



Evidence to **Action** Towards UHC

Good, **R**eplicable and **I**nnovative **P**ractices







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सत्यमेव जयते



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Good, Replicable and Innovative Practices

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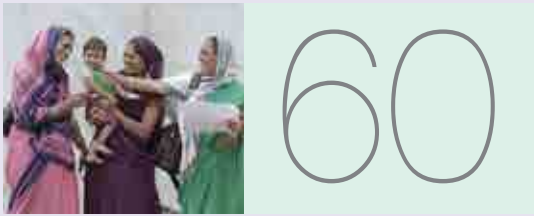


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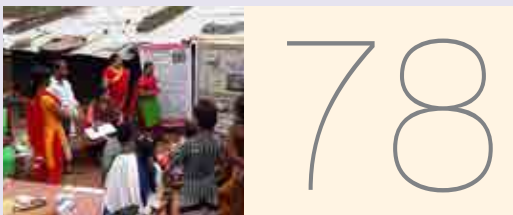
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Introduction



From the first summit held in 2013, the National Summit on Good and Replicable Practices and Innovations in Public Healthcare Systems in India, has, in a short space of time, become an institutional mechanism for the sharing of innovations supported by the National Health Mission.

This is the fifth publication in this series and captures 119 best practices and innovations, including health programmes, medical devices and technologies. They span programmatic areas ranging from health systems, maternal and new-born health, family planning, tuberculosis and other communicable diseases, non-communicable diseases, mental health and e-health. They also include innovations that apply systems thinking to health problems such as the use of information technology to strengthen continuum of care and to addressing human resource shortages and challenges in capacity building, and innovations that address the needs of vulnerable slum populations in the National Urban Health Mission. The publication includes the presentations made at the fifth national summit held at Kaziranga, Assam where both 39 oral and 80 poster presentations were made.

The National Health Innovation Portal (NHINP), which was launched during the Shimla summit of 2015, represents the Ministry of Health and Family Welfare's unstinting effort towards identifying and nurturing good practices and innovations. Since 2015, over 1132 proposals have been received through this portal. In the last one year, more than 200 proposals have been uploaded on NHINP. These have been subjected to criteria based reviews by various technical and programme divisions of the MOHFW, and the National Health System Resource Centre. The aim is to ensure that as we move towards realizing the aspirations of National Health Policy 2017, all sections of population, specially, those most disadvantaged, are benefited by new knowledge and new learning.

The portal has attracted interest from several policy think-tanks, the NITI Aayog and the Prime Minister's Office. This further supports and encourages future endeavours on enabling and fostering innovations at all levels, through public and private sector and addressing various dimensions of health systems challenges, both unfinished and emerging.

Innovations that are included in the publication include Programme and Product Innovations. Programme innovations are designed at various levels of health care delivery as a response to a specific problem to improve a health outcome or addressing a programmatic dimension required for improved performance. This may include (but are not limited to) innovations in service delivery, human resources for health, community processes, financing and governance. Among health product innovations, medical devices, innovative technologies in Healthcare IT, m-health, and tele-health/e-health are also included. New vaccines and drugs are not included in this set of innovations since there are other mechanisms for identification, assessment and incorporation into large scale systems.

PRINCIPLES OF IDENTIFICATION AND ASSESSMENT OF INNOVATIONS

All innovations that are uploaded on the portal are assessed using certain guiding principles. They include:

Inclusion Criteria for Programme and Product Innovations

- Innovations that are relevant to health care needs of the population, particularly those who are disadvantaged and marginalized.
- Innovations that address locally endemic health problems or diseases.

- Innovations that facilitate better health care reach to people in terms of accessibility (including reach to the rural areas, tier II and tier III urban settlements), affordability (including potential to reduce cost of care), quality (inclusive of safety of a health care product or process) and equity.
- Innovations that bridge a crucial specialized skill gap required in delivery of health care services.
- Innovations that apply a systems approach to health problems that are persistent and are common across states.
- Innovations that address issues of convergence with Implication for social and environmental determinants.

Exclusion Criteria

- Specific drugs, surgical, medical procedures or practices that need evaluation through Randomized Control Trials or Systematic Reviews.
- Incomplete documentation of innovation: For any innovation to be reviewed the document should include adequate information on process, human resource requirements, and infrastructure need, capacity building strategies, outcomes, costs, and challenges.

Evaluation of Innovations

Criteria for evaluation of proposed innovations include- as per norms- i) Strength of Evidence; ii) Scale of Coverage; iii) Impact and iv) Potential for Replicability across varying contexts.

All stakeholders involved in health issues, centre and states, public sector, Non -Governmental Agencies, private sector organisations, academic and research agencies, and development partners must work in tandem utilizing each other's strengths to design innovative models of healthcare delivery.

The transition from the MDGs to SDGs, the realisation of the ambitious goals of Universal Health Coverage and of the National Health Policy 2017, require new ways of thinking, not in fragmented vertical programmes, but through a broader health systems approach. Launch of Ayushman Bharat and setting up Health and Wellness Centers across country are steps in this directions. Existing solutions need to be reworked and innovations that address current realities and people's aspirations need to be nurtured. The National Health Mission will continue to provide a platform for the engagement of stakeholders in creating innovations that can be scaled up for universal access to affordable and equitable health care.



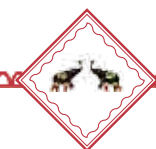


Health Systems Strengthening





KNOWLEDGE COMMAND CENTRE



Problem Statement

There is a need to use technology to develop Electronic Health Records (EHRs) and electronic medical records (EMRs), to improve treatment of an individual patient as well as utilize data for public health purposes, while ensuring mechanisms of consent, data protection/privacy and access to data by owners of data.

