the reservation criteria for these positions leading to bias, improper promotional practices etc. There is also a need to extend the public health positions up to the block level to bridge the gap between the community and the health providers at grassroots level. A supportive legal act will further substantiate the public health system in the State.

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TAMIL NADU PUBLIC HEALTH CADRE



Under the Directorate of Public Health and Preventive Medicine, 42 District Health Units comprising of about 40 Primary Health Centers are functioning

PROBLEM STATEMENT

In early 20th century, diseases such as cholera, plague, small pox led to high mortality in the State and the existent human resources for health were not trained to manage these epidemics alongside their routine activities. This led to the need for a dedicated cadre to investigate and manage outbreaks and contribute to improving the wider determinants of health such as sanitation and cleanliness.

PROGRAMME DESCRIPTION

The Directorate of Public Health and Preventive Medicine (DPHPM) was formed during 1923 in Tamil Nadu with the main objectives of (a) provision of maternal and child health care to the rural and urban people; and (b) prevention and control of communicable diseases. In 1980, the Directorate of Primary Health Centers was formed exclusively for PHCs and in 1996 it was again brought under the control of (DPHPM). All National Health Programmes are implemented through the PH Cadre and in-service training programmes for the cadre continues. The Public Health Act 1939 empowers the Health Officers to enforce Public Health Law to safeguard the health of the people.

PROGRAMME OUTCOMES

The main focus of the department includes prevention and control of communicable diseases and provision of community based maternity and child health services in rural and urban areas through universal primary health care. There is remarkably good management of natural disasters, disease outbreaks, complete immunization, improved sanitary conditions, and availability of potable water and disease surveillances.

FINANCIAL INVESTMENT

Out of the total State health budget in the financial year 2014-15, 1.32% was allocated to the Public Health Department.



CONCLUSIONS/LESSONS LEARNT

With passage of time some sections of the PH Cadre have emerged as separate entities with their own regulatory framework. This has led to a lack of coordination between divisions such as nutrition, water and sanitation. This has diminished the involvement of public health department in areas such as food adulteration, and sanitation issues. Also greater involvement of Block Level Medical Doctors in the cadre is desirable to further bridge the gap between health services and the community.



INGDS

The rise of non-communicable diseases creates an enormous burden on health systems. But this is not just a health challenge; it undermines economic growth and act as a chronic poverty trap for the poorest, derailing international efforts in poverty reduction *– Dr Ala Alwam, WHO*

KERALA AROGYAKERALAM PALLIATIVE CARE PROJECT



PROBLEM STATEMENT

The project was started with the aim of providing services to the rising number of terminally ill patients in the State. The services are aimed at improving the quality of life and infusing a sense of belonging in these patients.

PROGRAMME DESCRIPTION

The Programme started in December, 2008 following the adoption of Kerala Palliative Care Policy in April, 2008 by the State government. Thence Kerala became the first State in the country to announce a Palliative Care Policy (Government of Kerala, 2008). Following this the NRHM launched the Palliative Care Project with the help of LSGI in 2008. Kerala's decentralisation is important in this respect. The State has assigned well-defined development responsibilities and 25-30 percent of the State plan allocation to LSGI.

An important precursor of the Programmeme was the Neighbourhood Networks of Palliative Care (NNPC), functional in Kerala since 2001. In 2008, the State's Palliative Care Policy laid down a road map for operationalising home-based care and integrating it with primary healthcare in the entire State. The Arogyakeralam Palliative Care Project was piloted in Mallapuram and Kozhikode districts since they had already well-developed community initiatives. It was then scaled-up to the entire State. The programme provides services at the following three levels:

a. **Primary Palliative Care** through PHCs and CHCs and is basically home-based palliative care by a team.

- b. **Secondary level** involves specialist care and is provided by district, taluk and general hospitals.
- c. **Tertiary Level** This includes advanced care, research and training through general hospitals and identified tertiary care centres.

EVALUATION

Different evaluations show that the Project is successful in achieving its overall objectives and lays down the road map for the development of palliative care programmes in the rest of the country.

FINANCIAL INVESTMENTS

Funding is mainly through corresponding LSGI, palliative care projects/DHS/LSGI/Geriatric care programmes/NCD programme/NHM/donations.

SCALABILITY

Kerala's success in scaling-up the programme provides evidence to the scalability of the project. However, community participation and the involvement of LSGI have been the key to the project's success. This would imply that the means of ensuring these would have to be found in other parts of the country.

CONCLUSIONS/LESSONS LEARNT

The programme is an example how community participation can ensure the delivery of services even in resource-poor settings. The Institute of Palliative Medicine, Kozhikode was designated as a World Health Organization Collaborating Center for community participation in Palliative Care and Long Term Care which is the first of its kind.

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Contact

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Kerala is the first state in the country to announce a Palliative Care Policy in 2008. The Institute of Palliative Medicine, Kozhikode was designated as World Health Organisation Collaborating Center for community participation in Palliative Care and Long Term Care



MAHARASHTRA SICKLE CELL DISEASE CONTROL PROGRAMME



1,38,48,343 solubility testing has been done from which 1,60,866 carriers & 13,499 sufferers has been identified & 13,458 (99%) patients from sufferers are taking regular treatment

PROBLEM STATEMENT

The studies carried out by different institutions in Maharashtra indicated that the overall prevalence of sickle cell disorder in different tribal populations is 8% for the carrier and 0.5% for the sufferer. The prevalence is very high among the Bhil and Pawara tribal groups from the Nandurbar district and the Madia, Pardhan, Otkar and Gond tribes from the Gadchiroli district. The possible cause for this could be inbreeding and therefore racial profiling is needed.

PROGRAMME DESCRIPTION

As per the DMER draft proposal of June 2008, Sickle Cell Disease is prevalent in 21 districts of the State. The Programme is being implemented in these districts in a phased manner by NRHM since 2008.

Objectives and Goal of the programme:

1. Creating public awareness and screening among the general population. (Target age group 1 to 30 years, special focus is on adolescent age group and pregnant women).

- 2. Identifying carriers and sufferers and issuing yellow cards to carriers and red cards to diseased individuals.
- 3. Counselling carriers and sufferers about marriage and the importance of regular treatment.
- 4. Providing screening facilities at Primary Health Centres, Rural Hospitals, and Sub- District Hospitals and District Hospitals.
- 5. Referring positive cases from Solubility positive samples for electrophoresis test to the nearest Electrophoresis Testing Centre.
- 6. Providing Prophylactic and Symptomatic treatment at Primary Health Centres, Rural Hospitals and District Hospitals.
- 7. Training of Medical officers and other paramedical staff at PHC, RH and DH for testing, counselling and treatment.

Out of a total of 2303 Health Institutions, 1215 including PHCs, RHs, SDH, DH, Women's Hospital, speciality hospitals and Medical Colleges, are involved in SCD Control.

The service package has been made for various levels of health institutions and service provision in SCDCP include free solubility testing, free Electrophoresis testing (Electrophoresis centre), counselling, regular health checkup of sufferers, prophylactic and symptomatic treatment to be provided, blood transfusion to Sickle Sufferer if blood storage centre or blood bank is available, specialty treatment, maintenance of records and register, and provision of day-care centre.

Colour coded cards are used under the programme-White Card for Negative, Yellow card for the Disease Carrier and Red Card for disease Sufferer.

PROGRAMME OUTCOMES

- Since 2009 under Sickle cell Disease control Programme 1,38,48,343 solubility testing has been done from which 1,60,866 carriers (1.16%) & 13,499 (0.09%) sufferers has been identified and Yellow and red cards have been distributed respectively up to March 2015.
- 2. Out of 13,499 Sufferers detected 13,458 (99%) patients are taking regular treatment.
- 3. After Counselling out of 62,770 married Sickle cell carriers, 56,686 (90%) carriers are married to healthy partners and out of 3,020 married sufferers, 2,716 (90%) sufferers are married to healthy partners.

IMPLEMENTING PARTNERS

Sickle cell disease is implemented in 9 districts through NGO's. Also, 8 Government Medical colleges are involved in this Programme.

CONCLUSIONS/LESSONS LEARNT

Addition of Caste/tribe in the colour coded SCD Card will be done so as to help track racial profiling at all

service outlets. A mechanism of digital tracking of Sufferers and carriers to avoid duplication need to be established. There is felt need of High prevalence Caste Population based Screening strategy to enhance yield of cases. Timely procurement of solubility & electrophoresis kits for screening of population is one of the critical component.

REFERENCES

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Contact

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PUNJAB

ESTABLISHMENT OF CANCER AND DRUG DE-ADDICTION TREATMENT AND INFRASTRUCTURE FUND ACT



The State Government has added about 600-beds capacity for Drug De-adiction & is also in the process of setting up of Advanced Cancer Diagnostic Treatment & Research Centre & Super Specialty Cancer Unit





PROBLEM STATEMENT

ancer and drug de addiction is a major challenge in the State of Punjab. There are ninety cancer patients per 100,000 people compared to the national average of eighty. Cancer is leading to nearly 34,430 deaths in the past five years, as per a survey conducted by the health department.

PROGRAMME DESCRIPTION

The State Government realising the gravity of problems associated with cancer and drug addiction, promulgated an Act passed by the State Legislature Assembly called, "The Punjab State Cancer and Drug Addiction Treatment Infrastructure Fund Act":

- This ligislation has helped the State Government in mobilizing the additonal resources by levying cess on tobacco and various projects. This fund is being used for the creation of infrastructure and treatment of cancer patients and persons afflicted with drug addiction. In the year 2013-14, the State Government was able to mobilze about Rs. 100 crores into this fund. Similar amount is likely to be collected in this Financial Year also.
- It is, however, submitted that the funds required for creation of infrastructure for treatment of cancer and drug addiction requires huge some of money for setting up of specialty hospitals, de-addiction and rehabilitation centres, recruitment of super specialists and paramedical staff, procurement of very high end equipments for the diagnostic and treatment and other expenses associated with this treatment.
- The State Government has added about 600-beds capacity for Drug De-adiction in the State and has also initiated the process for recruitment of specialists and medical and paramedical staff. Similarly, the State is also in the process of setting up of Advanced Cancer Diagnostic Treatment & Research Centre at Bathinda, the super specialty cancer unit in the Guru Gobind Singh Medical College Faridkot, Cancer and Radiotherapy facilities in Sangrur for the time being.
- The State shall be creating infrastructure about Rs. 500 crores over a period of two years to complete all these activities.

FINANCIAL INVESTMENT

Approximately Rs. 500 crores over two years.

Contact

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TAMIL NADU HOME BASED PAIN AND PALLIATIVE CARE PROGRAMME



Covering 169 panchayats in a population of around 4.2 lakhs in the UG PHCs -The patient load, needing palliative care services vary between 200-300 patients

PROBLEM STATEMENT

Alarge number of **bed-bound people** with noncommunicable diseases in the community have poor access to health-care, and when available, the care may not be appropriate. The services to elders are the **State obligations** under "The Maintenance and Welfare of Parents and Senior Citizens Act, 2007" and in the "National Policy on Older Persons".

PROGRAMME DESCRIPTION

Home Care Services

Home service includes hydration, dressing, enema, ascitis tapping, maggot removal, pressure sore dressing, management with homemade diapers, sponge bath, eye care, oral care with mint mouthwash etc. These are to be provided by a team of personnel adopting proper protocol for clinical treatment to give a dignified living standard prior to the end of the life.

Hospice Type of Service in CHC/UG PHC (30 Bedded)

Patients unable to be managed at home require hospitalisation for inter-disciplinary consultation services and are admitted in the NGO-run hospital or at the UG PHC.

Home care, hospital-based palliative care or out-patients' care all must go hand-in-hand and complement each other.

Measureable Output

- 1. The expected level of home care is 2 visits per patient per month.
- 2. Drugs and dressing by health worker?? times per month.
- 3. One visit by doctor per month.
- 4. Number of patients selected for interventions, number added thereafter and deletion of dead and migrant.

The project was initiated on February 2012 with the support of NRHM in one block of each of the districts **Kancheepuram**, **Trichy**, **Tiruvallur and Villupuram**, covering a population of around 4.2 lakhs. The NGO will train the health worker VHN in different approaches to different persons in her area.

PROGRAMME OUTCOMES

In a block population of 1 lakh, generally 250 – 300 cases require palliative care. To know the patient's level of comfort, a patient satisfaction survey was conducted by the NGO.

IMPLEMENTING PARTNERS

Sudharsana, RMD Palliative care and M/s. Deepa Muthaiha & Scope.

FINANCIAL INVESTMENTS

Our experience in the pilot study shows that Rs. 20/- is required per patient for home care for drugs, dressings and consumables without overheads and travel cost.

SCALABILITY

TN has already established NPCDCS in all the districts. It is proposed to establish hospice type of palliative care services in 10 DHQ with home and it is planned to expand it to the entire State.

CONCLUSIONS/LESSONS LEARNT

The established centres are well accepted by the family members and the patients. In a few years time we can expect to see a visible change in the mindset of family members regarding care for elders in their family. Indirectly, instances of the elders roaming as destitutes and beggars are likely to get reduced. Gradual withdrawal of the NGO with community-based volunteers leading the services is expected.



UTTAR PRADESH

ESTABLISHING ENCEPHALITIS TREATMENT CENTERS IN ENDEMIC DISTRICTS



The JE vaccine coverage increased from 24.7% to 91% for the first dose and for second dose it increased from 33.6% to 66%. JE positivity rate has also come down from 9% to 2.2%

PROBLEM STATEMENT

J n 2005, a massive outbreak of Acute Encephalitis Syndrome/Japanese Encephalitis (AES/JE hit several districts in eastern Uttar Pradesh (U.P.) and the adjoining districts of Bihar. AES outbreaks are still being reported from seven endemic districts of eastern U.P. of Gorakhpur and Basti division (Gorakhpur, Maharajganj, Deoria, Kushi Nagar, Basti, Sant Kabir Nagar and Siddharth Nagar) with high mortality.

In these districts the main cause of high mortality was found to be the prolonged time taken to transport the patient over long distances without proper basic supportive medical care i.e. first aid/oxygenation up to the tertiary facilities. Added to this is the inadequate clinical infrastructure and non-availability of trained staff. To combat this problem, GoUP developed innovative ideas for early referral and prompt treatment of AES cases to prevent mortality due to AES.

PROGRAMME DESCRIPTION

In 2013, GoUP convened an expert group which recommended that an Encephalitis Treatment Centre (ETC) model should be used for clinical care management of AES cases to reduce mortality and disability. This model worked on the two principles: early oxygenation and quick transportation/referral to a health facility within 10 kms, which not only reduced the mortality of the AES/ JE but also brought down the severity.

By leveraging funds from the National Health Mission (NHM), by July 2014, 104 primary and secondary health centres were upgraded as ETCs across the 7 districts of Gorakhpur and Basti division. 10 ICUs equipped with ventilators, supplemented with 24x7 availability of trained government health personnel were established. Linkages were established with the existing free 108/102 ambulance service to transport suspected AES patients to the ETCs within minimum time.

Intensive IEC was done through various IEC/audio visuals material and media sensitisation workshops. Vaccine availability and the logistics management system were strengthened to ensure immunisation of beneficiary with JE vaccine in the Universal Immunization Programme (UIP).

Using the cascade training model, over 30,000 health personnel were trained in the 7 districts on communication for managing AES outbreaks and AEFI with JE vaccine.

Special JE vaccination catch campaigns were conducted to cover the left-out children.

PROGRAMME OUTCOMES

In the intervention area (7 Districts) during 2013-14:

- The JE vaccine coverage increased from 24.7% to 91% for the first dose JE vaccine and for second dose of JE vaccine, from 33.6% to 66%.
- CFR from AES has reduced from 21% to 15% and the CFR for JE has reduced from 35% to 28%.
- JE positivity rate has also come down from 9% to 2.2%.
- The number of referrals from the field through ambulances and number of patients seeking treatment increased.

IMPLEMENTING PARTNER

PATH

SCALABILITY

The ETC model is a low-cost model which can be easily scaled-up with limited resources.

Way forward

Strengthening and expansion of ETCs with additional interventions:

- Rehabilitating children disabled with AES/JE.
- Conducting mass community awareness campaigns in affected districts.



Strengthening Vector Borne Disease Surveillance Units in affected divisions.

CONCLUSIONS/LESSONS LEARNT

The ETC model is a cost-effective and workable model. Its visible impact can be demonstrated by reduction in the mortality due to AES and JE whereby millions of innocent lives of children can be saved.

Contact

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WEST BENGAL

A MULTI-PRONGED ACTION AGAINST DISEASE TRANSMISSION AND A CONCERTED EFFORT TOWARDS THE KALA-AZAR ELIMINATION GOAL



Total population of approx. 4.9 lakhs were taken up for the case search. The no. of blocks having annual incidence more than the cut-off level of elimination went up from 7 in 2013 to 11 in 2014



PROBLEM STATEMENT

It is a national goal to eliminate kala-azar by the year 2015. The State of West Bengal is endemic for kalaazar and is in 3rd position in terms of the number of kalaazar cases in the country, next to Bihar and Jharkhand. It was felt that in order to bring down the new incidence, the hidden cases be found out and treated, and measures be taken to control the environmental factors to cut off transmission chains.

PROGRAMME DESCRIPTION

Objectives

- To find out the undetected cases of VL and PKDL and put them on treatment.
- To strengthen control of vectors and environmental factors to reduce disease incidence.

Actions taken

- Active case search and proper treatment: Microplans were prepared at block level for survey and diagnostics camps. A special drive of rapid intensive case search (House-to-house) and diagnostic camps (Crash Programme) were undertaken. Confirmed cases were referred to pre-scheduled diagnostic camps and put on treatment with an anti-kala-azar drug as per national protocol. The new anti-kala-azar drug i.e. inj. liposomal amphotericin-B was introduced and the use of liposomal amphotericin was decentralised up to the block PHC level, after necessary training of staff. Intensive IEC activities were done in the villages before the active case search.
- All the search workers, supervisors and Medical Officers involved in the intervention were given orientation training.

- Administrative actions: kala-azar has been declared as a notifiable disease in the State, a State level Task Force is constituted as per the national road map to elimination and guidelines have been issued to the District Programme Officers to strengthen routine surveillance.
- Since poor housing condition is an important factor behind sustained kala-azar transmission, an endeavour has been taken up to improve housing in high case load villages.

PROGRAMME OUTCOMES

A total population of approx. 4.9 lakhs were taken up for the case search. Out of 3324 suspected cases 259 cases (103 VL and 156 PKDL) were confirmed. The number of blocks having annual incidence more than the cut-off level of elimination went up from 7 in 2013 to 11 in 2014.

EVALUATION

In order to assess the impact of IRS, a vector survey was done at the same place(s) before and after IRS. The results showed a mixed picture of impact, probably due to inconsistent quality and coverage of IRS.

CONCLUSIONS/LESSONS LEARNT

To sum up we State that we have taken to fight the disease problem at the levels of (i) the hosts, (ii) the disease agent, (iii) the environment including the vectors and (iv) programmatic aspects. Already we have made a significant advancement towards reaching our goal and are hopeful that a concerted effort will give us success in the end game too.





I I I I Pance

•Quality Improvement means to achieve efficiencies and other improvements with limited resources •

– Anonymous

CHHATTISGARH

IMPROVING QUALITY OF CARE THROUGH PATIENT FEEDBACK SURVEYS AT DISTRICT HOSPITAL DURG



PROBLEM STATEMENT

Inspite of having good clinical excellence within the Public Health System, services at Public Health Facilities generally are perceived to be of poor quality. Overcrowding, long waiting time, compromised cleanliness, absence of amenities in waiting area, lack of information, etc. contribute towards this impression.

PROGRAMME DESCRIPTION

As a part of implementation of Quality Management System, management at District Hospital Durg took a decision to establish a system of patient satisfaction survey, analyzing the findings and taking necessary actions to address the issues raised by the patients and their next of kin, visiting the health DH Durg. The initiative was started in September 2011.

Methodology

Selection of Questionnaire: NHSRC template for OPD and IPD patients having ten and twenty questions respectively is being used after translating them in Hind. Patients feedback has been taken on scale of Poor to Excellent on a Five-point 'Likart scale'.

Selecting Sample size: Scientifically calculated 'Sample size Calculator' (at 90% confidence interval) based on the case load (OPD and IPD) is being used to identify required number of respondents.

Collecting Feedback from Patients: Hospital Manager takes Feedback from OPD patientsat the time of exit and Staff nurse on duty takes feedback from IPD patients at the time of handing-over the discharge sheet. For illiterate respondents, questions are explained in vernacular language before collecting their responses.