Program Description

Knowledge Command Center (KCC) is the analytics wing for the Health, Medical and Family Welfare department, Government of Andhra Pradesh. Data from health facilities and care centers are captured using IT system and the same is used to a) identify communicable disease incidence and non communicable disease prevalence, b) to calculate the effectiveness, efficiency and quality of government health programs, c) to monitor progress of districts and state on various health indicators and identifying areas that need additional focus. The data analyses then serves as an input to the government to make appropriate policy or administrative interventions. The process description does not fully explain the mechanisms for informed

consent, data protection/privacy and right to access data etc.

Program Outcome

The data analytics of KCC has helped in better management of diseases especially malaria, dengue, heat strokes and other non-communicable diseases; it is used by the government to measure the performance of programs on efficiency, effectiveness and quality. A set of 100 key indicators are monitored on a quarterly basis and areas that need additional focus are identified at the state and district levels, which guide appropriate interventions and programs. An independent evaluation of this recently launched initiative will provide further information on its effectiveness.

Scalability

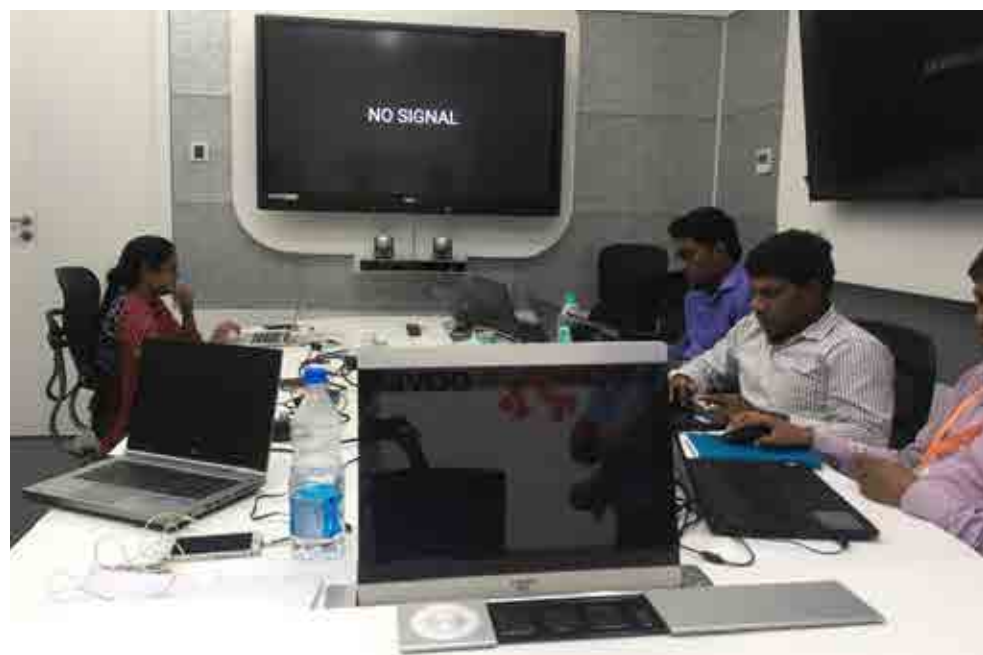
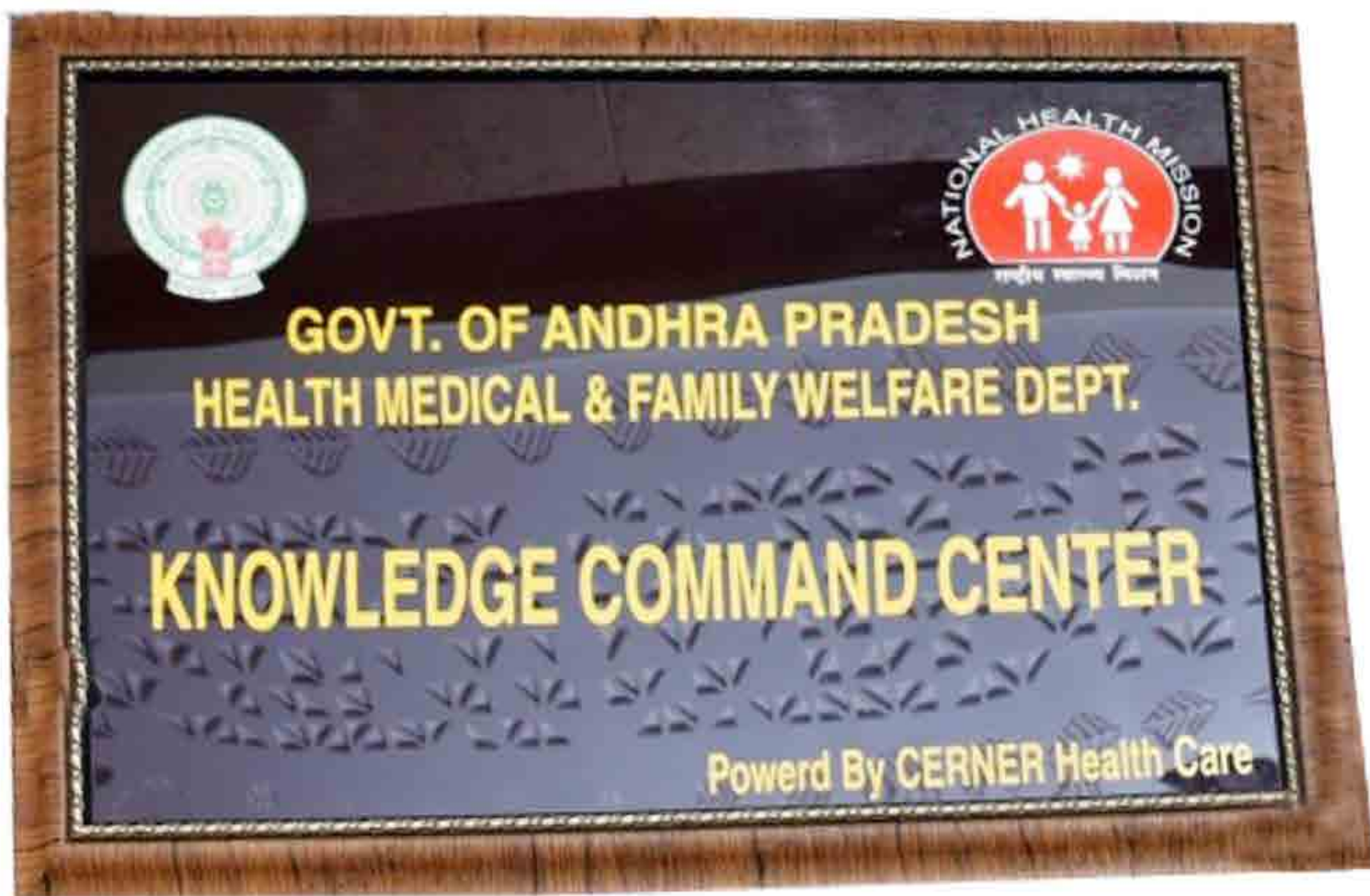
After data from independent evaluation and on cost effectiveness are available, similar models may be replicated in other states. The draft Digital Information Security in Healthcare Act of the MoHFW proposes to leverage technology in creation of Electronic Health Records, for the purposes of individual treatment of patients