Improvement in overall Patient Satisfaction score from 2.4 to 3.9 since the project started



Frequency/Periodicity: we started conducting feedback analysis on monthly basis but later on started taking it quarterly.

Analysis of Feedback: Hospital Manager analyses the collected feedback forms. Average of each attribute and overall average score of the Hospital and lowest two performing attributes are identified for addressing these two issues in a focussed manner.

Action Planning: Issues related to lowest performing areas are discussed in monthly review meetings to find the 'root-cause' and an Action Plan is prepared to address these issues.

PROGRAMME OUTCOMES

- Significant improvement in overall Patient Satisfaction score (from 2.4 to 3.9) during last 4 years.
- Improved utilization (significant increase in OPD and IPD).

- Better patient amenities (Sitting arrangement, Fans, Drinking water, clean toilets).
- Reducedovercrowding and waiting time through computerized registration, separate Registration counters, Token system and calling system.
- Improved signages.
- Some good practices such as monitoring of near expiry drugs, use of housekeeping checklist for monitoring cleanliness level, etc. were initiated after getting feedback from patients.

FINANCIAL INVESTMENT

Financial investments are minimal in conducting surveys (Rs. 400 for printing formats) but for addressing issues identified during surveys, investments varied At DH Durg most of the issues were addressed using funds from Jeewan Deep Society Annual Grant and local support.

SCALABILITY

Patients Feedback Analysis is one of the most important and useful tools for understanding the 'voice of customer'. It is pivotal in improving delivery of healthcare services, and helps the managers in planning and prioritizing healthcare interventions.

CONCLUSIONS/LESSONS LEARNT

An easy to implement and low cost 'Patient Centric' Intervention for improving quality of care.

Contact

Civil Surgeon DH Durg



GUJARAT MAHATMA GANDHI SWACHHATA MISSION



PROBLEM STATEMENT

Increase in hospital-acquired infections due to improper a. Start Date: Chief Minister of Gujarat on 6th December, 2014 launched the State wide and hygiene services and improper bio-medical waste management.

PROGRAMME DESCRIPTION

- campaign on Swachtha mission in health care facilities.
- b. Objectives of the Mission:
 - i. Minor repairing and renovation of buildings and landscaping of the whole campus.
 - ii. Provision of clean and adequate drinking water, routine cleaning of toilets. maintenance and periodic bacteriological surveillance of instruments and equipment used in hospital.

Facilities with grading A (> 90% compliance) increased from
 8% to 27%, Grading B from 36% to 59%, facilities with Grading C decreased from 35% to 13% & Grading D from 21% to 1%



- Audit Report of health Facilities (6th Dec. 14, 6th Jan 15, 6th Feb 15, 13th March 15, Chine P GUIARAT 100% 20% 19% 17% 80% 60% 35% 58% 50% 59% 40% 20% 20% 6th Dec 6th Jan 6th Feb 13th March 15th April 3rd May 2015 2014 2015 2015 2015 A B C D Grading As per % - A- Score >90%, B- Score >75-90%, C-Score >50-75% & D- Score 0-50% Mahatma Gandhi Swachhata Mission, Health & Family Welfare Departme
- vii. Regular condemnation of out-of-order equipment as per standard policy.

EVALUATION

Result of internal Audit conducted by the State on 6th Dec 2014, 6th Jan 2015, 6th Feb 2015, 13th March 2015, 15th April and 3rd May.

FINANCIAL INVESTMENT

For FY 2015-16: Cost for Development of Complaint Redressal Application is Rs. 2500000 & for Award to the best performing facilities for cleanliness is Rs. 897000. Total cost for Implementation of the Cleanliness Standards as per State Guideline, in total of 1541 Health Facilities is Rs. 9135000.

SCALABILITY

a. Strong commitment of the Government of Gujarat in expediting the process of the Swachtha Guidelines in a phased manner, for the short-term phase (till December

2014), medium-term phase (2014-16) and long-term phase (2014-19).

- b. Online reporting mechanism has been developed for tracking the progress of cleanliness in facilities.
- c. Adoption of Kayakalp guidelines.

CONCLUSIONS/LESSONS LEARNT

A very cost-effective approach for infection control and improving the utilisation rates of the public health facilities. Involvement of 'Jan Pratinidhi' in the process helps increase the community-level ownership for cleanliness in public health centres, which creates a positive pressure on the system, RKS and facility In-Charge to keep the facilities clean.

Contact

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- iii. Hospital waste management.
- iv. Training of doctors, para-medical staff, patients (indoor and outdoor) and their relatives on personal hygiene as per standard guidelines.
- v. Ban and fine on use of tobacco products as well as punishment for not maintaining cleanliness in public.
- vi. Residual chlorine monitoring at community level.

KERALA ACCREDITATION AND CERTIFICATION OF GOVERNMENT HOSPITALS





PROBLEM STATEMENT

erception of poor quality of health care dissuade patients from using the available services. Most of the common causes for maternal mortality are Postpartum haemorrhage and eclampsia and three major causes contribute to about 75 per cent of all deaths in the newborn period: pre-maturity, birth asphyxia and infections.

PROGRAMME DESCRIPTION

- a. Start Date: September 2009 for NABH, KASH, Guidelines for MMR and IMR in 2012, and NQAS in 2013.
- b. Kerala Government has initiated the following Quality Assurance programme for the Government Hospitals:
 - i. National Accreditation Board for Hospitals and Health care organization.
 - ii. State Level Accreditation Programme- Kerala Accreditation Standards for hospitals.
 - iii. National Standards on Quality Assurance published by Ministry of Health and Family Welfare, government of India.
 - iv. Measures to reduce MMR in Kerala.
 - v. Measures to reduce IMR in Kerala.
- c. Six Government hospital and one government blood bank in Kerala was accredited by National Accreditation Board for Hospitals and Health care organization.

- d. The Kerala Accreditation Standards for Hospitals (KASH) are prepared for 4 different levels of hospital, which are Primary Health Centre (PHC), Community Health Centre (CHC), Taluk level Hospitals (THQH) and District level Hospitals including specialty and General Hospitals. These standards are framed after referring the accreditation programmes in different countries and other existing accreditation and certification programmes. So far 17 health care organizations are accredited under KASH.
- e. The Health Services Department also started to implement the National Standards on Quality Assurance developed by the Ministry of Health and Family Welfare, Government of India. The standards are being implemented in selected hospitals in the Health Services Department.
- f. A quality standard document has been prepared for reducing the maternal death during the delivery services. Quality standards that are derived from evidence-based clinical guidelines and that are agreed by relevant stakeholders provide powerful levers to drive and measure quality improvement in health care institutions. It focuses on improving the care mothers receive in hospitals (public and private) to help reduce maternal mortality, one of the main health priorities in Kerala. Outcome of the implementation of Quality standards in selected hospitals has resulted in a decrease in the PPH and decreased referral to higher centres. The patients were stabilised before the referral and decrease in the use of blood products.

g. The Quality Standards was prepared for the major causes of IMR. It is expected that implementation of Quality Standards in the antenatal and paediatrics practice may lead to further reduction in IMR, which has stagnated in the State.

EVALUATION

No external evaluation on impact assessment of Accreditation/ Certification system has been undertaken till now.

FINANCIAL INVESTMENT

No details provided by the State.

SCALABILITY

Accreditation to NABH Standards may be expensive, which other States may find difficult to emulate. Certification to KASH and National Quality Assurance Standards would be scalable, which is being followed in other States.

CONCLUSIONS/LESSONS LEARNT

State has introduced many quality assurance programmes for the improvement of the quality of services been provided in the public health facilities. However its full impact on outcome is yet to be evaluated. The Ministry of Health & Family Welfare has already evaluated NABH Accreditation process through an independent organisation in the year 2011-12. The NABH process was found expensive and time-consuming.

17 health care organisations are accredited under KASH-Kerala Accreditation Standards for Hospitals





• Good urban health governance helps ensure that opportunities and advantages are more evenly distributed and that access to health care is fair and affordable **9**

nc PSBV

– WHO Report 2010

GUJARAT INNOVATIONS UNDER NUHM IN SURAT

URBAN HEALTH AND CLIMATE RESILIENCE CENTRE (A PUBLIC HEALTH OBSERVATORY), SURAT

PROBLEM STATEMENT

Using the greatest threat to human health in the 21st century. Climate change currently contributes heavily to the global burden of disease and premature deaths and there shall be an increase in the frequency of cardiorespiratory diseases due to increases in ground level ozone. We cannot eliminate changes due to climate, but we can mitigate the risk with collective efforts.

PROGRAMME DESCRIPTION

The idea is to generate city-based scientific evidence on the links between climate change and health, assess local vulnerability to climate impacts and contribute to making urban settings prepared for and resilient to climate induced risks/diseases, emergencies and disasters.

Urban health and Climate Resilience Center (UHCRC) was launched in March 2013 by the Asian Cities Climate Change Resilience Network (ACCCRN) and supported by Rockefeller foundation through Surat City Climate Trust in which Surat Municipal Corporation is a main stakeholder.

UHCRC thrives to become the knowledge hub in the subject of Urban Health and Climate Change Resilience & aims include piloting assistance Programmes for city authorities in India and beyond to improve urban health services.

PROGRAMME OUTCOMES

1. A national workshop was organized on developing vulnerability tools and indicators for climate change and urban health.

- 2 Urban Service Monitoring System (UrSMS) is one of the seven projects selected as Project to Watch from 40 projects scrutinized by United Nations Global Pulse.
- 3. Six Arogya Samvad (Community Health Dialogue Forum) were organized to know the community perception on climate change and health vulnerability.

IMPLEMENTING PARTNERS

Surat Municipal Corporation.

EVALUATION

Due in this year by international agency.

FINANCIAL INVESTMENT

UHCRC is developed under the seed money (INR. 16561,625) by ACCCRN for 3 years and has an excellent potential of sustainability.

SCALABILITY

Keeping in view the achievements of UHCRC, yes it has a great potential for scaling up.

CONCLUSIONS/LESSONS LEARNT

Evidence based research is one of the key areas of the Centre with the mission of "Healthier Citizens in Healthier Cities".

Contact

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ENHANCING ACCESSIBILITY TO SPECIALISTS' HEALTH AND MEDICAL CARE AT PRIMARY HEALTH CARE CENTRES CARE

PROBLEM STATEMENT

Surat, one of the rapidly growing city with highest migration rate in the country. 10% of city population is in slums and 40% of city area is slum. Surat Municipal Corporation has initiated several need based initiatives at its cost.

Patients attending UPHC OPD need referral services and the most in need of such care are likely to drop out for referral. To minimize drop-out rate of patients in need of Consultants care a Public Private initiative has been statrted.

PROGRAMME DESCRIPTION

Consultants services was initiated as pilot as early in the year 1978, which is enhanced since 2005 and there is a sustained long term planning to further.

Private consultants (Physician, Obstetrician, Paediatricians, Anaesthetists, Dermatologists, Ophthalmologist) are invited to join as honorary consultants to provide fix day fix site services at at 22 UPHCs selected on the base of OPD load and population characteristics.



In year 2014-15 total 34,911 referral cases consulted by specialists. UrSMS project virtually connects 492 health units across the city

URBAN SERVICES MONITORING SYSTEM (URSMS) -TOWARDS STRENGTHENING ROUTINE HEALTH MONITORING SYSTEM

PROGRAMME OUTCOMES

In the year 2014-15 total 34,911 referral cases of consultancy level services were attended by these honorary consultants.

FINANCIAL INVESTMENT

Total cost of honorary consultancy services at present is Rs. 20,00,000/-which is completely borne by Surat Municipal corporation from its budget. Future projection at this rate of honorarium is 70,92,000/-.

SCALABILITY

Scaling in progress for all 42 urban primary health centers.

CONCLUSIONS/LESSONS LEARNT

Honorary consultants services have improved the access of higher level medical care for needy patients at primary health care level, its cost effective approach and is due for upscale.

Contact

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PROBLEM STATEMENT

Routine urban health monitoring system is one of the basic requirements for evidence base urban health interventions.

Till 2012 health department of SMC had manual data collation system with paper-based approach. A felt need of real time data collection and analysis system lead to UrSMS project.

PROGRAMME DESCRIPTION

UrSMS project was launch by SMC 2012 after initial pilot. This system virtually connects around 492 health units across the city. These units provide information on a daily basis to the health department.

The system has two main interfaces:

- Mobile interface for sending and receiving structured data via SMS.
- PC interface with Internet Mapping Service for collecting data and visualizing the information as charts, reports and maps.

PROGRAMME OUTCOMES

In year 2014, 97,537 reports received from Private clinics, 12271 reports from UHCs, 21047 Reports from Public + Private Hospital & 10936 number of cases reported with patient and disease details (line listing).

EVALUATION

Under UN Big Data Climate Challenge award (2014)was recognized as winner "Projects to Watch".

FINANCIAL INVESTMENT

Initial cost of Programme and server around 50 lakh Unit is operationalised and maintained by Information system department Surveillance centres, even private are not charging anything for data transfer.

CONCLUSIONS/LESSONS LEARNT

system brings resilience to disease monitoring framework by providing timely information about quality of water supplied from distribution stations as well as occurrence including outbreak of diseases within Surat.

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KARNATAKA

GIS FOR NATIONAL URBAN HEALTH MANAGEMENT SYSTEM - BENGALURU



PROBLEM STATEMENT

for the NUHM project in Bengaluru, the various decisions contributing to the success and effectiveness of project need to be taken. Some of the important decisions are which facilities need to be added and improved in a particular place.

PROGRAMME DESCRIPTION

Start Date: November 2014

The project involves extensive use of GIS technology which consists of locating and mapping of existing facilities along with key attributes such as the facility description, the resources available, the equipment available and their readiness to deal with medical care, the service area and the population breakup.

The marking of the boundaries along with the assistance of the health care personnel and a physical survey to gather information was conducted. It helps to understand location of health care facilities; population density to provide health care, health conditions, facility capacity and infrastructure, identify geographical location can help better understanding of needs, health care facilitators along with the specialization.

The system has been designed to capture the micro and macro components of community health like disease profile of target i.e. urban poor who needs these health services at affordable cost and in a timely manner. It specifically can address slum or area with migratory population within an urban administrative unit such as ward level data.

The system is also capable of giving the decision support system indicators such as nearby health facilities, its services, cost and other information so that project implementation monitoring team can take need based decisions.

EVALUATION

The Solution provides a searchable view of the primary Healthcare centers along with key attributes. The system also has facility for buffer search which can be defined by the user, displaying key components within that buffer such as slums, disease profiles, staff and equipment gap analysis.

The System also has route and planning for community health programmes such vaccination and other related programs. This enables the decision makers to understand the current situation as well as improvements needed to service the needs of the area.

By gathering water supply, conditions, hygiene and sanitation conditions, disease profile (epidemic and non epidemics), health hazard conditions.

The department can analyze and have information to deal with epidemics, data Analysis of Slums, Understanding of disease profiles and care needed.

SCALABILITY

The solution can be included with several analytics and understand disease profiles, mitigation, improve sanitation and hygiene conditions. Improve upon existing conditions and include and involve private institutions along with health care and diagnostic facilitators to provide cost effective healthcare with modern technology and equipment to diagnose, administer better care.

The system will be hosted on a public platform and have information on all the health related facilities in the city of Bengaluru such as hospitals, blood banks, emergency care centers which can be single point of all health related information.

CONCLUSIONS/LESSONS LEARNT

In the process of developing the solution and the data gathering an understanding of improving the current situation to provide an efficient and effective programme for health care providers. It provides planning and execute mitigation steps, wellness programmes and awareness.

Contact

IT Advisor, BBMP Bengaluru

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System provides information on the key parameters that can be used as a benchmark to achieve NUHM goals

WEST BENGAL

USE OF TECHNOLOGY IN RSBY



PROBLEM STATEMENT

- a. Under utilization of data captured at various levels
- b. Lack of information of Different Stakeholders
- c. Fraud and abuse
- d. Weak monitoring system
- e. Lack of awareness among beneficiaries

PROGRAMME DESCRIPTION

RSBY uses different types of technologies at various stages. Each type of technology is there for a different purpose. The following technologies are being used in the scheme:

- a. Smart Card Technology
- b. Biometric Technology
- c. Key Management System
- d. Web-based Data Transfer
- e. Web Portal Services

The web portal of RSBY has multiple roles. It not only provides the details of RSBY with the outside world, but also acts as the portal for data transfer, data sharing, and a monitoring tool for the internal stakeholders of the scheme. The aim of the scheme is to use technology not only for control of fraud and monitoring, but also to find innovative solutions. The following activities are being done under the programme:

- a. Online Monitoring through IT Usage
- b. Online Claim settlement

- c. Online Registration of Patient
- d. Online Grievance Submission
- e. Patient Details Tracking

Automated SMS service

A toll free number 18003455384 with dedicated call centre support has been established for giving replies to the queries raised by beneficiaries.

Medical audit team

District wise medical audit team has been set up who provides considerable support towards assessing all types of grievances that the hospitals raise or faces.

Integration of Rogi sahayata Kendro with RSBY

Rogi Shayaks of Rogi Sahayata Kendro were sensitized to facilitate the RSBY beneficiaries coming to the Hospitals which were extended up to BPHC and RH.

Women as head of family in RSBY card

To honor the role of Women and to empower them RSBY card are being printed in the name of the eldest women in the family as Head. This is done for first time in India by any State.

PROGRAMME OUTCOMES – are as follows

- a. Real time monitoring
- b. Improvement in access to healthcare
- c. Increase in coverage
- d. Reduction in Out of Pocket Expenditure (OOPE) on Health
- e. High level of satisfaction
- f. Greater awareness
- g. Prevention of fraud and abuse

EVALUATION

Independent Household Evaluation on RSBY carried by GIZ.

CONCLUSIONS/LESSONS LEARNT

Although the scheme has welcomed a lot, but it is just the beginning and we are working on online pre authorization, digital record of the patient, and integration of State Illness Assistance Fund with RSBY (as top up) for the packages which are beyond 30,000 ranges.

Contact

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To honor the role of women, RSBY cards are printed in the name of the eldest woman in the family as Head. This is done for first time in India by any state. 60.58 lakh household covering more than 2.5 crore population is covered under RSBY



Gen GOUGP

n m e n t TUGS

INDIA NEWBORN ACTION PLAN (INAP)

The India Newborn Action Plan (INAP) is India's committed response to the Global Every Newborn Action Plan (ENAP), launched in June 2014 at the 67th World Health Assembly, to advance the Global Strategy for Women's and Children's Health. The ENAP sets forth a vision of a world that has eliminated preventable newborn deaths and stillbirths. INAP lays out a vision and a plan for India to end preventable newborn deaths, accelerate progress, and scale up high-impact yet costeffective interventions. INAP has a clear vision supported by goals, strategic intervention packages, priority actions, and a monitoring framework. For the first time, INAP also articulates the Government of India's specific attention on preventing stillbirths.

INAP is guided by the principles of Integration, Equity, Gender, Quality of Care, Convergence, Accountability, and Partnerships. It includes six pillars of intervention packages across various stages with specific actions to impact stillbirths and newborn health. The six pillars are: Preconception and antenatal care; Care during labour and child birth; immediate newborn care; Care of healthy newborn; Care of small and sick newborn; and Care beyond newborn survival.

The India Newborn Action Plan is a concerted effort towards translating commitments into meaningful change for newborns after carefully executing a bottleneck analysis and framing out actionable strategies to achieve the goals envisaged in INAP. It will serve as a framework for the States to develop their area-specific action plans.


JANANI SHISHU SURAKSHA KARYAKARAM (JSSK)

In order to reduce the high Out Of Pocket Expenditure (OOPE) during pregnancy and childbirth, Government of India launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011.

The scheme is estimated to benefit more than 12 million pregnant women who access Government health facilities for their delivery. Moreover it also aims to motivate those who still choose to deliver at their homes to opt for institutional deliveries. It is an initiative with a hope that States would come forward and ensure that benefits under

JSSK would reach every needy pregnant woman coming to government institutional facility:

- The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section.
- The entitlements include free drugs and consumables, free diet up to 3 days during normal delivery and up to 7 days for C-section, free diagnostics, and free blood wherever required. This initiative also provides

for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. This has now been expanded to cover sick infants.

The scheme aims to eliminate out of pocket expenses incurred by the pregnant women and sick newborns while accessing services at Government health facilities.