as well as for a set of defined public health purposes. It also lays down the mechanisms for informed consent, privacy, data protection, anonymisation, access and use of digital information.

Contact

ddmiscfw@gmail.com

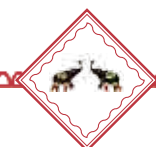






ASSAM

EXTENSION OF CPHC IN THE REMOTE CORNERS OF ASSAM Through HWC, MMU, Boat Clinic



Problem Statement

The backbone of any Health Care System is its primary health care component. The provision of Comprehensive primary healthcare reduces morbidity, disability and mortality at much lower costs and significantly reduces the need for secondary and tertiary care. Estimates suggest that almost 52% of all conditions can be managed at the primary care level.

Under Ayushman Bharat Comprehensive Primary Health Care Program, the sub centres are transformed as Health and Wellness Centers by recruiting an additional member to the Primary Health Care Team called Mid- Level Health Providers who have completed six-month Certificate Program in Community Health developed by IGNOU imparted through notified Program Study Centers. As the country is facing crisis of mid level provider to roll out the comprehensive primary healthcare to operationalize Health and wellness centre, Assam is advanced stage as Assam has already a mid level provider Community Health Officer (CHO). The CHO courses started in the year 2004 under AHRA act.

Programme Description

Assam is in the forefront of implementing the Ayushman Bharat with its two key components of Operationalising Health and Wellness clinics alongside the implementation of Pradhan Mantri Jan Arogya Yojana (PMJAY). with respect to the Health and Wellness centres, Assam is in an advantageous position with already existing Community Health Officers who are the mid-level service provider cadre which is unique to the state of Assam.

Community Health Officer (CHO) who have undergone 3 ½ years course from the Medical Institute, Jorhat are already engaged as mid-level service providers for operationalising Health & Wellness Centres.

In order to provide proper health care services to the people of remote areas, particularly to ensure good health of pregnant women and to enable their safe motherhood, 691 Community Health Officer (CHO) have been posted all over the state by NHM Assam. Community Health Officer provides basic but good quality health care services to the people of remote and fur-flung areas of the State. The Community Health Officer besides doing the necessary ante-natal

checkups for pregnant women also conduct normal delivery cases in the Sub-Centres. Community Health Officer also conduct OPD sessions and provide basic treatment for various ailments among the general people. With the deployment of CHOs, the institutional deliveries have started in sub centres. CHO emphasised to work in home delivery point in rural area along with NCD screening, treatment of communicable disease, other RMNCH+A services.

Program Outcome

CHOs are posted at the remotest Sub Centres which are far away from existing PHCs. In the tribal & hilly districts like KarbiAnglong, Dima Hasao, Chirang, Baksa, Kokrajhar, Udalguri, etc, services of CHOs have been widely appreciated as there was acute shortage of Doctors in those areas. Similarly, services of CHOs appreciated in riverine and char areas where health care services were very poor:

- **Infrastructure Development and Uniform facade branding** completed for 120 Health & Wellness Centres (H & WC) as per design prototype provided by Govt. of India. Comprehensive Primary Services are available in the 120 Health and wellness centre, within December 2018.



- CHO has been made the in charge of HWC.
- As CHO course is 3 year 6 months course, a refresher 5 days training has been provided to the CHOs in CPHC concept to operationalize HWC.
- To improve labour room kakyakalp initiatives has been taken in the HWC.
- Tele consultation hub has been established.

Scalability

As the programme brings down new hopes of quality health care services to the rural masses

it is definitely considered as a role model for adoption at large. The population living in the remote parts of the state are benefitted the most and got the opportunity to improve their health indicators with the dedicated and selfless services of the CHOs.

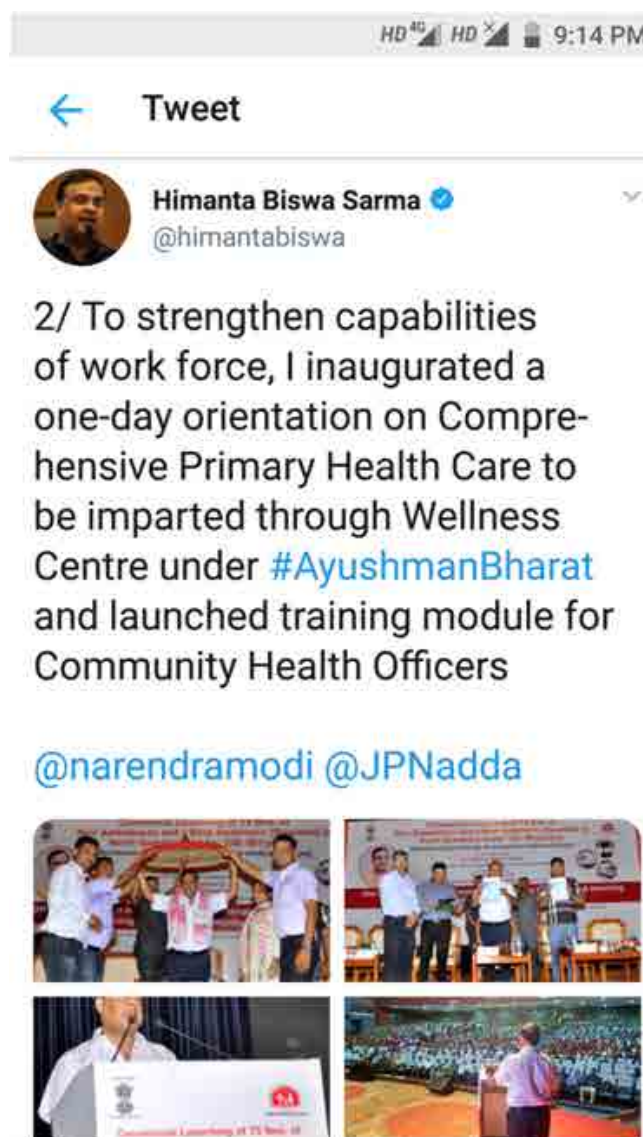
Conclusion

All the CHOs have now started assisting the MOs in their respective Health Institutions whether it is OPD or delivery cases. The burden of the MOs has been taken over by a great deal by these CHOs. At least now public find someone in the

hospital to cater to their medical needs. They are quite enthusiastic about their work and this has led to nearly half of the work done. Step has been initiated to promote them as public Health Officer in PHC.

Contact

spm.nhmassam@gmail.com





HUMAN RESOURCE INFORMATION MANAGEMENT SYSTEM (HRIMS)



Problem Statement

Human resource for health acts as the backbone of the health system. Sound understanding of functions and composition of HR is an essential factor for planning capacity building programs to enhance their skills to deliver quality services. Information received through manual recording systems are found to be inadequate to plan such activities. Hence, Chhattisgarh State decided to implement Human Resource Management Information System (HRIMS) developed in-house with the support and supervision of NIC.

Program Description

HRMIS is a centralized repository that stores, processes and manages employee data, such as personnel histories, skills, capabilities, hiring organization, engagement type (regular/contractual), salary and information about

dependents along with other functions like recruiting, application tracking, performance appraisals, e-pays slips and leave application. The functions available in HRMIS includes Master data management, Organizational management, such as positions and departments, Employee and manager self-services, Absence and leave management, Benefits administration, Work flows, Performance appraisal, Recruiting and applicant tracking, Compensation management, Training tracking and organizational development, Reporting and basic analytics.

Program Outcome

More than 38503 employees have been registered and using HRIMS which has enabled the HR department to spend less time on clerical tasks, helps ensure the accuracy of employee data. It also enable employees to take a greater role in the management of

their own information. Various reports can be generated for further analysis for e.g. head count, turnover etc.

Scalability

This inhouse developed HRIMS system helped HR management to improve beyond par and the best part about this is its very cost effective and hence can be reciprocated in other states very easily.

Contact

santoshcc@yahoo.com





Leave Application

Date of Application : 15/10/2018

Employee Details

Officer Code	: NSPMU17033	Place of Posting	: SPMU RAIPUR
Name of Applicant	: Deepak Dheewar	Mobile No.	: 9993039522
Post Held	: State Computer Programmer(NHM)	Intercom/Telephone No.	: 9993039522
Reporting Officer	: Dr. Surendra Pambhoi	Class	: -1

Type of Application

 Fresh Leave
 Leave Extension
 Leave Cancellation

Leave Balance

CL	: 8	OL	: 2
Credited Upto	: 01/01/2018		

Leave Details

 Single Leave
 Combination Leave

Nature of Leave	: --Select--	Max	: days at a time
From (DD/MM/YYYY)	: <input type="text"/>	To (DD/MM/YYYY)	: <input type="text"/>
Period of Leave	: <input type="text"/> days		
Saturday, Sunday & Holiday, If Any Proposed To Be Prefixed/Suffixed To Leave		<input checked="" type="radio"/> Yes	<input type="radio"/> No

Employee Registration

Welcome CMHO

Personal Information

Post Type: Select Post Type

Employee Type:

Employee Code:

Employee Name (Hindi):

Employee Name (English):

DOB:

Gender: Select sex

Appointing Authority: Select Category

Is your disability valid? No

Is female? No

Employee Class: Select Employee Class

Date of Birth:

Appointments Details

Order No:

Order Date:

Employee Registration - Details

Employee Name:

Employee Code:

Employee Type:

Employee Class:

Appointing Authority:

Order No:

Order Date:

Registration Date:

Registration Status:



Dashboard

Total No. of Employees	Total No. of Employee not updated their record	No. of Employee updated their record	No. of Employee Updated & Forwarded to CMHO for verification	No. of Employee Updated but not forwarded for verification to CMHO	No. of Employee whose objection is pending for clearance	No. of Objections Cleared
1370	0	1370	1367	1	5	328

CMHO VERIFICATION STATUS

Number of employee verified by CMHO	Number of employee Rejected by CMHO
1116	1

SPECIALIST

Total Number of Specialists	Total No. of Specialist not updated their record	Total No. of Specialist updated their record	No. of Specialist Updated & Forwarded to CMHO for verification	No. of Specialist Updated but not forwarded for verification by CMHO
26	0	26	24	0