KAYAKALP-AWARD TO PUBLIC HEALTH FACILITIES

The Swachh Bharat Abhiyaan launched by the Prime
 Minister on 2nd October 2014, focuses on promoting cleanliness in public spaces. Cleanliness and hygiene in hospitals are critical to preventing infections and also provide patients and visitors with a positive experience and encourages moulding behaviour related to clean environment. As an effort to ensure Quality Assurance
 Public Health Facilities, the Ministry of Health & Family Welfare launched a National Initiative to give Awards 'KAYAKALP' to those public health facilities
 that demonstrate high levels of cleanliness, hygiene and infection control. To supplement this initiative, Swachhta Guidelines for Public Health Facilities have also been prepared and issued.

The Objectives of award scheme are as under:

- To promote cleanliness, hygiene and Infection Control Practices in public Health Care facilities.
- To incentivize and recognize such public healthcare facilities that show exemplary performance in adhering to standard protocols of cleanliness and infection control.
- To inculcate a culture of ongoing assessment and peer review of performance related to hygiene, cleanliness and sanitation.

• To create and share sustainable practices related to improved cleanliness in public health facilities linked to positive health outcomes.

NUMBER OF AWARDS

- Best two District Hospitals in each State (Best District hospital in small States) in the current FY 2015- 16 & onward.
- Best two Community Health Centres/Sub District Hospitals (limited to one in small States) in the next FY & onward (FY 2016-17 onward).
- One Primary Health Centre in every district in the next FY & onward (FY 2016 – 17 onward).

AWARD AMOUNT

- Based on the set criterion prize winners will receive a cash award with a citation.
- Certificate of Commendation plus cash award would be given to such facilities that score over 70%, but do not make it to the list of top two/one in a particular year.



MISSION INDRADHANUSH

fission Indradhanush was launched on 25th December 2014, with a focus on interventions to improve the Routine Immunization coverage in India from reported 65% (2014) to at least 90% target children in next five years. The Mission is planned to work through organizing special catch up campaigns. The Mission Indradhanush, depicting seven colours of the rainbow, targets to immunize all children against seven vaccine preventable diseases namely Diphtheria, Pertussis, Tetanus, Childhood Tuberculosis, Polio, Hepatitis B and Measles. In addition to this, vaccines for JE (Japanese Encephalitis) and Hib (Haemophilus influenzae type B) are also being provided in selected States.

201 high focus Districts have been identified for coverage during first phase of the Mission in Year 2015. These

Districts have been identified on the basis of coverage of routine immunization of nearly 50% of all unvaccinated or partially vaccinated children. Out of these identified 201 districts, 82 districts lie in four States namely, UP, Bihar, Madhya Pradesh and Rajasthan. Nearly 25% of the unvaccinated or partially vaccinated children of India live in these 82 districts of 4 States. Furthermore, another 297 districts will be targeted in the second phase of year 2015.

The Government has planned four special vaccination campaigns starting from April to July 2015. All these vaccines are already available free of cost under universal immunisation programme in India. Under this mission, government plans to intensify its efforts and thus increase accessibility of these vaccines to all the children of India.





NATIONAL DE-WORMING DAY

Hith an aim to intensify efforts towards STH control among children in India, the Ministry of Health & Family Welfare, Government of India (GOI) decided to observe National Deworming Day (NDD) on 10th February 2015. The National Deworming Day was followed by a Mop-Up Day (MUD) on 13th February 2015 with the intent of deworming children who missed the dose on February 10th. It was decided that all Government and Government aided schools and anganwadi centers will be the sites for implementation of National Deworming Day across the country. The initiative was decided to begin with in selected 12 States/UTs namely Assam, Bihar, Chhattisgarh, Delhi, Dadar & Nagar Haveli, Haryana, Karnataka, Maharashtra, Madhya Pradesh, Rajasthan, Tamil Nadu and Tripura in the first phase.

A fixed National Deworming Day approach has the potential to ensure maximum coverage with optimal utilization of resources, by leveraging existing programmes and infrastructure. A Fixed Day approach will motivate States to prioritize deworming within current ICDS and school health programmes and increase public awareness around deworming with standardized campaign messages across the country. It is also expected that the initiative will also increase coverage of target beneficiaries and will establish structures to easily track and respond to any cases of adverse events. A quality and consistent reporting of coverage is also expected to be established through this initiative.







RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

omprehensive child health care implies assurance of extensive health services for all children from birth to 18 years of age for a set of health conditions. Under National Rural Health Mission, significant progress has been made in reducing mortality in children over the last seven years (2005-12). Whereas there is an escalation of reducing child mortality, there is a dire need to improve survival outcome. This would be reached by early detection and management of conditions that were not addressed comprehensively in the past.

Rashtriya Bal Swasthya Karyakram (RBSK) is an initiative aiming at early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Deficiencies, Diseases, Development delays including disability. Universal screening would lead to early detection of medical conditions, timely intervention, ultimately leading to a reduction in mortality, morbidity and lifelong disability. The 0-6 years age group will be specifically managed at District Early Intervention Center (DEIC) level while for 6-18 years age group, management of conditions will be done through existing public health facilities. DEIC will act as referral linkages for both the age groups. First level of screening is to be done at all delivery points through Medical Officers, Staff Nurses and ANMs. Dedicated mobile teams at block level are responsible for screening will for 6 weeks to 6 years at anganwadis centres and 6-18 years children at school.



QUALITY ASSURANCE IN PUBLIC HEALTH FACILITIES

Inclusion and maintenance of quality standards in public health facilities was a crucial area envisaged in the 12th Five year Plan. The plan had re-affirmed Government of India's commitment - "All government and publicly financed private health care facilities would be expected to achieve and maintain Quality Standards. An in-house quality management system will be built into the design of each facility, which will regularly measure its quality achievements." It was observed that while implementing the Indian Pubic Health Standards (IPHS) developed during 11th Five Year Plan, the focus of the States has been mostly on creating IPHS specified infrastructure and deploying recommended Human Resources. The requirements of ensuring quality services at public health facilities were often overlooked.

There was an urgent need to develop sustainable quality guidelines for Public Health Facilities which not only delivers good quality but also cater to the needs of the clients. With this aim, the guidelines on Quality

Assurance in Public Health Facilities were developed at operational guidelines and accompanying compendium central level. The guidelines define the relevant quality standards, a robust system of measuring these standards and institutional framework for its implementation. These

of cheek-lists are intended to support the efforts of States in ensuring a credible quality system at Public Health Facilities.



WHO COLLABORATING CENTRE FOR PRIORITY MEDICAL DEVICES & **HEALTH TECHNOLOGY POLICY**

inistry of Health and Family Welfare, Government of secretariat for assessment and uptake of innovations into India, along with the WHO Country office for India and National Health Systems Resource Centre (NHSRC) formally identified National Health Systems Resource Centre (NHSRC) as a WHO Collaborating Centre for Priority Medical Devices & Health Technology Policy on 20 March 2015 in Nirman Bhawan, New Delhi.

MoHFW has been working in the area of technologies and its policy interface, through a technical resource group located at NHSRC. The scope of its work includes: Framing of technical specifications for technologies procured under National Health Mission; best practices for technology life cycle management and maintenance; public health systems; health technology systems research such as proposing roadmap for establishing testing laboratories; supporting MoHFW on issues related to free essential diagnostics and other technology intensive services; domestic manufacturing capacity, quality & safety criteria for healthcare technologies; and conducting health technology assessments.

This imperative step would strengthen this technical associated for greater reach, acceptability and use of critical knowledge amongst public health partners and foster advancement of health goals in India as well as mission of the World Health Organization.



EMERGING INITIATIVES

Health Sustems Strengthening

KERALA

MOVING TOWARDS UNIVERSAL HEALTH COVERAGE THROUGH PROVISION OF COMPREHENSIVE PRIMARY HEALTHCARE

PROBLEM STATEMENT

eed of comprehensive primary health care, including disease prevention and health promotion, to prevent diseases, reduce morbidity and mortality (on account of double burden of disease) and also reduce the out-ofpocket expenditure.

PROGRAMME DESCRIPTION

Primary Health Centre, Kallikkadu is owned and operated by the Grama Panchayath, Kallikkadu. The centre provides comprehensive health services. The staff at PHC and SCs works as a part of one team under the leadership of the MO. There is ownership and active involvement in all decisions and activities of the Local Self Government members. Appointed health volunteers (Every 50 houses one health volunteer) from the community, apart from ASHAs take the ownership of health activities. There is a strong focus on prevention and promotion and community-level interventions such as active vector surveillance and source reduction etc. Locally developed innovative IEC/BCC materials and activities are planned, implemented and the behaviour change is measured (Reduced OPD, Sanitation, reduced outbreaks etc). The annual action plan is prepared based on family health survey.

PROGRAMME OUTCOMES

- Full immunisation and ANC service coverage.
- IEC- BCC 347 group talks, 12 group gatherings, 13 health education classes, 298 interpersonal communications conducted. Around 4500 locally designed Health IEC calendars provided apart from other IEC materials.

EVALUATION

Social Audit of PHC is conducted.

FINANCIAL INVESTMENT

Funds received from NHM, LSGD and UHC.

SCALIBILITY

- Involvement and empowerment of the community for owning their health is important and is very much feasible with appropriate mechanisms. Active involvement of Local Self Governments is a challenge at this stage. But active pursuance from the Health Department and its team including participation by community members will definitely lead to active involvement of LSGs.
- Public Health orientation in both medical education and in-service training can produce good leadership at the primary level care. Good leadership and mentorship is of utmost importance for the success of implementation of primary level care.
- Primary care level target setting, periodic monitoring, use of data, smooth flow of information across cadres till community, etc., are critical for improving the health of the community.

CONCLUSIONS/LESSONS LEARNT

- Ownership of health of community in the hands of the community.
- Proper mechanisms needed to empower community to own their health.
- Top Priority Focus on prevention and promotion and community-level interventions including addressing social determinants of health and context-specific IEC-BCC strategy.
- One Primary Healthcare Team (PHCs and SCs as one unit) plus involvement of community in the team (ASHAs and Health Volunteers), training and mentoring of the staff.

 Practising public health is an art and needs imbibing by all (staff as well as community) – public health orientation both in medical education curriculum and in-service trainings.

Contact

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MADHYA PRADESH

REAL TIME MONITORING OF JSSK TO REDUCE OOPE

PROBLEM STATEMENT

adhya Pradesh had the fourth highest Maternal Mortality Ratio at 335 per 100,000 live birth in India as per SRS 2004-06. GoI had launched the conditional cash transfer scheme to increase access to institutional services. However, key barriers of inequitable distribution of Health centres and no access to referral transport created pockets of low institutional delivery and geographical exclusion. Additionally a higher load of deliveries was found in First Referral Units (FRUs) where capacity of health care providers was also affecting quality of care. This diluted the gains of JSY scheme.

Thus UNICEF along with District Health Society (DHS) and GoMP together developed a four pronged strategy to increase access to Institutional:

1. Provide 24x7 Free Referral Transport for pregnant women and children (Home to Facility, Inter Facility and Drop back).



- 24x7 safe delivery close to community -Facility services
 Level 1 MCH centres.
- 3. Ensure Free Drugs, Diagnostics, Food, and treatment
- 4. Real time monitoring with JSSK monitoring and feedback system.

Referral Transport Services:

- 1. A total number of 604 Basic and Advanced Life Support Ambulance Services -108 for all emergencies were provided.
- 2. Additional Janani Express for transport of Pregnant Women and Sick Children to hospital and drop back.
- 3. Call Centre Connectivity of Janani Express for real time coordination and monitoring of service calls completed and dropped by the Janani Express.
- 4. Online monitoring of Janani Express Yojana (JEY) to record data on calls completed, beneficiaries reached, communities reached and to monitor the most marginalised and vulnerable populations reached through these centres.

PROGRAM DESCRIPTION

The programme was piloted by UNICEF & NHM GoMP in Guna and Shivpuri and up-scaled by NHM Madhya Pradesh State wide. Intrapartum Care and 24x 7 Access to Institutional Delivery under Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK).

PROGRAMME OUTCOMES

- With Technical support of UNICEF, initially the State provided 39 ambulances and 28 Delivery centres in Shivpuri district. State has now up-scaled to 1041 Janani Express Ambulances to provide 24x7 referral transport services in 50 districts in 2014. All vehicles were installed with GPS and online monitoring was linked for all.
- Beneficiary/Client feedback was in built for JSSK under the JEY online monitoring soft-ware. The software was completely supported by UNICEF.

- With the support of the online monitoring system call conversion rate was reported for the period Jan 2013-6th May 2015 at 96.5 % (of total beneficiaries who called 96.5% received the services of the Janani Express.
- The online monitoring system also records feedback of JSSK services from clients regarding money spent by mothers/beneficiaries on different services, post -natal services and JSY transfers.
- Finally MCH level 1 Services were brought closer to the community. In the pilot districts of Guna and Shivpuri Health Sub Centres in remote village pockets were upgraded to provide institutional deliveries with trained skilled birth attendant and upgraded 24x7 MCH centres with a well quipped labour room.

EVALUATION

All the above strategies led to over 4 million pregnant women being transported for institutional deliveries. DLHS 3 data was considered as the baseline for Pilot districts Guna and Shivpuri. The institutional delivery rate increased from 50% in Guna during DLHS 3 (2007-08) to 93% in AHS 12-13. Similarly it increased from 44% in Shivpuri during DLHS 3 to 89% in during AHS 12-13. For the State of Madhya Pradesh Institutional delivery increased from 47% in DLHS 3 to 83% in AHS 12-13.

SCALABILITY

Based on the encouraging results found from the Guna & Shivpuri pilots, the programme was scaled up to whole State.

Contact

DD, MH, NHM MP and MD NHM MP

MIZORAM

GOOD PRACTICES AND INNOVATIONS IN LABORATORY SERVICES AT CIVIL HOSPITAL: AIZAWL

PROBLEM STATEMENT

Laboratory services at Civil Hospital, Aizawl were established in 1958; with investigations for malaria, routine urine and stool examination. Till 1973, no trained Laboratory technician was available except under the National Malaria Eradication Program (NMEP). In 1978, first graduate Lab Technician& Pathologist joined & basic bacteriology, culture & sensitivity and biochemistry sections were established.

Though with time qualified Human resource & equipments were available to provide diagnostic services in the hospital but accuracy & precision of the result provided were always uncertain as there was no internal & external Quality assurance Mechanism. Aside resource deficiency and its poor management, lack of maintenance of essential equipments, improper documentation & haphazard work distribution and improper work supervision were area of concern.

PROGRAMME DESCRIPTION

Implementation of Quality Management system & certification to ISO 9001:2008 Standards

In the year 2001 under the NRHM, Civil Hospital, Aizawl was selected for implementation of Quality Management System as per ISO 9001:2008 Standards. During implementation phase various activities like Gap analysis, formation of Quality team, establishment of Quality procedures, trainings (both technical & managerial) were done with technical support from NEERC/NHSRC. After gap analysis, Quality Manual, Standard operating procedure, and work instructions were developed. Quality Policy & Quality Objectives were also defined.

For ensuring reliability of our tests the hospital laboratory established Internal & external Quality Assurance System, where the Biochemistry tests were externally validated by CMC Vellore, Haematology by AIIMS New Delhi & Cytology by PGI Chandigarh. Calibration of all measuring equipment was also undertaken. All other requirements like internal audits etc were completed in 8 months' time and ISO 9001:2008 certification was undertaken in

December 2010. Since then the hospital is maintaining its **CONCLUSIONS/LESSONS LEARNT** certified status.

PROGRAMME OUTCOMES

- 1. Working Manual and SOP: All Laboratory Departments have their own Working/Quality Manual and Standard Operating Procedure (SOP).
- 2. Quality Objectives and Goal: New objectives and goals are set by each department every year and is analysed at the end of each year.
- Quality Control System: External Quality Control is 3. maintained as follows:
 - Biochemistry monthly QC with CMC Vellore. a.
 - b. Haematology - Quarterly QC with AIIMS, New Delhi.
 - Cytology Half yearly QC with PGI, Chandigarh. c.
- 4. Preventive & Safety Measures adopted:
 - a. Fire extinguishers placed at suitable place & selected technicians were trained.
 - b. DANGER sign put up at electric distribution site, old wiring replaced.
- Customer complaint system: Integrated with existing hospital customer feed-back system, like Customer Satisfaction Survey, Complain Box, Recording of verbal and telephonic Complaints, etc. which are followed by proper follow-up action.
- 6. Free Diagnostic Service: Free diagnostic services are provided under JSSK and for poor & marginalized section of the society.

SCALABILITY

- Since 2010, Quality Management system is in place & the Hospital is sustaining the quality certification to ISO 9001:2008 Standards.
- Under National Quality Assurance Standards, baseline assessment was done, where hospital has scored 62%. For National level certification, a minimum of 70% of the score is required.

- 1. Motivation and ownership development among the staff is one of the key factors for success in improvement of laboratory services.
- Minimum resources are required to initiate Quality 2. management system. For example -documentation, record maintenance, signage and information boards for customers, internal training and meetings, proper work distribution among the staff etc.

Contact

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STRENGTHENING THE DIAGNOSTIC SERVICES ACROSS THE STATE

PROBLEM STATEMENT

The percentage of pregnant women receiving free diagnostic services under JSSK in the year 2013-14 has increased to 62% as compared to 20% in the year 2011-12 as per the State JSSK report. H&FW Department, Government of Odisha has reiterated its commitment to provide quality, accessible, affordable diagnostic services to its entire population. For meeting these objectives 'Strengthening Diagnostic Services' is one of the key interventions. Since the JSSK Scheme is limited to pregnant mothers and infants only, a large section of other beneficiaries has been left-out. Therefore, considering the disease burden in the State and demand of the community, the diagnostic services at the facilities are proposed to be strengthened under this initiative.

PROGRAMME DESCRIPTION

Even though various models are used for strengthening the Lab services, the State of Odisha has focused on the **System Strengthening** model for improvement of diagnostic services across the State. The advantages of System strengthening initiative are **Sustainable, Cost-effectiveness and Wide coverage in rural areas.**

Modality of Implementation

For achieving improvement in the availability of diagnostic services, it is proposed to strengthen the laboratories at DH and CHC levels by transforming them into "Integrated labs" where all the diagnostic-related services are intended to be provided as one-stop. Services through integrated labs will be provided till CHC level whereas below the CHC level more focus will be given on Kit-based tests. The activities for establishment of integrated labs are planned to be done in three different levels which are listed below:

- **Level 1:** Seeking approvals for all the necessary plans prepared for integrated labs.
- Level 2: Providing the infrastructure (manpower, equipment) for the functionality of the programme as per the design approved through **Pooling** of **Resources and Automation of** equipment instruments.

Level 3: Full scale Implementation across the State.

PROGRAMME OUTCOMES

The intervention is under various stages of implementation and its full impact is yet to be assessed.

SCALABILITY

The State intents to prepare Standard Operating Procedures (SOP) with focus on quality control and biomedical waste management, focus on primary healthcare-based diagnostic services through the use of rapid testing kits at PHCs and SCs. The State has proposed to provide round-the-clock services with also appropriate IT-enabled reporting systems.

CONCLUSIONS/LESSONS LEARNT

H&FW department of the State intends investing more resources to provide impetus to ensure quality laboratory services despite issues and challenges related to deployment and availability of skilled manpower, interrupted power supply, and supply of equipment. In the coming years, it is expected that by putting adequate resources, stronger quality and regulatory mechanisms, usage of IT and putting the right structures in place, diagnostic services will be implemented effectively.

Contact

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UTTAR PRADESH SEHAT SANDESHWAHINI

PROBLEM STATEMENT

In order to improve the uptake of health services, NHM has introduced a number of health services and facilities for rural and urban people. Sehat Sandshwahini Programme was planned to create awareness and change in the health-seeking behaviour among the rural community.

PROGRAMME DESCRIPTION

The project was initiated with an objective to public NHM schemes being implemented in the State of Uttar Pradesh to bring about a change in health-seeking behaviour among the rural community through video van shows. Implementing agencies were selected through an open tender procedure and Audio/Video CDs were developed and designing/branding of video vans was done. Blockwise selection of villages and fixing of programme schedules was undertaken by CMOs. Per block 20 villages were selected for SSW shows. The Programme was launched on 20th February, 2014.

EVALUATION

A total 16360 villages were covered under this programme and approximately over 24 lacs people were informed through video van shows. An evaluation study conducted by PRC Lucknow showed that 85 percent of the respondents found the programme very informative.

SCALABILITY

The programme may be scaled-up to cover all villages of the State. All the procedures/systems have already been developed for implementation of the programme.

CONCLUSIONS/LESSONS LEARNT

A cost-effective programme implemented in a decentralised manner for reaching up to the village level to promote health services and facilities being provided by NHM. For retention of information, the Sehat Sandeshwahini video show should be repeated at least once in every village.

REFERENCE

www.sifpsa.com

Contact

Executive Director SIFPSA edsifpsa.org; General Manager (IEC), SIFPSA



EMERGING INITIATIVES

Community Processes

'ASHA APNE AANGNE' - RADIO PROGRAMME FOR ASHAs

PROBLEM STATEMENT

J ack of regular communication channels with ASHAs regarding key health messages and updates about government schemes.

PROGRAMME DESCRIPTION

The State of Gujarat launched the radio programme for ASHAs known as "ASHA AAPNE AANGNE" in mid 2014, drawing lessons from the ASHA radio programme in Assam. The key objectives of the programme are to improve the knowledge of ASHAs on topical health issues, strengthen communication capacity and to provide information on government schemes. The programme uses an infotainment approach, with a combination of Storytelling/Discussion/Questions/Answer and Review. The content of the programme includes recent developments in health programmes with a special focus on maternal and child care. It also provides information in areas of water and sanitation, and organizing a successful VHND. A catchy theme song on 'ASHA AAPNEAANGNE' is the soundtrack and serves to mobilize ASHAs and generate interest in the community. The script for each episode is prepared in consultation with subject experts. Each prerecorded episode is verified by the team before it is aired.

Information about the programme and its objectives is provided through specially organized SAT COM sessions, communication to beneficiaries through the e-mamta system, and newspaper advertisements. The Gram Sanjivani Samiti (equivalent to the Village Health, Sanitation and Nutrition Committees) purchase the radio set based on a set of specifications at a price of Rs. 500. The 15 minute programme is aired twice a week on Saturdays between 6.45 pm to 7.00 pm, with a repeat broadcast on Wednesday from 12.30 pm to 12.45 pm. All ASHAs under GSS come together to listen to the programme on Saturday at a fixed venue. Repeat broadcast of the programme is scheduled such that community can listen to the programme along with ANM, AWW and ASHAs on Mamta Day (equivalent to Village Health and Nutrition Day).

A total of 31 episodes of 'ASHA AAPNE AANGNE' radio programme have been AIR successfully. Field based monitoring is done by Data Assistant & Block Information Education Communication Officers (BIECO) in districts, and a quarterly review by senior officials from IEC, Rural Health and from collaborating agencies (Prasar Bharti and UNICEF-Gujarat), chaired by the Mission Director, National Health Mission.

PROGRAMME OUTCOMES

Field reports indicate wide acceptance of radio programmes among ASHAs and other community members.

IMPLEMENTING PARTNERS

Prasar Bharati/All India Radio (AIR), Ahmedabad, National Health Mission, Gujarat and UNICEF.

FINANCIAL INVESTMENT

In addition to the cost of procuring the radio set, the cost of production for 54 episodes is Rs. 6,06,744 and for broadcasting it is Rs. 9,28,368.

SCALABILITY

The use of in-house experts from health departments in developing content and the broadcast through Prasar Bharti (AIR) has made it possible to minimize the cost of the initiative. Similar radio programmes for ASHAs have also been implemented in States of Assam, West Bengal and Jharkhand and the launch of this initiative in Gujarat indicates that there is increasing acceptance of this form of communication with ASHA and the community, and the potential for scaling up.

CONCLUSIONS/LESSONS LEARNT

The initiative has facilitated communication with ASHAs, and made it possible to reach all ASHAs with standardized messages, leaving little room for confusion, common where there is a cascading model of information provision. However weak transmission in certain pockets hampers the reach especially to ASHAs residing in the most difficult and hard to reach areas.

Contact

Consultant-IEC, Gujarat, Project Manager-ASHA Resource Centre, Gujarat



NAGALAND

WEAVING A DREAM: A PEOPLE'S INITIATIVE FOR HEALTH CARE

PROBLEM STATEMENT

In 2010, NRHM Nagaland initiated a strategy which is collaboration between the people of *'Changsang Range'*, Tuensang district and the *Eleutheros Christian Society (ECS)*, a local NGO engaged with the local community for the promotion of livelihood, education and also running an AIDS Hospice at Longpang, to holistically address the health needs of a socio-economically underdeveloped community by weaving various activities around the goal of 'Sustainable Development'.

Recognising that health is a shared responsibility, the villagers of the 17 villages comprising about 8000 households got together to address the health gaps of the area by establishing a collectively self-financed and managed health unit for easy access and affordable healthcare delivery services. To finance the health facility, the villagers decided to link it with the promotion of livelihood and skill-building, availing insurance policies, promoting education and awareness and also by contributing financially and man-days towards health infrastructure development.

PROGRAMME DESCRIPTION

Highlights of activities undertaken to support **Weaving a Dream: a People's Initiative for Healthcare** project:

- 1. Collectively self-financed and managed health unit: Health is a shared responsibility
 - a. Subsidised user's fee-based health facility.
 - b. Villages contributed more than 1000 man-days in the development of site and construction of 3 staff quarters and the hospital kitchen.
 - c. Every household (8000 households) in the 17 villages contributed Rs. 10/- each annually.
 - d. 16 Churches contributed Rs. 2000/- annually towards the management of the hospital canteen.
 - e. Every Village Council gave Rs. 500/- as yearly registration.



- f. Earning from 1 orange plant per household annually (amounting to more than 5 acres of citrus plantation annually) goes to the health facility.
- g. Each SHG member contributed Rs. 30/- annually.
- h. Assistance from government and other agencies.

2. Health Insurance: Insuring for a healthy future

- a. *Edou Banks:* The women in the project villages formed Women's Self Help Groups to manage '*Edou Banks*' to raise finance for medical treatment.
- b. Collaboration with Birla Sun Life Insurance.

Promotion of Livelihood: Sustainable health

Orchards in 700 acres of land: the villages started a massive inter-cropping project with support from NABARD. Piggery Farms: 1000 Households received financial assistance from State Bank of India and NSCB for piggeries.

Education: Health through awareness

Reviving *'morung' or 'sochum'*: All the villages have revived the traditional *'morung'* or *'sochum'* to make it as a 'centre for learning skills for progressive living'.

'Onou' – A special scheme for promotion of Institutional Delivery.

An ECS in consultation with and support from the community and Village Councils introduced a special

scheme called 'onou' which means 'Grace' in Chang Naga dialect.

Nutritional Support to Pregnant Women

PROGRAMME OUTCOMES

Longpang PHC, which was earlier functioning as an AIDS Hospice, is conducting institutional deliveries since July 2011. Pre- and post-pregnancy counselling sessions are being held regularly. The PHC also admits People Living With HIV/AIDS (PLHA) with free accommodation, medical consultations, diet, medications, referral if required etc. The PHC is also involved in conducted various health awareness camps in the surrounding 17 villages. A Health Newsletter is being published every quarter.

SCALABILITY

The success of this programme could also be replicated in areas where the healthcare service delivery is poor due to varied reasons. But for this, the community first has to participate and take ownership of the existing healthcare delivery system and try to build upon it.

Contact

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EMERGING INITIATIVES

RMNCH+A

ASSAM

NUTRITION COUNSELLING CUM MANAGEMENT CENTRE: A COMMUNITY FOCUSED APPROACH TO COMBAT MALNUTRITION & UNDER FIVE MORTALITY

PROBLEM STATEMENT

ssam has a population of about 32 million, of which 4.5 million are infants and young children. Prevalence of under-nutrition is high in Assam with 41.1 per cent of children under three years stunted, 35.8 per cent underweight, and 16.7 per cent wasted with 4 per cent children severely wasted. The proportion of infants who initiate breastfeeding within one hour of birth is 76 percent; however the proportion of children who are exclusively breastfed for six months is only 40 per cent. Timely introduction of complementary foods (with continued breastfeeding) in infants 6-8 months old is 60 per cent.

PROGRAMME DESCRIPTION

Nutrition Counselling-cum Management Centre (NCMC) is a unique initiative of Assam, implemented by National Health Mission. Presently 25 NCMCs are functional in Assam. NCMCs are set up at different levels as per the health needs and where large proportion of marginalized people resides. Each NCMC has a full time nutrition counsellor who provides nutrition counselling to pregnant women and mothers of young children (<5 yrs. of age) in the OPDs, prenatal, post-natal ward and children's ward. They also provide community outreach services at VHND once in a week for nutrition counselling and identification of children with SAM.

The outreach of NCMCs have been increased by organizing screening camps in areas with a high proportion of undernourished children as well as in the remote and interior areas that do not have a PHC or an NRC in its neighbourhood. The screening camps were organized on a priority basis at the sub-centre level jointly by the dieticians, nutrition counsellors and ASHA supervisors in different blocks of the district. About 11,000 frontline health workers have been trained by the dietician and nutrition counsellors on identification and referral of children with SAM through use of MUAC tapes and have been provided with it.

PROGRAMME OUTCOMES

1. The percentage of SAM cases referred to NRC has been increased from 41 per cent in 2013-14 to 66.5 per cent in 2014-15.

- 2. It is evident from AHS that breastfeeding rates within 1 hr of birth increased from 69.6% (2010-11) to 75.6% (2012-13).
- 3. It is evident from AHS that exclusive breastfeeding rates up to 6 months of age increased from 39.2% (2010-11) to 40.4% (2012-13).
- 4. The percentage of counselling sessions given to pregnant and lactating mothers has also increased by 30-50 per cent from the previous year.
- 5. Credible weighing efficiency: AWWs feel accountable for weighing and correct plotting, identifying undernourished children and take corrective actions to reduce under-nutrition.
- 6. Interdepartmental cooperation and team work achieved: AWWs, ASHA and ANM are required to verify each other's actions and work together to provide counselling, immunization and take the severely undernourished child to NCMC/PHC/ NRCs.
- 7. Mothers feel more aware, involved and responsible: A constant line of communication has opened up between government functionaries and mothers, generating awareness, information and responsibility.
- 8. Increased detection and treatment of severely acute malnourished children: The initiative has led to more NCMC screening camps being organized for SAM detection. The increase in the number of SAM children has led to the creation of multiple NRCs.

Challenges still to be addressed

- Lack of awareness and empowerment of mothers.
- Reluctance of parents to take the children to NRC.
- Interruptions in the supplementary nutrition provided at AWCs.
- Weighing and plotting disparities.
- Extremely harsh socio-economic conditions.
- Demographic variations.
- Early marriage and early motherhood.
- Law and Order Situations in certain areas.

SCALABILITY

The initiative, anchored at the district and sub-district level, encourages communities to identify severely undernourished children before they require inpatient care. Acting as mediator between communities, frontline health workers and health facilities, NCMC has served the purpose of mentoring as well as service provision. These efforts led to extending the initiative to additional districts and its gradual scale-up to begin integration into the primary health care system.

CONCLUSIONS/LESSONS LEARNT

The NCMCs have increased the visibility of severely underweight children and children with SAM. As a result, more SAM children are being identified and referred to the NRCs for treatment. The detection of high levels of moderate under-nutrition, especially in the lower age groups of 0 to 5 and 6 to 11 months, highlight the need for preventive measures to be emphasized in the working of the system. Also accelerating interventions aimed at improving infant and young child feeding (IYCF) at community level is a key priority in the effort to improve survival, growth, and development of children with equity.

Contact

Child Health Division, National Health Mission, Assam



GUJARAT

NUTRITION REHABILITATION CENTRE (NRC) FOR MALNOURISHED CHILDREN

PROBLEM STATEMENT

evere malnutrition is the underlying cause of almost onethird of under-five deaths in children in Gujarat. Around 44.6 per cent of Gujarat's children are underweight, 51.7 percent are stunted and 18.7 percent of children are wasted as per the NFHS-3 report.

PROGRAMME DESCRIPTION

The "Mission Balam Sukham" was hence conceptualised to provide an enabling mechanism to the different key departments in the State to converge together under one umbrella and undertake concerned efforts to address and improve the nutritional status of the targeted population in Gujarat. The "Mission Balam Sukham" is expected to focus on both i.e. preventive and curative aspects, preventive aspects are looked after by Department of Women and Child Development (DWCD) whereas curative aspect by Health department.

The programme was launched on 18th September 2012 with an aim to combat malnutrition across the State. The State has initiated a 3-tier approach for the management of children with SAM through the establishment of Nutrition Rehabilitation Centres (NRCs) at the district level, Child Malnutrition Centres (CMTCs) at the sub-district level, and Village Child Nutrition Centres (VCNCs) at the village/community level.

Since 2013, "Mission Balam Sukham" has been handed over to the WCD Department. The curative aspect of this mission CMTC/NRC is run by the Health Department, which focuses on a 2-tier approach for integrated management of malnutrition through Facility base management at different levels (NRC/ CMTC). Community base management at Anganwadi level has been done by the WCD Department.

Gujarat has 124 Balsanjivani Kendras(NRC)/Balseva Kendras (CMTC) to treat the malnourished and severely malnourished children at the facility level.

The focus is now on rolling out of IYCF practices – Nation Iron Plus Initiative (Life cycle approach to combat Anaemia) and strengthening of Facility-based management of children with Severe Acute Malnourishment (SAM) children.

PROGRAMME OUTCOMES

Facility	2012-13	2	2013-14	2014-15 (upto Nov)		
Туре	No. of children treated	No. of children gained weight	No. of children treated	No. of children gained weight	No. of children treated	No. of children gained weight
CMTC	705	612 (86.8%)	7161	6511 (90.92%)	7520	6987(92.91%)
NRC	218	165 (75.7%)	2070	1760 (85.02%)	2130	1980 (92.95%)
Rural/Urban	Rural (Tribal)					
Population covered	Not provided (Target population is all pregnant women in Tribal Blocks of State)					
Sector	Public					
Evaluation	Not provided					
Cost	Not provided					
Website	Not available					



GUJARAT

MAMTA GHAR-BIRTH WAITING HOME

PROBLEM STATEMENT

amta Ghar is the key element to 'bridge the geographical gap' obstetric care in rural areas, with poor access to medical facilities. The purpose of Mamta Ghar is to provide a setting where high-risk women or women from remote areas can be accommodated during the last 7-10 days of pregnancy, or even longer if need be, near a hospital where obstetric and newborn-care facilities are available.Here additional emphasis is put on education and counselling regarding pregnancy, delivery and care of the newborn infant and family.

Objectives of Mamta Ghar

- Increase the utilisation of the hospital by women from remote areas for delivery and care.
- Enable high-risk women or women from remote areas to access medical care during delivery period.
- Increase percentage of women delivered a baby with trained providers at health facility.
- Promote early and exclusive breast-feeding.

Promote minimum 48 hours of post-partum stay in Other Related Services the Institutions.

PROGRAMME DESCRIPTION

The flowing services is being provided in Mamta Ghar:

Health Services

- Routine antenatal examination.
- Nearby 24hr on-call availability of skilled birth attendant.

Health Education

- On childbirth and post-natal care.
- Birth-spacing and family planning.
- Newborn care.
- Kangaroo mother care for pre-term or low birthweight babies.
- Early and exclusive breast-feeding.
- Vaccination
- Nutrition

- Food facilities: To beneficiary and one attendant.
- Child care.
- Ambulance service.

Administration and Staffing

- Each Mamta Ghar is to be managed and administered by the Facility Incharge.
- To facilitate beneficiaries in the Mamta Ghar, 3 Caretakers, one Sweeper and one Security person are sanctioned for each Mamta Ghar.

PROGRAMME OUTCOMES

Average number of beneficiaries per Mamta Ghar/Per Year is 294 pregnant women.

CONCLUSIONS/LESSONS LEARNT

It is evident from the present research that Mamta Ghar provides essential care to mothers before delivery. Continuous utilisation of service is also encouraging.



EFFECTIVE DEVELOPMENT PARTNERSHIP UNDER RMNCH+A

PROBLEM STATEMENT

ujarat has achieved MMR of 112 per 1 lakh live births and IMR of 36 per 1000 live births with accelerated reduction over the period, but still, achieving a reduction in NMR (26 per 1000 live births) needs concentrated efforts with the involvement of all stakeholders (SRS 2013). To reduce disparities in health outcomes, the State has planned for effective and efficient collaboration and alignment of support towards the various needs and priorities. This can be done by harnessing the collective power of each partner's strength and capacity to work in the directions of policy, financial and service delivery commitment to provide the best possible health outcomes.

PROGRAMME DESCRIPTION

The Health and Family Welfare Department, Government of Gujarat, has partnered with organisations – international, national and local for strengthening of RMNCH+A services across the State for harnessing support in knowledge management, technical assistance, skill enhancement and service delivery.

UNICEF, an international NGO, is the lead partner for Gujarat for strengthening RMNCH+A interventions in 8 HPDs and technical assistance at the State level. The partnership also has been extended to other International NGOs like JHPIEGO, Engender, Micro Nutrient Initiative, Ipas etc.

The State has identified commitments that will enable partners to better harmonise financial and technical support, and to ensure that these are closely aligned to government policies, strategies and plans.

UNICEF has supported policy and planning for child survival and development-related activities by multisectoral engagement. Other health international partners: MI, JHPIEGO, Engender, Ipas are contributing towards activities of knowledge management for Diarrhea Alleviation by Zinc-ORS (MI), orientation on implementing Safe Child Birth Checklist protocols (JHPIEGO), on job training and supportive supervision in post-partum IUCD insertion (Engender), sensitisation and training support for Safe Abortion Services (Ipas). IAP and FOGSI have supported the State in strengthening the acclaimed Chiranjeevi Yojana and Baal Sakha Yojana in Gujarat.

EVALUATION

Overall the periodic evaluation is being done by regular review of health outcomes and indicators by the State in coordination with each stakeholder.

FINANCIAL INVESTMENT

The financial management is supported by NHM and the State Regular Budget on Public Private Partnership Mode.

SCALABILITY

Various modes of PPP have higher potential for scale-up across the health sector. MA Yojana, Chiranjeevi Yojana and GIA/NGO services of Gujarat are well known examples and have received many awards. To enhance the coverage of RMNCH+A services, these interventions are part of the platform to provide Universal Health Coverage.

Contact

Additional Director, Family Welfare, Government of Gujarat

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Period	MCH Services provided during the period (cumulative)								
	ANC 4	PNC (Up to 14th day)	Vaccination				TV shows	Mike	
			TT 2+Booster	BCG	Pentavalent 3	Measles 1st dose	Measles 2nd dose		prachar
April to Nov. 2014	538	341	1117	696	922	1020	1028	944	943

GUJARAT "KHILKHILAT"

PROBLEM STATEMENT

Though after the implementation of JSSK, out of pocket expenditure has been reduces significantly but still stay at hospital for 48 hours after delivery is a major change.

PROGRAMME DESCRIPTION

As a measure to reduce the out of pocket expenditure and to promote 48 hours of stay after delivery, the Government of Gujarat has come out with a cost-effective initiation. Accordingly, the already available recycled fleet of EMRI 108 vehicles are utilised for dropping home all mothers and new-born infants after 48 hrs of delivery. This is supported by JSSK and the State budget.

This initiative was named "Khilkhilat". Each Khilkhilat van is expected to be operational for drop-back services for about 2, 00,000 km and/or three years of services, whichever is early. This is supplemented with small body new vans procured from the State budget:

- Drop-back provided to all pregnant and delivered women and children under 1 year of age from enlisted government facilities.
- A token packet of nutritious food packet (Sukhadi) is given to delivered women.
- IEC kit in vernacular language (Gujarati) is given for awareness regarding Home Based Newborn Care (HBNC).
- The van is equipped with AVLTS (Automatic Vehicle Location Tracking System) with GPS Monitoring and Real-time Reports.
- The service has been operationalised with GVK EMRI vans in tandem with 108 services utilising their existing call-centre for fleet management.

The JSSK Help desk is established at district hospitals with high delivery workload wherein a Helpdesk coordinator **•** is appointed for:

- Motivating beneficiaries for a 48-hours stay.
- Ensuring that beneficiaries of JSSK gets all the entitlements.



- Co-ordinating between Khilkhilat and Hospital so as to provide drop-back to each and every beneficiary.
- To provide the beneficiary list to Khilkhilat Pilot well in advance.

PROGRAMME OUTCOMES

- About 168 Khilkhilat vans are functional in the State covering 187 Government health facilities with high delivery points and extended to 58 pickup points.
- Till November 2,42,086 Mothers, 2,33,832 Infants and 4,33,938 Companions have been provided with dropback service, which amounts to about 9,15,306 total beneficiaries.
- Out of 2,42,096 Mother beneficiaries, 155950 (65%) of drop-backs were in rural areas and 86146 (35%) of drop-backs were in urban areas.
- More than 16000 drop-backs in 2014 were provided in the months of September, October and November.