MEDICAL OFFICER

Total Number of Medical officers	Total No. of Medical officers not updated their record	Total No. of Medical officers updated their record	No. of Medical officers Updated & Forwarded to CMHO for verification	No. of Medical officers Updated but not forwarded for verification by CMHO
65	0	65	65	0

CMHO / DPM/JE

Total Number of (CMHO/DPM)	No. of employee(CMHO/DPM) not updated	Total No. employee(CMHO/DPM) updated their record	No. of (CMHO/DPM) Updated & Forwarded to CMHO for verification	No. of (CMHO/DPM) Updated but not forwarded for verification by CMHO
2	0	2	1	0



Leave And HQ Leave

October 2018

Calendar view showing leave status for October 2018.

Legend:

- Approved Leave
- On Leave
- On Holiday
- On Sick Leave
- On Casual Leave
- On Maternity Leave
- On Family Leave
- On Other Leave
- On Unpaid Leave
- On Suspend
- On Retire
- On Death

Leave Application:

Leave Status:

Employee Details

Employee Name:

Employee Code:

Employee Type:

Employee Class:

Appointing Authority:

Order No:

Order Date:

Registration Date:

Registration Status:



GUJARAT

LET HUNDRED FLOWERS BLOOM: An Action-oriented Consultative Seminar on Health Planning in Gujarat



Problem Statement

Decentralized bottom-to-up planning, though a core component of NHM, has remained a critical challenge. Involving the community and front line workers, is perceived to be a resource intensive and time consuming process. Lack of capacity to plan well at district levels, often results in plans being made by district and divisional managers and at times may not represent the actual issues and challenges faced by the frontline workers and the community. There is a felt-need of consultative planning but not much has happened on this front at a large scale.

Project description

In direction to achieve “bottom to top approach” planning the State of Gujarat conducted an action-oriented planning seminar with consultative discussions which provided a platform for all health functionaries from grass roots to the upper most echelons of policy making to participate in making strategies to address the issues in the state. There were broadly 11 thematic areas ranging from immunization, nutrition to human resources and Information technology that were

selected for the seminar which are significant to give a strong bulwark for a comprehensive health plan.

Programme Outcome

The seminar provided a comprehensive road map along with activities to be carried out for each of the themes, the progress of which could be monitored over a period of time. The participation of actual implementers made the plan realistic and practical. The sharing of thoughts and newer ideas from different districts and health functionaries from various levels enthused and boosted morale of all.

Implementing Partner

The activities have been implemented by the State & Planning division of NHM Gujarat.

Financial Implication

Two sets of consultative action seminar conducted by Gujarat Team, one at the time of preparation of NHM PIP 2018-19 for ensuring the program commitment through practical strategies and 2nd after receiving the RoP of NHM PIP 2018-19 for assessing the current situation and implementing approved NHM Program implementation plan.

Scalability

The system has already been Rollout for all districts and it can be replicated across all States of India.

Contact

[spmuh.health.gujarat@gmail.com](mailto:spmu.health.gujarat@gmail.com)







GUJARAT

AUGMENTING BLOOD SERVICES THROUGH BLOOD COLLECTION AND TRANSPORTATION VANS

Problem Statement

Access to blood in rural areas of India is very difficult due to continued neglect of the blood banking services. Due to high level of illiteracy, poverty and superstition, very few people are ready to donate blood in rural India. The potential of augmenting blood through voluntary blood donation camps has not been fully exploited by states, which is only 40% of total collected units.

Program Description

To facilitate voluntary blood donation, support under NHM is being provided for strengthening blood services including for blood Mobile-blood collection and transportation vans with dedicated manpower to augment availability of blood through Voluntary blood donation.

Program Outcome

- Voluntary blood donation increased.
- Awareness on voluntary blood donation increased due to promotion on VBD as well as grouping camps through mobile vans.
- It makes easy to organise smaller camps in rural areas too.

- The availability and accessibility of safe blood ensured due to mobile vans.
- It has ensured availability and accessibility in tribal areas liked Dahod, Godhra, Navsari, Tapi, Bharuch and Narmada etc.
- Ensured availability and accessibility of safe blood at blood storage centres at FRUs.
- Helpful to reduce maternal mortality due to availability and accessibility of blood.
- Ensured availability of safe blood where no Govt. Blood Bank in the districts like Dahod, Tapi, Navsari, Bharuch, Narmada, Anand, Kheda and Amreli.
- Helpful to organized camps in all the social and religious events, i.e. birthday to Besana.

Contact

ircsguj@hotmail.com







GUJARAT

LAQSHYA Initiative - Sharing Experience of Getting First Accreditation



Problem Statement

Evidence dictates that improving quality of care around birth and ensuring Respectful Maternity Care leads to maximum benefits towards reducing maternal mortality, neonatal mortality and still births.

Program Description

Ministry of Health and Family Welfare has launched initiative 'LaQshya', which aims to adopt a holistic and comprehensive approach at all levels of care to improve and strengthen quality of care (QoC) during intra-partum and immediate post-partum period. Under the initiative, a multi-pronged strategy has been adopted such as improving infrastructure up-gradation, ensuring availability of essential equipment, providing adequate human resources, capacity building of health care workers and improving quality processes in the labour room.

To strengthen critical care in Obstetrics, dedicated Obstetric ICUs at Medical College Hospital level and Obstetric HDUs at District Hospital are operationalized under LaQshya program.