- On an average each Khilkhilat van provides a dropback to 2 beneficiaries and has a maximum capacity to carry 4 beneficiaries including relatives.
- 5.40% of drop-back services is provided to beneficiaries living more than 200 km from the base i.e. Hospital.

EVALUATION

An internal evaluation has been done.



KERALA

NEWBORN SCREENING PROGRAMME

PROBLEM STATEMENT

There was no detailed study of inborn error of metabolism in Kerala. Congenital Hypothyroidism was present in the community and it was necessary to ensure that the excellent work undertaken by the Health Services department is in pace with the best international practices for early detection and intervention of selected disorders to prevent serious consequences like mental retardation.

PROGRAMME DESCRIPTION

Newborn screening test aims at the early detection of disorders to prevent serious consequences by timely interventions. The current NBS programme of Kerala provides screening tests for Congenital Hypothyroidism, Congenital Adrenal Hyperplasia, Phenyl Ketonuria and Glucose-6 Phosphate Dehydrogenase deficiency which are carried out through the four PH labs. (State PH Lab and three Regional PH Labs).

PROGRAMME OUTCOMES

During the period from March 2013 to Feb 2015, a total of 115279- cases have been screened.

FINANCIAL INVESTMENT

The required funds are provided through the State plan as well as NRHM and the programme is implemented free-of -cost to the beneficiaries.

SCALABILITY

The NBS programme can be implemented in any of the States after arranging the following facilities:

 Equipping selected Government laboratories for starting NBS screening tests (equipment, test-kits, reagents, HR provision and necessary training should be given).

- Selection of delivery-conducting hospitals for running the programme.
- NBS sample collection and transportation guidelines should be given to the hospitals.
- Timely dispatch of test results from the laboratory to concerned institutions(by email).
- In the second phase, the NBS programme may be extended to all the delivery-conducting Government Hospitals in Kerala. Screening for Congenital Hypothyroidism and Congenital Adrenal Hyperplasia has to be continued.
- Phenyl Ketonuria can completely be excluded and G6PD may also be excluded, since the consequences associated with G6PD is less serious when compared to Congenital Hypothyroidism and also considering the financial viability when all the Government hospitals are included under the programme.
- The Government may give direction to private hospitals in the State to screen the babies for at least Congenital Hypothyroidism at their own facility since there is a high prevalence in the State.
- Inclusion of any other inborn error of metabolism screening under the programme can be considered after discussion with the Senior Clinicians.

CONCLUSIONS/LESSONS LEARNT

New born screening programme of Kerala is one of the most advanced and successful programmes implemented in the recent past. This is the first expanded pilot programme of the State where 44 selected Government hospitals are included covering all the 14 districts.

Since this report is based on the two years of data of New Born Screening Programme of Kerala, it more or less

gives the actual prevalence of the selected inborn errors of metabolism:

- The most common disorder detected through this programme is Congenital Hypothyroidism (67 Confirmed cases), that shows a prevalence of one in 1720 cases. All these babies are on treatment now. Early detection of Congenital Hypothyroidism through NBS programme has helped to prevent serious consequences like mental retardation in these babies.
- There was not a single positive case of Phenyl Ketonuria found through the screening.
- Two confirmed cases of Congenital Adrenal Hyperplasia are there, that shows a prevalence of one in 57634 only.
- 9 confirmed cases of G6PD Deficiency, which shows a prevalence of one in 12809 cases.

The selected government hospitals participated in the programme with varying levels of enthusiasm with major delivery-conducting hospitals being more enthusiastic.

REFERENCE

New Born Screening in India, NHS Programme in UK.



MEGHALAYA MATERNITY BENEFIT SCHEME (MMBS)

PROBLEM STATEMENT

Regulation of maternal and infant mortality in Meghalaya is a major challenge. The objective of the innovation is to reduce maternal and infant mortality.

PROGRAMME DESCRIPTION

Meghalaya Maternity Benefit Scheme was launched in 2011-12. It provides coverage to all pregnant women (19 years and above) belonging to BPL families. The scheme is limited for the first two children. It can be availed after the mother completes 3 ANC check-ups, TT injections and IFA tablets. Financial assistance of

Rs. 4000 is provided to the mother for antenatal care and post-natal care. ASHA receives an incentive of Rs. 1000 for promoting antenatal care and institutional delivery. The services can be availed at the government hospitals & accredited private hospitals. To avail the benefits each beneficiary registered should have a MMBS card along with an M&CP Card. A grievance redressal cell supported by the DPMU has been set up at district level.

CONCLUSIONS/LESSONS LEARNT

There's a reduction in maternal mortality rate and increase in the institutional deliveries.

REFERENCE

http://nrhmmeghalaya.nic.in/pdf/Meghalaya_Maternity_ Benefit_Scheme.pdf.

Contact

Directorate of Health Services, Shillong, Meghalaya



MAHARASHTRA

MAHILA AROGYA ABHIYAN

PROBLEM STATEMENT

The socio-cultural inequality offers subordinate status to women. This affects the decision-making power of women as well as healthcare seeking. This programme symbolises the scope to enhance women's healthcare.

PROGRAMME DESCRIPTION

In order to bring women's health into focus and provide them with specialised services, the Department of Public Health, Government of Maharashtra decided to observe "MAHILA AROGYA ABHIYAN", a Healthcare awareness drive for 15 days in all the healthcare facilities. The Abhiyan began with Women's Health Day (26th February 2015) and was extended to 12th March 2015, with special camps being held on the International Woman's Day (8th March 2015). The major objective was to improve the health of women by providing better access to healthcare delivery and quality services at their doorstep. The tag-line for the Abhiyan was "Save Girl Child, Safe Delivery, Clean and Well-equipped Hospitals".

A series of innovative programmes were launched:

- The drop-back service vehicle for Mother and child was named "Vatsalya".
- Toll-free mental health Help line 104.
- Inauguration of unique logo for the Public Health Department of Maharashtra.
- Inauguration of skill lab "Kaushalya".
- Camps for screening women, especially of the reproductive age group, for various types of cancer.
- Guidelines for Surakshit Matrutva i.e. Safe Motherhood.
- ASHA diary.

The services in the Abhiyan include:

- Organising comprehensive camps for anemia detection for women in the age group of 15-49 years, especially for pregnant women.
- Screening of High Risk Pregnancy cases, Pick-up and Drop-back referral services for ANC and PNC patients.

- Organising NCD camps for screening women
 for various types of cancer such as oral cancer, cervical cancer and breast cancer. Also screening for Hypertension and Diabetes Mellitus with the help of IDA, IMA and NGOs working for healthcare.
- Beti Bachao Abhiyan, Safe Motherhood, blood donation camps and organ donation drives.
- Organisation of camps for detection of sickle cell and Thalassemia, RKSK, RBSK and AYUSH camps, organization of special surgery camps under RGJY.
- Inauguration of OPD token system in various Health Institutes.
- Kayapalat (face-lifting of various PHCs).
- ASHAs felicitation, sensitisating them and also arranging their medical checkups.
- Implementation of the We-care concept.

Outreach camps were also organised in urban slum areas of all 95 cities under the Mahila Arogya Abhiyan.

PROGRAMME OUTCOMES

- 5396 severely anemic mothers were identified (38%). Around 71000 mothers underwent PNC checkups. About 13079 pregnant mothers were given pick-up service through referral transport and 14382 were given drop-back referral services.
- Out of 7.6 lakhs females screened in NCD camps, 2600 females were suspected for oral cancer, 6200 females suspected for cervical cancer, 2300 females suspected for breast cancer, 44000 females suspected for Hypertension (6%) and 25500 females suspected for Diabetes Mellitus (3.4%).
- There were 650 confirmed cases of cancer, approximately 9600 confirmed cases of Diabetes Mellitus and 15000 confirmed cases of Hypertension up till 16th March 2015. Oral pre-cancerous lesions were found in 1650 females and 532 females had oral cancer.
- RKSK Helpline-DILASA was inaugurated on 8th March 2015. About 3000 RKSK camps were held.
- Inauguration of OPD Token Systems was carried out in about 1100 Health Institutes.

- Over 2900 institutes carried out condemnation drives and about 12500 institutes carried out cleanliness drives.
- 80% ASHAs, 100% ANMs and 89% staff nurses were felicitated for their outstanding performance.

IMPLEMENTING PARTNER

IMA- Maharashtra, IDA, Tata Memorial Center Mumbai, service NGO's.

CONCLUSIONS/LESSONS LEARNT

A well-focused and designed mass campaign created great awareness in the general public about women's health issues with support from IMA and other NGOs working in the health sector.

REFERENCE

GOI Directives to celebrate women's day.

Contact

Asst. Director, State Program Manager Quality Control Officer (Sicklecell)



MADHYA PRADESH MAMTA RATH - HEALTH COMMUNICATION FOR ALL

PROGRAMME DESCRIPTION

amta Abhiyaan, a massive historic and ambitious effort to reduce mother and child deaths (IMR, MMR) and reduce TFR in the State of Madhya Pradesh, focuses on 12 simple life-saving practices and increasing those behaviours in the population.

Mamta Rath is the vehicle of this ambitious Mamta Abhiyaan. Mamta Rath is not just a communication outreach - it is community mobilisation and dialogic communication linked to services. Mamta Rath is currently running in all 313 blocks in 51 districts. It has covered 21,500 villages and 16,91,150 beneficiaries in a span of 90 days. The plan is to cover all the villages on a six-monthly basis. At the district level, the district IEC coordinator/ MEIO/Dy MEIO/Designate IEC officer; at the block level BEE/Designated BEE and at the village level Supervisor/ MPW is the nodal person for successful roll-out of Mamta Rath. As innovative tools for Mamta Abhiyaan - MAMTA Geet/Anthem has been created to salute mothers, 12 TV spots featuring the life-saving behaviours ranging from 45 seconds to 60 seconds are effectively intertwined with messages from the Honorable Chief Minister directly appealing to his people to ensure healthcare for their women and children, 35 Mamta Videos of 20 minutes each about the 12 key life-saving behaviours in an edutainment format have been prepared. Health Camps by Sector Medical Officers are being organised simultaneously with the Rath in each village.

PROGRAMME OUTCOMES

Social Mobilization

16,91,150 beneficiaries covered that include adolescents, mothers and men have been mobilised till date for dialogic communication across 12 life-saving critical behaviours.

Counselling sessions held with audiences in villages across the issue of routine immunisation, ANC check-up, anemia in adolescents and women, hand-washing and menstrual hygiene through use of interpersonal communication (IPC) and group counselling.

Service delivery: Approximately 85,780 women have been given IFA tablets.

66,120 children received ORS packets; 1,66,644 couples counselled for adoption of family planning methods and received contraceptives; 10,350 high risk pregnant women were counselled and referred to medical facilities.

FINANCIAL INVESTMENT

Successful negotiation with the Ministry of Health and Family Welfare, GoI has led to funding support of Mamta Raths in the current financial year.





PROBLEM STATEMENT

The State of Madhya Pradesh (MP) with a population of 73 million and an annual birth cohort of 1.9 million has the highest infant mortality rate (IMR) in the country. To address the issue of high and stagnant neonatal mortality and use the opportunity of increasing institutional delivery for improving new born survival rate, the Government of MP with technical support of UNICEF has put a strong focus on strengthening facilitybased new born care by establishing special newborn care units (SNCUs) to complement ongoing communitybased strategies.

PROGRAMME DESCRIPTION

SNCUs are primarily meant to provide specialised care to small and sick new borns who account for 80% of newborn deaths. The State initiated simultaneous steps to develop infrastructure, ensure availability of equipment and attract adequate human resources to facilitate rapid scale- up of SNCUs from the initial two units in Guna and Shivpuri in 2007-08 to achieving State-wide scaleup across all 50 districts by 2013. This made MP the first State in the country to achieve universal coverage of SNCUs at district level as per the norms recommended by Government of India (GoI), with 270,000 newborns treated in last six years.

The need of a robust real-time data management system to monitor the performance and long term outcomes of newborns discharged from SNCUs was addressed in 2012 by piloting an online data monitoring system which was developed by UNICEF, and realising the relevance it was subsequently taken up by GoI for national level scale-up. All these initiatives coupled with increase in institutional deliveries have contributed to the State showing 20% decline in the neonatal mortality rate in the last five years (2007-2012). SRS 2013 revealed the highest drop of 3 points in Neonatal Mortality in Madhya Pradesh, the national decline in Neonatal Mortality being 1 point.

PROGRAMME OUTCOMES

- 1. MP registered the highest decline in neonatal mortality rate in the country (SRS 2013). The achievement is largely due to improved survival of neonates because of successful treatment of sick newborn through SNCUs.
- 2. State-wide scale-up in five years with 53 SNCUs and 270,000 newborns treated MP has become the first State in the country to achieve universal scale-up of SNCUs covering all 50 districts in the State. The scale-up has been fast and methodical without compromising on the quality and has benefitted more than 270,000 newborns in the last six years with an overall mortality rate of 12.4 % during treatment. Average Bed Occupancy in the year 2013 for SNCUs in Madhya Pradesh was 106.4 %.
- 3. Utilisation of services across all caste categories including the most vulnerable: The services in the SNCUs have been kept free for beneficiaries across all castes, to reduce out-of-pocket expenses and remove cost barriers in access to care.
- 4. **Standardiation of quality of care and accreditation of SNCUs:** In order to have standardised certification of quality of care, National Neonatology Forum which is the apex professional body of neonatologists of India has been assigned the task of accreditation of SNCUs in India.
- 5. **Ripple effect on care in labour room and at birth:** Analysis of SNCU data showed prematurity, birth asphyxia and neonatal sepsis as the three major causes for admission and deaths in SNCUs. MNH wings have been sanctioned for all 50 districts of the State and several of them have been made functional.
- 6. Special care for low birth weight and pre-term Baby-Kangaroo Mother Care Ward 48 districts have sanction for Kangaroo Mother Care Wards to provide special care to Low Birth Weight babies. Till date, 22 Kangaroo Mother Care Wards have been made functional.

CONCLUSIONS/LESSONS LEARNT

The strong collaboration between State government and UNICEF, working closely from pilot to scale-up on different components like civil work, procurement, HR recruitment, capacity-building and putting up a robust monitoring system was critical. The experience also highlighted the importance of district-level leadership, secured funding under flagship, sound planning, strong bureaucratic commitment and high political buy-in for an intervention addressing the need at the ground level. It also showed that by removing administrative bottlenecks in recruitment, improving remuneration and pay packages and providing suitable working conditions, it is possible to attract and retain specialised human resources in SNCUs. Thus, the combination of all these factors helped in turning the dream of scaling-up of SNCUs into reality. Future challenges will now focus around quality of care, improving outcomes, using data for decision-making and ensuring long-term survival, growth and development of babies after discharge from SNCUs by effectively linking facility-based care with community-based care.



MADHYA PRADESH

NUTRITION REHABILITATION CENTRES OF MADHYA PRADESH – INNOVATIONS FOR REPLICATION

PROBLEM STATEMENT

adhya Pradesh has 12.6 lakhs severely-wasted children, **the highest in the country**. As per National data, Madhya Pradesh is home to about 1.89 lakhs children with medically complicated SAM. Since the mortality rate for these children is approximately 9 times higher than that of healthy children, it becomes imperative to provide them with immediate medical treatment and nutritional rehabilitation.

PROGRAMME DESCRIPTION

Bal Shakti Yojana was launched in October 2005, whereby Nutrition Rehabilitation Centres (NRC) were established in District Hospitals and later on scaled-up across the State. There are 314 NRCs in Madhya Pradesh, with a minimum of one NRC per block:

- Promoting maternal health and nutrition: Mothers are provided with a free balanced and nutritive diet. The daily menu is planned keeping in view the RDA of an adult pregnant/lactating mother. Maternal micronutrient supplementation, is ensured alongwith examination of co-existent medical ailments.
- Linking of family planning service and catering to unmet need: About 54% i.e. 12,367 eligible mothers have accepted some form of family planning method during their NRC stay.
- Promoting standardised counselling through use of counselling tools for NRCs: An illustrative flip book guide was developed on an essential nutrition package, which equipped the feeding demonstrators/ ANMs/grass root level health volunteers with the required IPC knowledge and skills.
- Promoting Infant and Young Child Feeding (IYCF) practices in NRCs through Supplementary Suckling Technique (SST): 'Mother's Milk Insufficiency' (MMI) is addressed by supporting the mother to breastfeed while simultaneously administering supplemental milk via an oro-pharyngeal gastric tube attached to the breast.
- Development of training modules on facility-based management of SAM for medical personnel, staff and

other front line functionaries: The F-SAM training modules have been developed in both English and Hindi, in consultation with national stalwarts.

 Strengthening convergence with line department viz. DoWCD for improved identification and referral of SAM: The frontline functionaries of ICDS i.e. AWWs have been trained and provisioned with MUAC tapes for early identification and referral of SAM.

PROGRAMME OUTCOMES

Out of 1, 28,000 SAM children treated in 2014-15 in the entire country, 73200 were treated in Madhya Pradesh.

EVALUATION

- 1. A third-party impact assessment study of Nutrition Rehabilitation Centres in Madhya Pradesh was done by Public Health Foundation, India (PHFI), New Delhi in 2012-13.
- 2. In 2013-14, UNICEF in collaboration with Gajaraja Medical College, Gwalior, undertook an evaluation study to assess impact of NRC programme in MP.

FINANCIAL INVESTMENT

Under NHM GoMP, an illustrative cost of 3090/- per SAM child (bifurcated as treatment cost @ Rs. 1880/- and follow-up cost @ Rs. 1210/-) is approved.

Cost of free diet and diagnostics for mothers of admitted SAM children are borne through the State budget. In addition, an annual maintenance cost of Rs. 30,000/- and Rs. 50,000/- for 10- and 20-bedded NRCs respectively, is provisioned for taking care of minor repair of equipments, provision of age-appropriate toys, replacement of damaged essential logistics etc., of these centres.

CONCLUSIONS/LESSONS LEARNT

NRCs of Madhya Pradesh have focused on facility-based management of SAM. This is primarily because a suitable nutrition therapy that can be used in the community is still not available in the country.

REFERENCES

- 1. Guidelines for the inpatient treatment of severely malnourished children, WHO, 2003.
- 2. Recommendations from IAP Guidelines on Hospital Based Management of Severely Malnourished Children (Adapted from the WHO Guidelines), 2006.
- 3. WHO child growth standards and the identification of severe acute malnutrition in infants and children-A Joint Statement by the World Health Organization and the United Nations Children's, 2009.
- 4. Operational Guidelines on Facility Based Management of Children with Severe Acute Malnutrition, MoHFW, GoI, 2011.
- 5. Manual for Facility Management of Severe Acute Malnourished Children in MP, NRHM- State level, 2011.

Contact

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Deputy Director, Child Health



PROBLEM STATEMENT

Though the State of Punjab has better health indicators as compared to many other States of the country, the Government of Punjab is committed to raising the health status of the people of the State. The rate of decline of infant and child mortality has not been comparable to the development of the State. The current IMR of 26/1000 (SRS 2013) and under-5 mortality rate of 34/1000 (SRS 2013) are still very high. The child action plan (2014-2017) – part of Mother and Child Health Action plan is one cogent step in that direction.

PROGRAMME DESCRIPTION

The Mother and Child Health Action Plan is a comprehensive document that lays out steps to improve maternal and child health in consonance with the RMNCH+A Strategy.

The plan lays out specific activities for the same:

- a. Care of the mother during pregnancy and delivery.
- b. Special care of the newborn child through Essential Newborn Care.
- c. Care of the children through infancy up to 5 years of age, during school going period and care of adolescents.
- d. Care of pre-pregnant women is also an important component of the Mother and Child Health Action plan.
- e. Emphasis has been laid on the care of the sick newborn, Home-based Newborn Care, Infant and Young Child Feeding, immunization, care of the sick child especially those suffering from pneumonia and diarrheal diseases.
- f. Provision of free drugs and diagnostics for all infants and for girl children up to 5 years of age.
- g. Free Diagnosis and treatment of 30 diseases in children has been provided under the Mother and Child Health Action plan.
- h. Prevention of anemia with Iron Folic Acid supplementation and biannual dose of Tab-Albendazole are important components.
- i. Free treatment is provided to school children suffering from heart diseases like RHD/CHD, Cancer and Thalassaemia at government and empanelled private super specialty hospitals.

- . Rational deployment of Human Resources and training of Human Resources for multitasking are an important part of the Action plan.
- k. Up-gradation of infrastructure, including establishment of SNCUs, NBSUs and NBCCs at different levels and construction of Mother and Child Health Hospitals throughout the State are being taken up to improve healthcare services for children.

PROGRAMME OUTCOMES

It will help in decreasing the early NNM, NNM, IMR, and under-5 mortality rate of Punjab. Under-5 Mortality Rate has reduced from 38 (SRS 2013) to 34 (SRS 2013) while IMR has come down from 28 (SRS 2012) to 26 (SRS 2013) and NMR from 24 (SRS 2011) to 17 (SRS 2012).

IMPLEMENTING PARTNERS

USAID, IPE Global.

FINANCIAL INVESTMENT

Funds provided under RCH & Mission Flexipool, Immunization Programme in the NHM PIP. Conclusions/Lessons Learnt.

The operationalisation of SNCUs and MCH centres started in 2012. There has been remarkable improvement in the care of sick newborns and reduction in their mortality. It is hoped that the results of this intervention would be clearer in the next 1-2 years and the State would be able to achieve the 12th plan targets and even go beyond that.

SCALABILITY

At present the plan is to start MCH centres and SNCUs at district hospitals. After the initial study the SNCUs may be

extended to the sub-divisional hospitals with good caseloads, depending upon the catchment area.

Contact

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FREE TREATMENT OF GIRL CHILD UPTO 5 YEARS

PROBLEM STATEMENT

The Child Sex Ratio is one of the major gender issues in the State of Punjab. There is a discriminatory attitude of people in the treatment of the girl child.

The care seeking for the girl neonates and children is often delayed or denied. This results in higher probability of complications and mortality among girl infants and children as compared to boys.

PROGRAMME DESCRIPTION

Year of start 2013-14. The State has taken various measures to improve the child sex ratio which includes strict implementation of PC&PNDT Act. Instructions have been issued to all appropriate authorities to enforce the PC&PNDT Act and take strict action against defaulters. Further, in order to give impetus to the reduction of sex discrimination, the State government has made provision for free treatment of girls up to 5 years of age by effectively extending the reach of JSSK beyond 5 years through its own resources. Under the State government scheme, all female children up to 5 years are given complete outdoor as well as indoor treatment and diagnostics, entirely free of cost in government health institutions. Even if some medicines or diagnostics are not available in the system, the cost is borne by the State. Active campaigns will be undertaken to raise awareness of the public on this issue of great importance.

Apart from implementation of PC&PNDT Act, the State started Balri Rakshak Yojana in April 2005. Under this scheme Rs. 500/- is deposited monthly in the post office account of the child up to 18 years of age.

PROGRAMME OUTCOMES

This will help improve the child sex ratio in the State and also improve the life expectancy for the female child.

FINANCIAL INVESTMENT

Rs. 1.5 crores annually.

SCALABILITY

This programme can be implemented as an extension of JSSK where free treatment is provided to the infant up to 1 year, which can be extended to 5 years for the girl child.

Contact

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PREVENTIVE MAINTENANCE OF COLD CHAIN SYSTEM AND NCCMIS

PROBLEM STATEMENT

rotecting health of the newborn children through immunisation is an important intervention. The delivery of safe and effective vaccines and minimising AEFIs requires a very efficient cold chain management system.

PROGRAMME DESCRIPTION

The State of Punjab has a population of 2.82 crores. There are 22 districts, 40 sub-divisions and 118 health blocks. The 740 cold chain points require continuous monitoring for delivery of safe and effective vaccines. Preventive maintenance of Cold Chain Management was started in 2010. It was envisaged that the Refrigerator Mechanics (Cold Chain Technicians) would visit every cold chain point at least once in three months in smaller districts (cold chain points less than 40) and once in 4 months in larger districts (cold chain points more than 40). Mobility support was provided to all cold chain technicians under NRHM/NHM.

Alongwith preventive maintenance, NCCMIS was started as a pilot in the State of Punjab by Government of India. All information on cold chain system is available online.

PROGRAMME OUTCOMES

There has been remarkable improvement in the breakdown rate of cold chains. As of December 2014, the Cold Chain Sickness Rate in the State of Punjab is 0.3% which is probably the lowest in the country.

IMPLEMENTING PARTNERS

Government of India for funding through NRHM/NHM.

SCALABILITY

The Preventive Maintenance System started by Punjab is now being scaled-up at the national level.

CONCLUSIONS/LESSONS LEARNT

Preventive maintenance of Cold Chain is very effective in maintaining the vaccines in good condition. It lowers the Cold Chain Sickness Rate with the result that the vaccines are always stored in perfect condition and lowers the risk of AEFIs.

Contact

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TAMIL NADU

DR. MUTHULAKSHMI REDDY MATERNITY BENEFIT SCHEME (MRMBS)

PROBLEM STATEMENT

To reduce the incidence of maternal and infant deaths in the State.

PROGRAMME DESCRIPTION

Muthulakshmi Reddy Maternity Benefit Scheme was implemented in 2006. It provides coverage to all pregnant women (18 years and above) belonging to BPL families. The objective is to provide financial support, compensate for wage loss and avoid maternal anemia during pregnancy (up to two children). Also to ensure a minimum 2.5 kg birth weight and immunization of infants. The scheme extends to Sri Lankan refugees and women members of Farmers Social Security Scheme. In the year 2011 the financial assistance received under the scheme increased to Rs. 12000 from Rs. 6000. This amount is disbursed in three equal installments to support for nutrition and referral transport. Amount is transferred to beneficiaries account from the treasuries through RECS. The beneficiaries are required to get themselves registered by opening a saving account in any Nationalized Bank. They are then allotted with a unique ID called PICME number which stores all the details of the beneficiary. All the details are entered online using the systems of browsing centre.

FINANCIAL INVESTMENT

In 2014-15, Rs. 716 crores were provided by the Government for a smooth functioning of the scheme.

CONCLUSIONS/LESSONS LEARNT

In 2013 - 2014 approximately 7 lakh beneficiaries received Rs. 652 crores as disbursements.

REFERENCE

http://kpmbphc.blogspot.in/2012/01/new-dr-muthulakshmi-reddy-maternity.html.





TAMIL NADU

MENSTRUAL HYGIENE PROGRAMME

PROBLEM STATEMENT

The objective of the Scheme is to:

- Increase awareness among adolescent girls on menstrual hygiene.
- Build self-esteem and empower girls for greater socialisation.
- To increase access to and use of high quality sanitary napkins.
- To ensure safe disposal of sanitary napkins.

PROGRAMME DESCRIPTION

The Menstrual Hygiene Programme was launched by Hon'ble Chief Minister of Tamil Nadu on 27.03.2012 at Chennai.

Under this Scheme:

- 3 packs of Priceless beltless sanitary napkins containing
 6 pads per packs are distributed every 2 months for
 each adolescent girl from 10-19 years of age.
- 18 packs are given for a year.
- Both school and non-school going girls in rural areas are benefited.
- The sanitary napkins are procured through Tamil Nadu Medical Services Corporation Limited.
- 7 packs (6 pads per pack) of Priceless belt-type sanitary napkins are distributed to post-natal mothers who delivered in government institutions.
- Initially these napkins are provided to the post-natal mothers in three Health Unit Districts (Kancheepuram, Thiruvallur and Poonamallee).
- 18 packs (6 pads per pack) of Priceless belt- type sanitary napkins are also given to women prison inmates and female inpatients in the Institute of Mental Health, Chennai.

PROGRAMME OUTCOMES

The beneficiaries under this scheme over the past three years are:

Sl. No.	Category	2012-13	2013-14	2014-15 April to Dec. 2014
01.	Adolescent girls rural (10-19 yrs) who at- tained puberty	32,79,028	32,79,028	32,79,028
02.	PN Mothers (Kancheepuram, Thiruvallur and Poonamallee	10,137	54,875	27,966
03.	Women prison in- mates	-	729	700
04.	Female inpatients in IMH Chennai	-	525	842

IMPLEMENTING PARTNERS

Belt-type sanitary napkins produced by Self Help Groups are supplied through the Tamil Nadu Corporation for Development of Women Ltd., and procurement is made through Tamil Nadu Medical Services Corporation Ltd.

SCALABILITY

The programme ultimately should cover both adolescent and post-natal mothers across the State.

Contact

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TAMIL NADU BIRTH WAITING ROOM

PROBLEM STATEMENT

The tribal population of the State is at different stages of social, cultural and economic development. There is a consensus agreement that the health status of the tribal population needs a lot of improvement because of their isolation, remoteness and being largely unaffected by the developmental processes going on in the country.

Birth Waiting Rooms are residential facilities available, where women who live remotely can wait before giving birth at a hospital or health centre. More women from remote areas would access birthing facilities if they could wait for the onset of labour in a maternity waiting home.

PROGRAMME DESCRIPTION

In 1991, the World Health Organization (WHO) highlighted the potential advantages of implementing Birth Waiting Rooms as part of a package of essential obstetric services. In view of the fact that most of the tribal habitation is concentrated in far-flung areas, forestland, hills and remote villages, and in order to remove the imbalances, reduce unmet needs and to provide better healthcare and family welfare services to tribal populations, there is a felt need for providing areas where they could stay close to the facility and utilise the services.

With this in view, Birth Waiting Rooms (BWR) were established at the foot hills of the PHCs in the tribal areas. So far 17 Foot hill BWRs have been established. Antenatal mothers along with their attendant, can stay in these waiting rooms, which are located in the foothills, well in advance of the expected date of delivery (7-10 days), and avail themselves of the EmONC services. In order to facilitate the stay of these mothers at the BWRs prior to delivery, 3 support staff have been provided for round-the-clock care and services. This is in addition to the staff nurse and M.O. in the PHC who will provide medical and technical assistance.

Services available in a BWR

- Round-the-clock BEmONC services.
- Nutritious diet for the mother and one attendant.
- Continuous monitoring of vitals especially in highrisk cases.
- Free delivery services in the PHC.
- Free referral services if needed for both mother and newborn.
- Free drop-back services.

PROGRAMME OUTCOMES

The Community Health Nurse of the Block Primary Health Centre will be the Supervisor of the BWR for all practical purposes in addition to her routine duties. She is the custodian of all records and registers related to the BWR. She is responsible for all financial expenditure with due supervision of the patient welfare society.

The PHC Medical Officer shall be the overall in-charge officer for the BWR.

District-level supervisors will be the Deputy Director of Health Services and District Maternal Child Health Officer.



IMPLEMENTING PARTNERS

Members of the family of the pregnant woman.

SCALABILITY

In due course this can be scaled up to all areas which are hard to reach or lacking easy accessibility to health facilities.

CONCLUSIONS/LESSONS LEARNT

This scheme has helped to reduce home deliveries as well as maternal and peri-natal morbidity and mortality in these areas.

Contact

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TELANGANA

LABOUR ROOM MANDATORY PROTOCOLS AND QUALITY PRACTICES: SAFE CHILDBIRTH CHECKLIST

PROBLEM STATEMENT

- Most mothers dying in postnatal period 48.2%.
- 21.4% mothers Maternal Deaths in labour.
- 28.6% in Antenatal period.
- 1.8% deaths due to Abortion.

PROGRAMME DESCRIPTION

The project was started on 11th March, 2014. Under the project all delivery points covering 10 HPDs were covered.

Geographical area of TS 114,840 sq.kms/44,360 sq.miles and 6.7 lakhs expected deliveries in public health facilities.

Methodology: Strategy for rollout

- State Level Sensitisation Workshop and TOT for creating State resource pool.
- District level trainings for service providers.
- Rapid assessment of Delivery points prior to implementation.
- Preparation of score cards and dissemination workshop focusing on complete gap filling.
- Implementation of labour room mandatory protocols and practices.
- Review and gap analysis by identified monitoring teams.
- Evaluation and discussion of findings at State level.
- Monitoring and supportive supervision.
- The monitoring team in the districts visit the facilities quarterly for supportive supervision.

PROGRAMME OUTCOMES

- 154 master trainers and monitors trained.
- District level TOT conducted training a pool of 10-12 master trainers per district.
- Rapid assessment of Delivery points in a phased manner covering high load conducted in 2014-15; gaps identified and dissemination of gap filling exercises conducted.

- Gap analysis presented and discussed in presence of **SCALABILITY** State level highest authorities.
- On duty job aid.
- Memory tool.
- Uniform standards and evidence of implementation/ gap (checklist).
- Checklist audits analysis is constant reminder of the gaps in infrastructure/drugs/consumables/adherence to protocols/best practices status.
- Minimising errors during the crucial period so as to reduce MMR and ENMR rapidly and significantly.

IMPLEMENTING PARTNERS

JHPIEGO

EVALUATION

Observation by 8th CRM Team 9 and JHPEIGO team but no formal evaluation.

FINANCIAL INVESTMENT

The total cost of checking with SCC including initial assessment, training of all service providers at all Delivery points, printing of checklist, monitoring and supervision with periodical assessment Rs. 122.93 lakhs. @Rs. 12 lakhs per district.

- Move from high load delivery points to optimal load i.e starting from Medical College DPs to District Headquarter Hospital, sub-district hospitals (AH/ CHC- FRU'S),24x7 PHCs and finally the private hospitals.
- Move from High Priority districts to all districts.

CONCLUSIONS/LESSONS LEARNT

SCC is unique by addressing important issues missed in MCH trainings and even included in curriculum at medical college.

REFERENCES

- 1. EMOC, BEMOC and SBA guidelines by MOHFW.
- Mudaliar and Menon's Clinical Obstetrics Book. 2.
- 3. Oxorn Foote Human Labor and Birth, Sixth Edition.
- 4. Ian Donald's Practical Obstetric Problems Book
- 5. DC Dutta's Textbook of Obstetrics.

Contact

State coordinator IIHFW Vengalrao nagar



EMERGING INITIATIVES

ICT in Healthcare

JAMMU AND KASHMIR EVIDENCE-BASED BUDGETARY RECOMMENDATIONS

PROBLEM STATEMENT

 \mathfrak{A}^n essential part of any public health system is to systematically evaluate the needs of the population and the systems' capacity to meet those needs, by developing evidence for policy-makers for proper planning, in order to improve the access and quality of health care services delivery. One of the major activities of the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) strategy is to conduct a "gap analysis" of delivery and potential delivery points in the high priority districts of India. In the State of Jammu and Kashmir, six districts have been identified as HPDs and the Norway India Partnership Initiative and Public Health Foundation of India (NIPI-PHFI) have been assigned as development partners for providing technical support to implement the RMNCH+A strategy in the State as per the framework developed by the Government of India.

PROGRAMME DESCRIPTION

With the help of NIPI-PHFI, through scientifically designed interventions, the District Coordinators, District Monitors and District Monitoring and Evaluation Officers were empowered with a custom-designed m-Health tool, an application installed on android tablets for uploading of the data on real-time basis from health facilities regarding RMNCH+A services and available infrastructure. From the checklist provided by Ministry of Health and Family Welfare, Government of India for conducting gap analysis in HPDs, twelve (12) themes were identified which are essential for improving the RMNCH+A services viz. infrastructure, equipment, capacity-building, IEC, etc. After filling the e-format, the data was uploaded on a central server where visualisation algorithms were designed to automatically analyse the data and present evidence for budgeting of resources needed to plug the gaps for these facilities. The identified gaps were then prioritised for each district and cross-validated with HMIS score-card that provided an overview regarding the performance of districts and gaps based on selected themes.

PROGRAMME OUTCOMES

Gap analysis using m-Health tool was completed in 1413 health institutions delivering RMNCH+A services across the State. Based on the gap analysis report, it was observed that 80% of the gaps can be resolved by administrative action and only 10% of gaps need financial support which can be met out of untied funds available with the institutions under NHM. This remaining 10% of identified gaps were prioritised and the resources needed were projected over a period of 3 years. The funds needed for the activities prioritised for the financial year 2015-16 have been budgeted as per the State Programme Implementation Plan (SPIP) format of MoHFW, GoI under the respective budget heads.


ODISHA

REPRODUCTIVE HEALTH COMMODITIES LOGISTICS MANAGEMENT INFORMATION SYSTEM (RHCLMIS)

AN ICT INITIATIVE FOR ENSURING CONTRACEPTIVE COMMODITY

PROBLEM STATEMENT

It was difficult for the program managers to have realtime data on contraceptive availability and utilisation at various health facilities and the contraceptive supply chain was barely monitored. Information on stocks and supplies on a real-time basis at sub-district levels (Community Health Centre, Primary Health Centre and sub- centre) where health records are maintained manually, was difficult to obtain. The forecasting and ordering of stocks did not follow a scientific process and supply was not need-based.

PROGRAMME DESCRIPTION

RHCLMIS is an innovative application of web portal (www.rhclmisodisha.com) and mobile phone-based text messaging for contraceptive logistics management was introduced for the first time in the country under the public health programme. It covered all districts, from State warehouses to ANMs. The application effectively enables in controlling the supply chain operation, reducing the supply imbalances, and regulating the flow of contraceptives at various levels through mobile short service messages (SMS). Commodities which are supplied by the Government i.e. Condoms, Oral Contraceptives Pills (OCP), Emergency Contraceptive Pills (ECP), Intra Uterine Contraceptive Devices (IUCD), pregnancy test kits and tubal rings (for laparoscopic sterilisation) are being handled on the RHCLMIS platform across the State connecting over 7000 health facilities.

PROGRAMME OUTCOMES

After implementation of RHCLMIS, substantial improvement has been noticed in strengthening the supply chain management of contraceptives. Some of the benefits of the system are reduced stock outs at facilities, reduced paper work and less time taken for indenting.

IMPLEMENTATION PARTNERS

UNFPA through State Family Welfare cell. Now completely managed by Directorate of Health and Family Welfare.

SCALABILITY

The intervention has a huge scope of replication in other similar areas where the supply chain plays a major role. Considering the scope, the following activities

have already been taken up for scaling-up the intervention:

- i. Considering the utility, NHM now plans to include the RMNCH+A 5X5 commodities on RHCLMIS platform.
- ii. Representatives from Bihar, Rajasthan and Madhya Pradesh have visited Odisha to study the details of application and are trying to replicate the same model in their respective States.
- iii. The Public Health Foundation of India (PHFI) on behalf of Government of India has captured the functioning of RHCLMIS as an innovation in ensuring the contraceptive supplies.

CONCLUSIONS/LESSONS LEARNT

Such a system has tremendously simplified the monitoring of the supply chain of health commodities down to the lowest level of public health system i.e. subcentre.

Contact

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Human Resources

MAHARSHTRA MEDICAL OFFICERS' CERTIFICATE PROGRAMME

PROBLEM STATEMENT

igh vacancy rates for specialist positions ranging from 60 to 70% in the public health facilities is further accentuated by a lack of rational deployment. Reasons for specialists' unwillingness to serve in rural areas include non-competitive salaries, lack of basic amenities and education facilities for their children etc. This has resulted in the State not being able to fully functionalize the FRUs and other secondary health facilities.

PROGRAMME DESCRIPTIONS

The Short Term Certificate Course for Medical Officers started in Maharashtra in 2011, is essentially a 6-months training course in Tertiary Care Hospitals/Medical Colleges. The objectives of the course include (a) updating the knowledge of MOs in non-surgical specialty such as Medicine, Pediatrics, Mental Disorders etc. (b) improving their understanding of ECG, Heart Disease, Septicemia in new born and treatment for malnutrition. The trained Medical Officers are posted at FRU level for these specialty services. The MOCP training batches are evaluated every year.

PROGRAMME OUTCOMES

72 doctors have so far been trained in Medicine and 97 in Pediatrics. Skill enhancement of these doctors has helped in health care delivery in the field of Medicine and Pediatrics where Specialists are not available. Lowering of CDR (Crude Death Rate - 6.2); IMR (Infant Mortality Rate - 24) and U5MR (Under 5 Mortality Rate - 26) in the State can be partially attributed to this initiative.

FINANCIAL INVESTMENTS

Grants sanctioned for this initiative over the years are Rs. 22.60 Lakh in 2012-13; Rs. 30.20 Lakh in 2013-14 and Rs. 30.20 Lakh in 2014-15.

NEW USER REGISTRATION

100	Public Health Department	
par-	Directorate of Health Services, Maharashtra	
•	Login to MOCP	
	Useraame	
	Log in Clear	
	Go back to the Homepage Click Here for New User Registration	
	Email ID : deepati-associegnetito.com & demt.kpmg@gmail.com Medical Officer Certificate Programme (MOC Puble Health Department	P)
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JHARKHAND

MIS FOR MALNUTRITION TREATMENT CENTERS (MTCs)/NUTRITION REHABILITATION CENTRES (NRCs)

PROBLEM STATEMENT

evere and Acute Malnutrition (SAM), increases the risk of death among children, under five, to upto nine times. According to NFHS-III (2005-06) about 11.8% of children below 5 years of age, in the State, have a very low weight for height (< - 3SD) with limited access to care. On the basis of these estimates, at any given point in time there may be around 5 lakh children, in Jharkhand, who need to be treated for SAM.