Program Evaluation

Two facilities of Gujarat; GMERS Gandhinagar has scored 95% & 97% in LR & Maternity OT resp. and GMERS Sola, Ahmedabad has scored 96% & 98% in LR & Maternity OT in the external assessment by Govt. of India and became India's 1st LaQshya certified facilities. They are eligible to get LaQshya certificate along with incentive of Rs. 6 lacs each and Platinum badge by scoring >90% in the assessment. Total Eight (8) Health Facilities are LaQshya certified as of now.

Implementation Partners

National Health Mission, State Health Departments and Medical college.

Program Outcome

- Reduces Maternal and New born mortality and morbidity due to APH, PPH, Retained placenta, Preterm, Pre-eclampsia & eclampsia, Obstructed labor and sepsis etc.
- Improvement in Quality of care during the delivery and immediate post-partum care and stabilization of complications.
- Enhanced satisfaction of beneficiaries visiting the health facilities.

Contact

drjlmeena@gmail.com

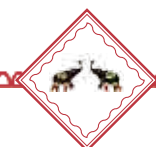






KARNATAKA

HEALTH AND WELLNESS CENTRES - the First Port of Call for Comprehensive Primary Health Care (CPHC) towards “Arogya Karnataka”



Problem Statement

Karnataka was one of the early beginners commenced UHC Pilots in districts of Mysore and Raichur in FY 2014. A series of assessments to plan UHC specific actions were commissioned which showed regional disparities in health service delivery, access and outcomes. Only 33% of routine ambulatory care in Mysore and 25% in Raichur was respectively sought at the level of PHCs in which nearly 85-90% cases related to only Reproductive and Child Health and basic treatment of certain communicable diseases. Nearly 1 in 3 (29%) HHs reported of experiencing financial difficulties due to health care event which was higher in vulnerable groups of aspirational district of Raichur. Based on the evidence from above findings NHM Karnataka decided to strengthen primary care facilities by upgrading the health sub-centres to Health & Wellness Centres (HWCs).

Programme Description

Delivery of Comprehensive Primary Health Care (CPHC) was first planned in 65 and 40 Sub Centres-HWCs of Mysore and Raichur respectively. As the National guidelines for CPHC were yet to be finalized, state constituted Technical Committee and State Working Teams to provide the necessary inputs and to orient all

associated stake holders. The essential inputs provided for operationalizing HWCs were.

1. Block saturation model by operationalizing all SHCs in T. Narsipura and Lingasagur blocks in Mysore and Raichur respectively.
2. Systematic Gap Analysis of SHCs using standardized checklist.
3. Action plan with fixed timelines to complete activities under HR, training and infrastructure upgrading simultaneously within one financial year in a phased manner.
4. Ensuring ownership of Local Self Governments for HWC.
5. Executing Infrastructure repairs through NHM Engineering Section.
6. Centralized planning, procurement and decentralizing supplies to HWC through Karnataka Drug Warehouse and Logistic Society.
7. Transparent Selection, training and recruitment of local candidates with BSc Nursing/Post Basic Nursing personnel with two years of experience as MLHPs.
8. Building a Team Approach for Primary Care through post recruitment induction training with the support from NGOs based in Bangalore Training of MLHPs and

Multi-skilling of Frontline Functionaries- 96/105 candidates cleared the Term End Examination. 473 ASHAs, 85 MPWs and 57 Staff Nurses have been trained in Population Based Screening for NCDs.

9. Karnataka has Drug MIS Indenting Application rolled out to the level of PHCs to ensure availability of Medicines and supplies.
10. ANMOL and NCD application have been institutionalized and ensured availability of IT equipment at the HWCs.
11. Community Outreach and need assessment through ASHAs.
12. Special Outreach Camps for NCD, School health etc. are being conducted by HWC Team.
13. Prioritizing PHCs with MBBS- MO as first referral centres and planning referral pathways.
14. Continuity of Care is ensured by linking the beneficiaries with financial protection schemes of the State.
15. At the State Level Nodal Officer CPHC-UHC of NHM is supported by PHFI Bangalore as Technical Partner and District Level Coordinators are placed to monitor activities under CPHC



Programme Outcome

The early results assessed based on service delivery reports submitted by District Coordinators show promising results. The health and wellness centres have become functional and has shown considerable progress in the footfall with more than 3.5 Lakh OPD in the Narsipura and Lingasagar Districts and are currently providing all the range of services as per the essential packages.

Contact

uhckar@gmail.com





MADHYA PRADESH

EQUIPMENT MANAGEMENT & MAINTENANCE SYSTEM (EMMS)



Problem Statement

The medical equipments are indispensable in providing efficient health care. The inventories, when not maintained properly, causes regression in the value of the equipments. Also, there is a need to streamline the process of procurement to as well as supply chain management for the efficient working of the system.

Programme Description

The Equipment and Management System (EMMS) product is designed to manage the existing Equipment and to procure New Equipment through IT enabled system with the help of CDAC-Noida. The major objectives of EMMS product include.

Maintenance of existing Inventory with the help of outsourcing agency to ensure the utility of equipments with its maximum efficiency through on-time preventive maintenance and calibration.

Procurement of New equipments through centrally executed Rate Contract in decentralized procurement system. State defines the annual

demand is mapped to Drawing and Disbursing Officer (DDO) with quantity where officers are restricted to procure the pre-fixed quantity with calculated budget.

To complete the full life cycle of supply chain management – State has mapped all its procurement processes online including payments to vendors through e - sign.

Program Outcome

Maintenance of equipment: Uptime of Equipment by 88.94%.

Complaints Redressal: Efficient tool for grievance redressal. Around 11319 complaints of Hospital authority are being lodged and only 13.59 % complaints are pending.

Approximately Rs.2.23 Cr payment to vendors will be disburse.

About 90% rural population is being covered under this programme.

Scalability

The Equipment maintenance and management System has implemented in CMHO stores,

District Hospital, Civil Hospitals, Community Health Centers and Primary Health centers in state of Madhya Pradesh. This system is covering all dimensions of socio economic entities to manage the increased demand of equipments by health system in controlled financial domain.