Under NHM, Department of Health and Family Welfare has established a network of 88 Malnutrition Treatment Centre which provide facility based care and treatment to children with severe and acute malnutrition. The State is equipped with 1025 beds to cater to severely wasted children.

PROGRAMME DESCRIPTION

An initiative has been taken up by the department (with support from UNICEF) to establish a robust monitoring and reporting system. A new online MIS has been created which will improve the child wise data entry through built in validation checks, improve follow-up mechanism through SMS based tracking, strengthen linkages between health and ICDS to improve bed occupancy and assist the District Collectors, Civil Surgeons and others to track progress of malnutrition treatment centres in their districts. The data sets will be automatically compiled at the district/ State level and system generated reports can be viewed by the nodal officers.

Levels of Monitoring

Under the new MIS, provisions have been made for specific dashboards for State and district officials, as well as system generated letters for improving bed occupancy and follow-up.

PROGRAMME OUTCOMES

Major advantages of the online MIS are as follows:

- Accurate reporting with inbuilt checks and validation tools.
- Real time transmission of information from the MTC to the State level.
- Strengthening the follow up mechanism: Automatic SMS alerts to caregivers and Sahiya/AWW for timely follow up of the children discharged from the MTCs.
- Promoting counselling at AWC level: Counselling messages to Sahiya/AWW on topics like breast feeding, complementary feeding, hygiene and

growth monitoring activities in order to assist her in counselling the caregivers of children discharged from the MTC.

- **Monthly SMS to officials:** The system is enabled to send SMS to officials (State and districts) giving them a brief report on all outcome indicators (Bed Occupancy Rate, Cure Rate and Avg. Weight Gain Rate). This may be used as a monitoring and review tool.
- Software is equipped with additional features wherein media clipping, official letters and initiatives can be uploaded.

Contact

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" Commitment to provide clinical management and reduce mortality among children with severe acute malnutrition "



Malnutrition Treatment Center

Halaschutum Tractasset Gentre (1977) is a root in a beeldy (college where shallows with forware acents Halaschutum (2010) are adjusted and managed. Collibers are adjusted as per the Johnsel adjustment entrais and provided with moderal and automousl Theorypetic Care.

MIZORAM

TWO WHEELER AMBULANCE AT AIZAWL CITY

PROBLEM STATEMENT

There are various constraints on tracking system, GPS, There is a need for dedicated telephone line, Capacity building/orientation training for manpower on is much required.

PROGRAMME DESCRIPTION

The project was started on 1st February 2014. The ambulance is equipped with Paramedics and emergency kits. As per the State record, Mizoram is the first State to practice this kind of innovation.

With the heavy traffic and poor road conditions within Aizawl City, Emergency Patient Transport is a big burden to save life in case of road traffic accident injury and trauma. The innovation is to reach the accident site within the shortest possible time to give basic life saving and First Aid to the victims.

Scale of coverage: The project covers only Aizawl city as a pilot with a population of more than 2 lakhs. There are 20 beneficiaries per month on average. The project is functioning with the NHM initiatives alone and stationed at Civil Hospital, Aizawl.

PROGRAMME OUTCOMES

There are 20 beneficiaries on average i.e 260 persons in total as on March 2015.

FINANCIAL INVESTMENT

Amount Approve under NHM/RoP 2014-2015 is Rs. 9.71 Expenditure 2014-2015 (April- March).

Office expense and motor cycle maintenance:

Total	:	Rs. 4,86,000
Balance	:	Rs. 4,85,000

SCALABILITY

With these minimal procurement and provision on medical equipments and kits, the project is functioning with only 6 manpower.

CONCLUSIONS/LESSONS LEARNT

Since the project is being functional there is much relieved on emergency unit/casualty dept at the State Hospital. The State Health & family welfare department as well as the other Inter department like Disaster Management & Rehabilitation, fire & emergency services etc are depndent on this project in terms of accidents and injury within the city.

REFERENCE

State PIP 2013-14 and RoP 2013-14.

Contact

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DISEASE Control Programme

MAHARASHTRA

"AROGYAVARDHINI" - NUTRITIONAL SUPPLEMENTATION FOR MDR/XDR TB PATIENTS

PROBLEM STATEMENT

In view of the high burden of MDR/XDR TB patients in Mumbai. (about 3000 MDR patients and 400 XDR patients reported in 2014), and as in these patients TB may lead to underweight and micronutrient deficiencies due to increasing energy requirements, changing metabolic processes, decreasing appetite and thereby poor outcomes. Also, poor nutrition may delay recovery by depressing immune functions. The State with financial support from IDBI Bank (for one year) conceived a project "AROGYAVARDHINI" for nutritional support to MDR/ XDR TB patients of Mumbai.

PROGRAMME DESCRIPTION

The objectives of the project are:

- 1. To improve the nutritional status of drug-resistant TB (DRTB) patients.
- 2. To increase adherence to anti-TB treatment amongst drug-resistant TB patients.
- 3. To improve the outcome in terms of early culture conversion in drug-resistant TB patients.
- 4. To assess thefeasibility of implementation of 'nutritional support initiative' in programmatic settings.

The nutritional supplementation is provided for daily consumption in the form of 250gm each of nutrient-dense, ready-to-cook 'Upma' and 'Sheera', extruded, fortified and blended content from Wheat, Soya, Moong and Peanuts providing 900gm of energy and 30gm of protein per day, alongwith vitamins, calcium, Iron and other micronutrients. This supplementation is over and above the regular intake of diet by the patient.

Patient Assessment and Nutritional Education:

- 1. Nutritional Assessment for all the DRTB patients enrolled in the programme will be done by the medical officer at the DRTB Centre.
- 2. Body Mass Index (BMI) of all DRTB patients will be calculated and classification of nutritional status has been done.
- 3. Written informed consent will be taken for all the DRTB patients enrolled in the project.

- 4. Periodic follow up physical examination, monthly during Intensive Phase (IP) and quarterly during continuous phase (CP) will be carried out and monthly weight of the patients recorded.
- 5. Timely cultures taken as per schedule to monitor the progress of treatment.
- 6. Patient education imparted during enrolment of all the DRTB patients for nutritional supplementation & during the course of DRTB Treatment at regular intervals.

PROGRAMME OUTCOMES

Before implementation, the project is being piloted in two districts (wards) to assess the acceptability of the nutritional supplement and document operational challenges. Pilot started on. The patient satisfaction/acceptability survey will be done soon.

IMPLEMENTING PARTNERS

- 1. Financial support (Approx. Rs. 4.00 Crore for 1 year) through IDBI Bank CSR support.
- 2. The nutritional packets are prepared and distributed by the Venakateshwar Mahila Audyogik, Utapadak Sahakari Sanstha Ltd Udgir.

SCALABILITY

Based on findings of evaluation of the project, appropriate policy decisions will be taken for resource mobilisation for continuation of nutritional supplementation to drug-resistant TB patients and expansion of the project throughout Maharashtra.

CONCLUSIONS/LESSONS LEARNT

Though it is too early to comment on acceptability of food supplements to the patients in terms of preparation, taste and daily intake by the patient, but the majority of patients, as of now, are accepting the packets.

Challenges

1. Distribution, Transportation and storage is a major challenge.

Contact

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PROBLEM STATEMENT

unjab has fulfilled the criteria of "Pre-Elimination of Malaria" as set by GOI i.e. the API (Annual Parasite Incidence) of Malaria for the State was less than 1 for 2014. The incidence of Malaria has seen a decline of >40% in 2014 as compared to 2013 (Malaria Positive cases have decreased from 1760 in 2013 to 1037 in 2014. The Concern of the State is to know the exact incidence of the disease i.e. Malaria and complete supervised treatment of all the positive cases of Malaria.

PROGRAMME DESCRIPTION

The following activities have been undertaken for this:

i. Malaria has been notified under Epidemic Diseases Act so that all the Private and Government institutions will have to inform about a case of Malaria to the Department of Health and Family Welfare, Punjab. This will help in deciphering the exact incidence of the Malaria in the State.

ii. Malaria Treatment Card has been designed for supervision of the complete treatment of Malaria. All the cases of Malaria are visited at home by MPHW (M) or ASHA before the start of treatment, the radical treatment is provided under supervision for 14 days by MPHW (M) or ASHA. The treatment card is signed by a Medical Officer certifying the complete treatment and outcomes of the patient.

PROGRAMME OUTCOMES

It is new initiative and the impact has yet not analyzed.

IMPLEMENTING PARTNER

Initiative of Department of Health & Family Welfare, Punjab.

FINANCIAL INVESTMENT

Funds available under PIP.

CONCLUSIONS/LESSONS LEARNT

The activity of introduction of Malaria Treatment Card is expected to help the State to ensure complete radical treatment to each positive case of Malaria as per the National drug policy of Malaria 2013.

Contact

Director Health & Family Welfare, Punjab State Programme Officer, NVBDCP Email: punjabnvbdcp@gmail.com



District with code:
Village:
Name of the patient:

HEALT

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME (NVBDCP) PUNJAB MALARIA TREATMENT CARD

District with code:																
Village:					S	ub-centre:					Case l	No./ye	ar:	//20)1	
Name of the patient:								Sex: M/F			PHC/	CHC:.				
Permanent address with Phor	ne No.:										Age:					
Present Address with Phone N	No.:															
Name and designation of Trea	atment provider:															
Name and address of Contact	Person:															
Initial home Visit by (with sig	nature & Date):															
ASHA/MPHW:		MPHS:				MO:										
Disease Classification	Dav	Date	BSC/RDK	B.S. No	Name of Lab			Smear Resu	1+					RI	OK Res	sut
Distast classification	2.49	Dute	200,11211	2101110		PV		PF		MIX					+ve/-ve	2
							Pfg	Pfrg							for PF	
P. Vivax	Initial															
P. falciparum	Follow up 7"															
Mix	Follow up 14"															
Complication if any (please	Follow up 28"															
specify).																
Note: RDK should not be used	t for follow up. If the trea	tment is init	iated on clinical gr	ound then also	follow up Blood	Smear should be taker	tor microscopi	c examination.								
I. INTENSIVE PHASE- Presc	ribed regimen and dosage	es: (Tab Chlo	oroquine 25 mg/kg	bw for 3 days	for P vivax and M	ix. ACT for 3 days for	P falciparum) T	ick () the appropria	te Category b	elow:						
P. Viva	ax P. I	alciparum		Mix												
3 days intensive (No. of Table	ets) 3 days intensiv	e (No. of Ta	blets) 3 days	intensive (No.	of Tablets)											
Chloroquine	Act		Act													
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DENGUE DEATH REVIEW

PROBLEM STATEMENT

Suspected deaths due to Dengue are reported every year. It had been observed that in many cases the cause of death was not dengue but other illnesses while dengue was just a co incidental infection.

PROGRAMME DESCRIPTION

Punjab was the first State to initiate review of all the deaths due to dengue. All the suspected/confirmed cases of dengue are reviewed at district level followed by review at State level. The following actions have been taken in this regard:

- a. Dengue Death Review Performa has been designed with inputs form PGIMER and specialists from discipline of Medicine, Paediatrics, Pathology, Chest & TB Anaesthesia, Public Health. The Performa has been designed keeping in view the case definition of Dengue, Dengue Haemorrhagic Fever and Dengue Shock Syndrome.
- b. A case of dengue death is reviewed by the District Dengue Death Review Committee (DDDRC) under the chairpersonship of the Civil Surgeon of the district. The committee comprises of specialists from disciplines of Medicine, Paediatrics, Pathology, Chest & TB, Anaesthesia, Public Health, IMA and representatives from scrutinized and events are recorded. The opinion of the DDDRC along with the medical records is submitted to the State.
- c. The report of the DDDRC is then reviewed by the State Dengue Death Review Committee (SDDRC) under the chairpersonship of the Director Health Services. The committee comprises of specialists from disciplines of Medicine, Paediatrics, Pathology, Chest & TB Anaesthesia, Public Health, PGIMER, ROHFW, IDSP and representatives from private hospitals treating the case.
- d. After deliberations and discussion of each case record the final opinion is given by the SDDRC.

PROGRAMME OUTCOMES

a. 97 deaths were reviewed in 2013 and 25 out of these were confirmed as deaths due to dengue in 2013.

- b. 17 deaths were reviewed in 2014 and 08 out of these were confirmed as deaths due to dengue in 2014.
 a. Antibodies for dengue are positive for approximate 90 days post infection. Sometimes, the presence of
- c. Strategies for Dengue Treatment Management were reinforced.

FINANCIAL INVESTMENT

Out of the funds available under NVBDCP Programme.

IMPLEMENTING PARTNER

Initiative of Department of Health & Family Welfare, Punjab.

CONCLUSIONS/LESSONS LEARNT

All death cases of dengue need to be audited on scientific grounds because:

- a. Antibodies for dengue are positive for approximate 90 days post infection. Sometimes, the presence of antibodies is mistaken by physicians for diagnosis of dengue although the patient may be suffering from other illness.
- b. Contributing factors leading to death in case of dengue fever or dengue haemorrhagic fever are identified by death audit/review which helps the physicians in identifying serious cases at the earliest in order to decrease the mortality.

Contact

Director Health & Family Welfare, Punjab State Programme Officer, NVBDCP Email: punjabnvbdcp@gmail.com

DENGUE DEATH REVIEW PROFORMA

Instructions: Please fill only those details which are available in the medical records. If the information is not available, leave them blank.

District: Dengue Death review done on (dated):

- 1. Name of the patient:
- 2. Age/sex of the patient:
- 3. Father's/Husband's Name:
- 4. Complete Address of the patient with contact no.:
- 5. Date of Onset of Illness:
- 6. Consultation history: (Chronological Order till the date of Death)

Place of Medical Consultation (Name of the Institute/Address	Date of Consultation	OPD/IPD	Provisional Diagnosis

7. Date of Birth:

8. Place of Birth: (Home/Govt. Institution with name/Private Hospital with name).

QUALITY ASSURANCE

BIHAR

ROLL-OUT OF NATIONAL QUALITY ASSURANCE PROGRAMME AT DISTRICT HOSPITALS

PROBLEM STATEMENT

Quality of Services at Public Health Facilities has been cause of concern. The envisaged system for Quality Assurance was expected to be internalised, flexible, less resource intensive and addressing the needs of Public Health System in the State.

PROGRAMME DESCRIPTION

After launch of the 'Operational Guidelines for Quality Assurance in Public Health Facilities' by the MoHFW GOI in Nov 2013, the programme has started in the State with the objective completing baseline assessment of all district hospitals, without waiting for induction of the additional HR into the Quality Assurance Team. So that actions for the gap-closure starts in full earnest. For completing the assessment quickly, a 4-5 members assessment team, consisting of Development Partners, Hospital Managers, DH functionaries, RPMUs, DPMUs (under NRHM) was formed in Dec 2013 with Deputy Superintendent having a pivotal role in the process. Base-line assessment of all district hospitals was completed in two phases. First phase was conducted from 1st June 2014 to 30th June 2014. Total 17 Sadar Hospitals + MCH Unit of PMCH and SKMCH covered in this phase. Second phase was conducted for

19 Sadar Hospitals from 1st October 2014 to 20th October 2014. Findings of baseline assessment has been categorised and resource allocation has been made. For strengthening labour rooms of 149 FRUs resources has also been allocated under Quality Assurance Programme.

In order to consolidate the gains made, 48 hospitals are being taken-up for the National level QA certification.

PROGRAMME OUTCOMES

- Improved external appearance of the health facility.
- Cleaner environment around and inside of the health facility.
- Display of signages and clear information about services, incentives and availability of free drugs.
- As per SOPs, services & service delivery practices are carried out.
- Functioning equipment.
- Reduced waiting times for registration and consultations.
- Increased uptake for both major and minor surgery increased OPD, deliveries in hospitals, better inpatient care.
- Improved and rationalised record keeping.

EVALUATION

External evaluation of the programme initiative has not yet been taken.

SCALABILITY

There are 17 district hospitals which have been proposed for the National certification. Baseline Assessment Process has already started in 30 FRU's and being prepared for the National certification.

CONCLUSIONS/LESSONS LEARNT

Implementation of Quality Assurance at Public Health Facilities needs harnessing available resources, creation of enabling environment, and supportive supervision. Patient satisfaction appears to have improved besides improvement in Staff morale.

Contact

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UTTAR PRADESH

QUALITY ASSURANCE IN AWANTI BAI WOMEN HOSPITAL LUCKNOW

PROBLEM STATEMENT

Solution of the services of the providing quality health care services to the people. In this regards an initiative was taken by the Dufferin Hospital. It was established in 1889 to provide safe and affordable services to all women.

PROGRAMME DESCRIPTION

This is the first hospital in UP where Quality Assurance Programme has been implemented with the aim to provide quality services to the population and to obtain National QA Certification. To ensure quality services, the following steps have being taken:

- a. Strengthening Institutional Framework: under which a team of QA and Infection Prevention committee was constituted.
- b. Orientation of staff for the activities under QA Programme.
- c. Baseline assessment of the facility using standard checklists.
- d. baseline score generated & gaps Identified.

Key interventions

Support from neighboring hospitals: For availability of blood, some nearby institutions like Balrampur Hospital & KGMU were contacted to ensure blood supply in the hour of need even without a donor.

Innovations: An initiative was taken to promote blood donation and students in the adjoining Christian College were motivated for it. Nearly 200 students have become volunteers. A list according to blood group along with contact numbers is available in the hospital.

System Strengthening

To upgrade the OT & Labour room new instruments have been procured. Proper sterilization and autoclaving is being ensured.

Patients' privacy was ensured by providing curtains/ screens both in labour rooms and OPD.

Proper layout of Signages, display of Citizen Charter, EDL and health related messages in Hindi:

- A 'Rainbasera' has been provided in the vicinity of the hospital where the facility of clean drinking water & toilet is available for the attendants of the patients.
- Round -the- clock duty of guards for security purposes as well as patient facilitation especially at night.
- Regular power supply has been ensured by generators and inverter.
- Lifts have been installed with rescue device and emergency alarm system for patients & attendants.

Infection Prevention: Appropriate infection prevention and BMW disposal measurements are being taken.

Capacity Building: EmOC/LSAS training for MBBS doctors and BEmOC training for staff nurses was given to improve quality of care.

Drugs & Diagnsotics

- A drug inventory management system has been established to counteract stock-out of emergency drugs and consumables.
- Rapid diagnostic kits (strips) for Hepatitis B and HIV were made available in labour room and emergency.

PROGRAMME OUTCOMES

- Improved Patient Satisfaction Score from 3.0 to 3.9.
- Reduced LAMA rate from 11.1 to 5.0.
- Better management of high risk patients such as pregnancy with severe anaemia, Eclampsia, Diabetes, etc.
- SNCU admissions increased by 20% in FY 2014-15.
- Maternal mortality reduced from 12 (FY 2013-14) to 10 (2014-15).

SCALABILITY

Often in adequate infrastructure and human resource are held responsible for poor quality of services in government hospitals but prioritization of problems, multi-tasking capacity building, positive behavior and enhanced motivation of staff can bring about the change in limited resources also as evident in Veerangana Awanti Bai Mahila Hospital. This model can be adopted across the State to replicate the impact in other Hospitals also.



CONCLUSIONS/LESSONS LEARNT

Uttar Pradesh being the most populous State of the country, the burden of providing optimum health care services to the population is huge. Often in adequate infrastracture and human resource are held responsible for poor quality of services in government hospitals.

but prioritization of problems, multi-tasking capacity building, positive behavior and enhanced motivation of staff can bring about the change in limited resorces also as evident in Veerangana Awanti Bai Mahila Hospital. This model can be adopted across the State to replicate the impact in other hospitals also.

NUHM

PROBLEM STATEMENT

The increasing concentrations of population in slums and urban poverty have elicited a strong interest in urban health conditions in general, and the health of slum dwellers and the urban poor, in particular. Generally, UPHCs are limited to primary healthcare, but due to the poor health-seeking behaviour of people, services beyond primary healthcare are required in the UPHCs. Poverty also plays a role in the poor-health seeking behaviour due to the non-availability of diagnostic services at UPHCs.

PROGRAMME DESCRIPTION

e-UPHC is a PPP model of government and private organisation (e-Vaidya) collaboratively working to implement the NUHM with focus on equitable health accessibility to the urban slum and vulnerable population using technology as a catalyst. This project was piloted for three months in Vijayawada city of Andhra Pradesh from January to March 2015 for a population of 50,000. Like any UPHC, the e-UPHC has a medical doctor, an ANM and AASHA workers and other medical staff. However, the uniqueness of the project is that 24 types of diagnostics are provided at the centre and specialized medical care is provided through tele-calling with a panel of specialist doctors. Medication is prescribed online and advanced cases are referred to secondary and tertiary level hospitals. The follow-up of the cases is done



periodically through the outreach staff, and the medical and health status of the beneficiaries is also tracked. The organisation has a robust IT platform to track all services provided by the e-UPHC.

Performance of e-UPHC (January – March 2015)

Services	Jan	Feb	Mar
OPD Patients Treated	1089	771	623
Male	834	416	329
Female	255	355	294
Children Below 15 years	70	35	14
Boys	39	17	9
Girls	31	18	5
Old Patients	192	175	186
Male	121	95	103
Female	71	80	83
New Patients	897	596	437
Male	713	321	226
Female	184	275	211
Diseases	1089	771	623
Communicable Diseases	54	47	31
Non-Communicable Diseases	510	345	321
Other Diseases	525	379	271

Source: e-Vaidya MIS records.

EVALUATION

Review meetings are held every fortnight, to get an update on the progress of the programme, identify gaps and for making strategic plans accordingly. Since the project was a pilot, an internal evaluation was conducted by NUHM that identified best practices and gaps which in-turn helps in modifying the programme strategies.

FINANCIAL INVESTMENT

Initially the e-Vaidya organisation has submitted a Techno-commercial proposal for an amount of Rs. 1,88,000 per month towards operational costs including online Doctor services, Paramedics and other necessary staff

alongwith diagnostics and health record maintenance of the equipment, technology and man power. Further, this amount does not include medicines and diagnostic consumables. The organisation has capital equipment worth Rs. 8,00,000.

SCALABILITY

The innovative, cost-effective and result-oriented initiation has got a very good response and demand from the community, political segment and Municipality management. This model can be extended to least one centre per ULB.

CONCLUSIONS/LESSONS LEARNT

As diagnostic services and specialised healthcare facilities are provided under one roof at the e-UPHC, there is scope for the betterment of the health-seeking behaviour and health of the urban poor and the vulnerable. Especially, through diagnostic services, the health of antenatal patients, newborn and infants could be improved thereby contributing in the reduction of IMR and MMR. Diagnosis of specialised healthcare needs like cardiac, ortho, pulmonary health issues also helps in reaching the poorest of the poor in the urban slums.

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CHHATTISGARH TABLET BASED RCH REPORTING

PROBLEM STATEMENT

In year 2010, a web-based reporting system was developed for RCH reporting. The data was not a real-time entry as ANMs used to enter data on a weekly or fortnightly basis. In order to overcome this problem, Chhattisgarh started a mobile-based reporting system. In this system mobile handsets (Nokia C2) were given to all ANMs to capture and report real-time maternal and child health service delivery data. This was implemented in all the districts of the State and the results are encouraging. To overcome the problems such as small screen size, difficulty in entering the data, insufficient memory capacity to implement new RCH register, etc., and to facilitate easy entry of data tablet-based android software has been developed.

PROGRAMME DESCRIPTION

All citizens of Chhattisgarh are registered in "Parivar Panji" family-wise, with each member's individual name, age, bank account number, RSBY/MSBY number and ration card number. The registration software has been prepared by the State NIC and registration process of all urban areas has been completed and for rural areas will be completed by 31st June 2015.

In the first phase the following components are covered:

- Complete web-based Android application.
- Important RCH indicators.
- Warning alert for providing the services and validation check.
- Small videos and message-based training to health workers.
- Financial reporting of untied funds and maintenance grants in Sub-centre.
- Due listing of services for Family Planning, ANC, PNC and Immunisation services.

FINANCIAL INVESTMENT

Sl. No.	Details	Unit	Physical Requirement	Total Budget (Lakh)
1.	Tablet	10000	4660	466.
2.	Biometric Device	2500	4660	116.5
3.	Internet charges per ANM	200 per Month	5100	122.4
4.	Training of ANM twice a year	300	5100	15.3
Tota	1			720.2

Note: There are total 5100 sub-centres (rural) in Chhattisgarh, tablets for 4660 ANMs are proposed in PIP 2015-16 and the rest of the tablets will be provided by UNICEF, Chhattisgarh.

EVALUATION

The software has been developed by NIC recently and the pilot has been initiated in urban areas so the project has not undergone any evaluation so far.

SCALABILITY

The following components will be added to the software:

- 1. Alerts for due services to beneficiaries, ANMs and Mitanins through messages.
- 2. Biometric identification of beneficiaries through finger-print scanning of beneficiaries thereby fetching their personal details from various linkages like ADHAR database.

CONCLUSIONS/LESSONS LEARNT

This is the era of technology and introducing IT-based innovations in health will lead to strengthening the data reporting and assured service delivery to beneficiaries.

Contact

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DELHI

DEFINING & DOCUMENTING ANM AREAS (GNCTD & MCD) IN URBAN SCENARIO



PROBLEM STATEMENT

I must be remembered that in rural States there are well defined villages and defined areas are being looked after by a particular PHC and an ANM. On the other hand, in urban States/mega cities, lacs of population, especially the vulnerable segments, stretch in continuity without definition and documentation of areas of responsibility of existing primary health care facilities.

The delineation for each center/each field functionary is a must for:

- 1. Ensuring universal coverage of each and every corner of the State.
- 2. Removing/minimizing the catchment area overlaps between centers belonging to same/different agencies.
- 3. Ensuring accountability of the health center/MO/ ANM/ASHA for the promotive and preventive care to all residents in the catchment area.
- 4. Defining facility specific benchmarks/expected outputs and thus facilitate meaningful evaluation.
- 5. Planning of resources manpower/logistics for each center as per the requirements and thus prevent wastage.
- 6. Facilitywise needbased deployment of staff & Facilitywise performance audit as the staff/expected

workload and actual achievements shall be available objectively.

- 7. Building Functional Referral linkages with higher centers.
- 8. Provide usable data regarding slums/J J Clusters/ resettlement colonies/village and the Health centers to which they are attached thus providing areas for targeted interventions for this vulnerable segment.
- 9. Addressing the multiplicity of the health care providers.

PROGRAMME DESCRIPTION

State has mapped 160 lac population demographically and geospatially to the existing health facilities using the polling stations as the basic unit of distribution. This information is available on the web based portal giving the demographic/geographical description of the population. The Geospatial maps are also available.

Description of individual ANM Areas in terms of population/geographical localization is shown above.

The mapping has been done for facilities belonging to the Government of NCT of Delhi and the three Municipal Corporations of Delhi. The same information has also been mapped on the Geospatial map which can be accessed on website.

Public Private Partnership

CHHATTISGARH

PARTNERSHIP WITH EKAM FOUNDATION FOR SNCUs OPERATIONALIZATION

PROBLEM STATEMENT

hhattisgarh has shown progress in the maternal and Child health indicator over the years but the trend of the SRS data of Infant mortality in Chhattisgarh shows that the neonatal and early-neonatal mortality as a proportion of the IMR has risen from 63% (Year 2008) to 67% (year 2013) of the IMR. There is an urgent need to strengthen the facility-based new born care services at all levels of service delivery. The State is lagging behind in establishing SNCUs as per the national guideline mandate of one SNCU per district. As on date out of 16 SNCUs sanctioned, only 5 were made functional and these units are also not adequately functioning as per the standard norms of Facility Based New-born Care (FBNC) of MoHFW, GoI due to lack of Human Resources. The State has not been able to recruit adequate skilled and trained human resources despite repeated recruitment drives.

In addition to human resources, maintenance of equipment is a major constraint towards optimal functioning of SNCUs as 50-60% equipments are lying non-functional and there is no equipment maintenance mechanism in the State.

PROGRAMME DESCRIPTION

To alleviate these contending issues, UNICEF, the lead development partner in Chhattisgarh, under the Call to Action strategy has made a Programme Cooperation Agreement (PCA) with EKAM foundation, Chennai on 1st September 2014 for operationalization and strengthening of SNCUs in the State. The National Health Mission Chhattisgarh has also signed an agreement during October 2014 with EKAM Foundation for outsourcing the human resources requirements of SNCUs to EKAM and the fund under NHM PIP for SNCUs staff will be mobilized for the same. The partnership administration costs and salary of the SNCU human resource were approved in the NHM PIP 2014-15. The objective of this partnership is to operationalize all the SNCUs in the State and ensure the quality of care through trained health human resources.

Major elements

a. **Staff Nurses for SNCU:** Under this partnership EKAM Foundation will ensure a minimum 11 Staff Nurses per unit and they will be properly trained on facility based new-born care.

b. **Maintenance of SNCU Equipment:** For establishing an Equipment Maintenance Mechanism, broad modalities under the partnership are: Baseline assessment, inventory of all existing equipment and their functional status, having Annual Management ? Maintenance?? Contract and establishing a dedicated helpline number where all breakdowns from the SNCUs are reported to ensure solving it in the minimum possible time.

PROGRAMME OUTCOMES

Maintenance of SNCU Equipment: Inventory Audit for all functional SNCUs as baseline has been completed, six engineers were deployed for equipment maintenance activity, major and minor overhauling and repairs completed in all 12 SNCUS, Inventory management logs for all the equipment at SNCUs prepared, routine maintenance mechanism established, preventive visits have begun, and for regular maintenance service a designated call centre has been established at State level.

Human Resources for SNCU: Eighty-eight staff nurses have been recruited, trained and positioned in the SNCUs.

Outcome of this partnership: With this partnership twelve (12) SNCU were made operational in the State, thus ensuring facility based new-born care in these districts.

IMPLEMENTING PARTNERS

National Health Mission, Chhattisgarh, UNICEF Raipur and EKAM Foundation, Chennai.

SCALABILITY

This partnership is one of the successful mechanisms for operationalization of SNCU. Through different agencies 290 staff nurses have been recruited and positioned at District Hospitals and CHCs of 10 districts. This mechanism will help to provide quality care from public health institutions thereby making the health facilities functional as per standard norms.

CONCLUSIONS/LESSONS LEARNT

National Health Mission must leverage resources, health professionals, and infrastructure from both the public and private health sectors in order to meet the health-related MDGs (Goals 4, 5 and 6) specially the maternal mortality and child mortality. Government can leverage the private sector (profit/not-for-profit) expertise and their resources to address challenges such as shortages of staff, equipment functionality and insufficient health workers.

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Contact

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MUKHYAMANTRI AMRUTUM "MA" YOJANA

PROBLEM STATEMENT

ue to high burden of out of pocket expenditures, households below the poverty line are not able to access healthcare and are also at high risk of facing catastrophic payments when they seek healthcare.

PROGRAMME DESCRIPTION

"MA" Yojana was launched in 2012 and covers all the below poverty line households in the State. It provides cashless treatment for 544 tertiary care procedures up to Rs. 2 lakh per annum for five household members on a family floater basis, inclusive of Rs. 300 towards transportation charges. These services can be accessed at empanelled public and empanelled private hospitals. ASHA receives an incentive of Rs. 100 per household, if she accompanies them to the respective Taluka kios k for enrollment. Every household receives a unique digital identity card called the Quick Response Coded Card. This card is a repository of fingerprints of the beneficiaries, clinical notes etc. The program is funded by the State government budget and implemented through the State Nodal Cell (SNC), supported by an Implementation Support Agency (ISA).The claims processing, awareness activities and empanelment of hospitals are supported by ISA. Claims processing is through a paperless integrated IT platform.

From 2014, under the Mukhyamantri Amrutam "MA Vatsalya" Yojana, benefits of the programme have been extended to women and children of all the households (55,124 households) with yearly income less than Rs. 1.2 lakhs.

PROGRAMME OUTCOMES

Until January 2015, approximately 22 lakh households have been enroled and 48000 beneficiaries have received cashless treatments.

CONCLUSIONS/LESSONS LEARNT

Implementation of the programme by the government department through a private partner supporting the claims process awareness activities, and empanelment of hospitals is seemingly successful in leveraging strengths of both public and private sectors.

REFERENCE

http://www.magujarat.com



HIMACHAL PRADESH

AUGMENTING RENAL CARE SERVICES IN PPP MODE

PROBLEM STATEMENT

hronic Kidney Disease affects 17.4% of Indian population, and delayed detection and treatment has led to a high prevalence of 785-870 pmp of End Stage Renal Disease (ESRD). Currently 10000 people suffer from ESRD requiring dialysis or transplant for survival, and only 17% are receiving treatment.

Limited infrastructure and resources in both government and the private sector have forced people to avail treatment from health care facilities in Chandigarh and Punjab. Treatment from outside the State creates undue physical, financial and emotional stress, necessitating an intervention by the State.

PROGRAMME DESCRIPTION

The project was started with the following objectives:

- To augment existing dialysis services in the State (IGMC Shimla).
- To subsidise treatment for economically weaker sections (BPL, Cancer, RSBY, etc.).
- To reduce dependence on treatment facilities outside the State.
- To monitor and analyse a model for future endeavours.

The bidding process was started in January 2014.

Description of intervention

Private partners were invited to augment renal care through setting up of State-de-arte dialysis units at three locations – Mandi, Dharamshala and Solan. The choice of locations was based on accessibility, existing infrastructure, population distribution and financial viability for private partners.

The project involved setting up of 6 Machine Hemodialysis units in Government Hospitals. The cost of setup and operations will be borne by the private partners. The dialysis units are to be managed by qualified and trained personnel with experience in dialysis. Treatment for

weaker sections (BPL, RSBY, etc) will be provided free-of- REFERENCES cost and reimbursed by the Government.

A single stage bidding process was conducted for selection 2. of private partners.

PROGRAMME OUTCOMES

Zonal Hospital Mandi commenced operations on 8 March 2015 and has received favorable response with 200 dialysis being performed in March 2015 and 117 free dialysis treatments in line with the desired project objective.

Zonal Hospital Dharamshala and Solan are scheduled to commence operations in the very near future (within the next one month).

IMPLEMENTING PARTNERS

Zonal Hospital Mandi and Dharmashala were awarded to RAHI Care Private Limited, a single specialty chain of dialysis units.

Zonal Hospital Solan was awarded to Sparsh Nephrocare Private Limited – also a single specialty chain of dialysis units.

FINANCIAL INVESTMENT

Space has been provided by the State Government in the premises of Hospitals free of any charges. After a competitive bidding process, the per dialysis (including the consumables) rates were discovered which range from Rs. 1200/- to Rs. 1300/- per dialysis which are 25% lower than the prevailing market price. For BPL/Free patients the payment is done through RKS of the concerned Hospital.

SCALABILITY

The model has demonstrated potential for scalability and the State government may explore opening additional facilities based on population distribution, location accessibility, and prevalent ESRD patient data.

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Contact

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UTTARAKHAND

NEPHRO DIALYSIS UNIT THROUGH PUBLIC PRIVATE PARTNERSHIP

PROBLEM STATEMENT

To provide quality renal care to patients.

PROGRAMME DESCRIPTION

This scheme was launched in 2010-11 to provide quality renal care to patients through public private partnership. The scheme is operational in two facilities in the State, Deharadun and Haldwani. The objective of the scheme is to provide nephro-dialysis services to the BPL population free-of-cost and the APL population can avail of the benefits at subsidised rates (15% below the MRP). The Directorate of Medical Health & Family Welfare has partnered up with Apollo Hospitals Enterprises Ltd., Chennai and Rahi Care Social Initiatives Pvt. Ltd., Chandigarh for setting up of these facilities in the State. The private provider runs the project on Build-Operate-Transfer (BOT) mode and is given a contract to run the facility for 5 years with possible extension based on performance. The government provides necessary assistance (grants, permissions etc) to the private partner for smooth functioning of the facilities.

CONCLUSIONS/LESSONS LEARNT

Since inception a total of 26903 patients (21351 BPL patients) have been treated at the Dehradun facility and 38967 patients (28948 BPL patients) have been treated at the Haldwani facility.



WEST BENGAL

FAIR PRICE RADIOLOGY DIAGNOSTICS FACILITIES AND DIALYSIS SERVICES THROUGH PUBLIC PRIVATE PARTNERSHIP

PROBLEM STATEMENT

High household out-of-pocket expenditures on diagnostic and dialysis services.

PROGRAMME DESCRIPTION

Department of Health and Family Welfare introduced fair price diagnostic facilities (CT scan, MRI scan, digital X-ray) and dialysis services in government hospitals to reduce household out–of-pocket expenditures. West Bengal Services Corporation Ltd. has implemented this programme at the sub-divisional hospital level and above through public private partnership. The corporation procured all required equipment amounting to Rs. 147 crore from vendors selected through a competitive bidding process. An Outcome and Monitoring (O&M) partner, is also selected through a competitive bidding process, who is responsible for the entire operation and management of these facilities with their own resources including deployment of Medical, Technical and other personnel and maintenance of the equipment. The O&M partners charge a user fee lower than market prices from the beneficiary for utilisation of the services. As part of an agreement with Rogi Kalyan Samiti, the O&M partner has to pay a fixed concession fee to the concerned hospital on a quarterly basis which is utilised to provide free services to poor and the vulnerable sections. Since inception 8938 patients have availed of benefits up to Rs. 50.8 lakhs from the services provided for fee.



WEST BENGAL

FAIR PRICE MEDICINE OUTLETS THROUGH PUBLIC PRIVATE PARTNERSHIP

PROBLEM STATEMENT

igh household out-of-pocket expenditures for medicines and consumables.

PROGRAMME DESCRIPTION

Department of Health and Family Welfare in 2012 started fair price medicine outlets in government hospitals to reduce household out-of-pocket expenditures. Implemented through a Public Private Partnership, the private partner establishing the outlet is selected through a competitive bidding process. On presenting a valid prescription the outlet provides a pre-approved discount (ranging from 48% to 77%) on MRP of medicines, consumables and implants. As on December 2014, a total of 94 such outlets are being operated at the rural hospital level and above, supplying a total of 142 generic medicines and 39 medical consumables. The drugs are procured through e-procurement. A quality audit for the procured drugs is conducted at National Accreditation Board for Testing and Calibration Laboratories. The logistics and drug inventory management system has been strengthened to provide round-the-clock services. Doctors are being encouraged to prescribe generic medicines. Since inception 1.2 crores of patients have utilised the services and availed discounts up to Rs. 344 crores.

FINANCIAL INVESTMENT

Since inception until 2013-14 the budget for drug procurement has increased by about Rs. 250 crores.

SCALABILITY

Due to the success of the programme in 2012, when 25 outlets were established, the programme has been scaled-up to 94 outlets in 2014.

CONCLUSIONS/LESSONS LEARNT

Implants are not accessible to all even after the huge discounts on MRPs. Hence alternative mechanisms for procuring these at cheaper prices are being explored.



Health Insurance

MEGHALAYA

MEGHA HEALTH INSURANCE SCHEME

PROBLEM STATEMENT

Up to f pocket expenditure in Meghalaya is very high. The project aims to decrease the out of pocket expenditure by households on health care.

PROGRAMME DESCRIPTION

Megha Health Insurance Scheme (MHIS) was launched in 2012. It provides coverage to all the households in the State for hospitalisation up to Rs. 1,60,000 on a family floater basis. Five members per household are covered, and each household pays Rs. 31 as registration fee for enrolment. There is no age limit and pre-existing diseases are also covered. State and Central government employees are excluded. Each enrolled household receives a unique digital identity card - MHIS smart card to avail of the benefits at both public and private empanelled hospitals for 1288 procedures (including cancer/critical care). Around 170 hospitals (in the State) and 13 super-specialty hospitals (outside the State) are empanelled. The premium on behalf of the enrolled household is funded by the State government. The programme is implemented by the State Nodal Agency through a private insurance company, selected through a competitive bidding process. In the empanelled public hospital, 30% of the reimbursements received is paid as an incentive to doctors and staff and the rest is utilised for infrastructural development. A grievance redressal mechanism has also been set up at the district level and above.

SCALABILITY

The total number of packages to increase to 1704 procedures, specially to include OPD benefits, criticalcare surgical benefits and follow-up care for critical illnesses.



CONCLUSIONS/LESSONS LEARNT

In 2013, approximately 2 lakh households (46% of total households) in the State have been enrolled and 32000 beneficiaries have availed of the benefits. From the reimbursements received by public hospitals the scheme has helped improve the public health facilities in the State through purchase of medical equipment, patient beds, generators and other infrastructure. A planned enrolment route map for enrolment is yet to be developed to increase enrolments. Activities to generate awareness to be held for beneficiaries.

REFERENCE

http://www.meghealth.gov.in/mhis/welcome.html

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