Implementation Partners

Center for Development of Advanced Computing (C-DAC), Noida, Department of Health, state of Madhya Pradesh.

Financial Implication

MoU Of Department of Health, Sate of Madhya Pradesh with CDAC Noida at 89 lakhs to design and development of Equipment maintenance and Management System.

Contact

mpaushadhi@gmail.com



MPHSC Login Desk

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Available Budget Details

Purchasing Authority	Equipment Name	Programme Name	Budget Line	Approved Qty	Ordered Qty	Value of Qty to be Ordered(£)
Imvex-CHC	OT TABLE HYDRAULIC	OT/AL/CHC	01F-0210-03-000-0100-7777-43-001	2	2	11544

Category Details

Category Name	Ordered Qty
OT TABLE CHC	2
Total	2

Rate & Quantity Details

#	Equipment Name (I)	Rate/Unit (Including Tax) (A)	Tax Amount/Unit (B)	Rate/Unit (Including Tax) (A+B) (C)	Ordered Qty (D)	Total PO Cost(£) (A*C) (E)	Net PO Cost(£) (D*B) (F)
1	OT TABLE HYDRAULIC	5772.00	577.00	6349.00	2	12698.00	11044.00
Total					2	12698.00	11044.00

Purchase Details

TPG Reference No. :

Generated By : [Purchasing Authority]

Remark :

(Allowed upto 500 Characters.)

Component Details

Master Plan

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ODISHA

PAYING FOR PERFORMANCE (P4P)



Problem Statement

In Odisha, all contractual manpower is engaged through Odisha State Health & Family Welfare Society for a contractual term of 11 months and their contract renewal is subject to satisfactory performance. With the lack of defined hierarchical structures, remuneration of staff was uneven and not commensurate with their qualifications, experience and level of posting, and reporting pathways were also not standardized causing dissatisfaction among staff. In addition, lack of defined job responsibilities for different levels of staff also posed difficulty in objectively evaluating their performance for contract renewal.

Programme description

In year 2009-10, the state devised new hierarchical structure and also developed an effective Performance Management System (PMS) for all positions under PMU. PMS serves as a useful tool for conducting contract renewal, determining staff compensation based

on performance grades and training need identification. The objective of the programme is to develop hierarchical structure for contractual staff based on level of posting, experience, job responsibilities and qualifications and define structured reporting pathways for all staff categories as well as to standardize fixed base remuneration based on hierarchy level. The programme also aims to define Terms of Reference and identify objectively verifiable deliverables for performance-linked appraisal and grading of incentives for different staff categories.

Performance Management System has a unique built-in mechanism of two-way communication for providing constructive feedback from appraisers to appraise.

Evaluation Result

No independent evaluation conducted so far. However, substantial improvement in fund absorption capacity under NHM observed with over two-fold increase to Rs. 1362.49

Crores FY 2017-18 from Rs 635 Crores in 2010-11. Significant reduction in staff turnover has also been observed after introduction of the process.

Financial Implementation

No additional investment incurred for development of hierarchical structure and performance management system. However, Annually, about Rs. 60 Crores are allocated towards performance incentives for about 4000 Programme Management Unit Staff and about 11,000 Clinical & Para-Medical staff working under NHM.

Scalability

With the staff positions under PMU largely similar across the states, the process may be scaled in other states also based on their state specific context.

Contact

sppmodisha@gmail.com

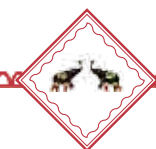






TAMIL NADU

A LIFE SAVING INNOVATION : Integration of 108 EMRI Ambulances with Tamil Nadu Accident and Emergency care initiative (TAEI)



Problem Statement

More than 20000 calls are received by the 108 ambulance service daily. However, local information, distance and other logistic issues have resulted in delayed ambulances by several minutes.

The Road Traffic Accidents in Tamil Nadu has been increasing exponentially and the Government of Tamil Nadu has taken several initiatives to implement the Trauma Care Network in the name of 'Tamil Nadu Accident and Emergency Care Initiative'.

Our current casualty settings are designed in such a way that there exists inadequacy in free flow of patients. Hence in order to establish full-fledged Trauma Care Centers in the State, and to ensure free flow for patients and installation of essential equipment, the old buildings requires to be designed as per the TAEI.

Programme Description

The state health department has launched a mobile app – Avasaram 108 to make this process easier. The app can be used to report

a crash or seek medical help. It automatically detects location with latitude and longitude (even with no internet connection) and alerts the call centre. The data is shared with a GPS enabled ambulance in the vicinity (deployed as per grid and cluster analysis), along with basic information on the kind of trauma and emergency.

Upon plotting all the accident locations (Fatal, Grievous & Simple Injury) in the map, entire state is divided into 4 Square kilometers grids. Among the grids, ones which have highest number of accidents are taken for intervention. In each district, top 10 Fatal Grids and top 25 Grievous grids are identified. In order to analyze road accidents at micro level, they are grouped into 100 meter clusters. Ambulances are deployed based on the focused cluster and grids identified. Major interventions like moving existing ambulances in the district towards these focused grids, launching the new locations within these grids, strengthening health institutions near to the focused grids etc. are implemented in these clusters. The focused grid details are shared with District Police department in order to improve the enforcement in the focused region and with

highways department for road engineering modifications (if required).

With the overall objective of building Comprehensive Emergency Care Services in all the TAEI network Hospitals, the aim of the entire project is to streamline the workflow mechanism in Emergency Room, integration of multiple disciplines of health care, leverage the technology for the best interest of the patients and care givers, develop a protocol driven model, eventually developing a robust system where each and every patient is given the optimal care with minimal time delay.

Programme Outcome

7% less accidental deaths have been reported in 2017 as compared to 2016. There has been a substantial increase in Road Traffic Accident victims being admitted in health facilities by 108 ambulance. Utilization of 108 services by critically injured has also increased over 50%. En-route complication while in transit by 108 has decreased and Response time to road accident emergency has been further reduced by 1 minute.



Scalability

Rational deployment of ambulance based on high priority areas is a good and scalable practice. Data being shared with other

departments for non-health interventions shows inter departmental convergence.

Contact

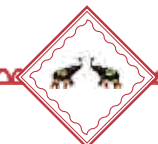
selvakumar_m@emri.in





UTTAR PRADESH

INNOVATION IN ROLLING OUT CERTIFICATE COURSE IN COMMUNITY HEALTH



Problem Statement

Under Ayushman Bharat Uttar Pradesh is targeting to transform 20,521 SHCs as Health and Wellness Centre in a phased manner. For operationalizing SHC-HWCs, the State would require recruiting Mid- Level Health Providers who have completed six-month Certificate Program in Community Health developed by IGNOU imparted through notified Program Study Centers. Considering the huge number of targeted SHC-HWCs the biggest challenges for the state was to operationalize 52 PSCs by December 2019, to ensure timely completion of IGNOU curriculum to create the required resource pool of MLHPs by ensuring the quality of trainings.

Program Description

To meet the target of recruiting huge number of MLHPs within a short span of time State Government decided to enrol fresh candidates from open market who are registered nurses with basic qualifications of GNM or B.Sc. (Nursing) for the Certificate Program. To ensure quality and standardized trainings across the PSCs, following steps were taken to operationalise the PSCs in the state:

- 1. One day State Level Orientation Workshop on Certificate Program in Community Health** was conducted to develop a common understanding about the certificate course and define roles and responsibilities key stakeholder.
 - 2. Program Study Centre level trainings** to sensitize on course curriculum, examination pattern and on financial and administrative aspects for program in-charges (PICs), academic counsellors and district officials.
 - 3. Development of standardized learning resource package** for the PICs and academic counsellors to ensure quality training across all operational PSCs.
 - 4. Structured Academic Planning:** which included course plan for PSCs, Master Rotation Plans (MRP) and Clinical Rotation Plans (CRP).
- Created a resource pool of 202 academic counsellors across the 25 PSCs.
 - A total of 71 standard presentations have been developed from the three modules of the course, ensuring conduct of structured theory and practical classes across all the PSCs.
 - Mentoring and quality assurance model piloted in January 2018, played a key role in mid-course corrections and bringing the desired quality to the trainings.

Financial Implication

Supported through State PIP (two state level orientations meeting- Rs. 2.00 Lakhs and PSC level trainings - Rs. 0.30 lakhs per PSC for January and July Sessions).

Implementation Partners

Planning and Coordination through Nursing Cell within State Program Management Unit (SPMU), and National Health Mission (NHM) Uttar Pradesh and technical partner, Jhpiego.

Contact

mdupnrhm@gmail.com





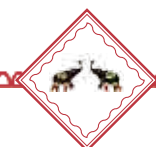




*D*isease Control Programme



TELE OPHTHALMOLOGY



Program description

The primary objective of the project is to make preventive eye care services accessible to the rural population. The provided eye care devices, software and other components of service delivery have been simplified, keeping in view the ease of use and to improve the efficiency of the Ophthalmic Officers. Patients identified with refractive errors are provided with free spectacles. To strengthen service delivery and ensure quality, the Ophthalmic Officers (PMOOs) posted at these centres have been trained on all the aspects of the project.

Technology Components of the Project

The project has multiple technology components, ranging from digital eye care devices to information technology devices. The technology component constitutes of Auto Refractometer, Fundus Camera and Lensometer.

Services Offered

- Fundus images are sent to a hub provided by the service provider, and are reported within 6 hours.

- All Diabetics and Hypertensive patients are screened yearly for retinopathy.
- Treatment of minor eye ailments Vision testing and provision of free glasses to all eligible people.
- Identification of cataract and referral.
- Referral of all cases identified with suspected retinopathy/glaucoma.
- Counselling

Programme Outcome

The project is currently operational across all of the identified 115 centres, and has already catered to a significant number of patients and their eye care needs. Within duration of 3 months since its inception the project has served eye care needs of 123999 patients. As of now, the total number of Diabetic retinopathy cases detected at the centre is 430 and that of hypertensive retinopathy cases are 13. More than One lakh twenty thousand refraction errors have been tested under this programme.

Contact

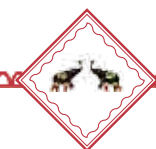
ddmiscfw@gmail.com







TREATING HEART ATTACKS IN INDIA : What is The Optimal Approach ?



Problem Statement

The contribution of most of the major non-communicable disease groups to the total disease burden has increased all over India since 1990, including cardiovascular diseases. Among the leading non-communicable diseases, the largest disease burden or DALY rate increase from 1990 to 2016 was observed for ischaemic heart disease, at 34%. In 2016, three of the five leading individual causes of disease burden in India were non-communicable, with ischaemic heart disease and chronic obstructive pulmonary disease as the top two causes and stroke as the fifth leading cause. The range of disease burden or DALY rate among the states in 2016 was 9 fold for ischaemic heart disease, 4 fold for chronic obstructive pulmonary disease, and 6 fold for stroke, and 4 fold for diabetes across India. While ischaemic heart disease and diabetes generally had higher DALY rates in states that are at a more advanced epidemiological transition stage toward non-communicable diseases, the DALY rates of chronic obstructive pulmonary disease were generally higher in the EAG states that are at a relatively less advanced epidemiological transition stage. On the other hand, the DALY rates of stroke varied across the states without

any consistent pattern in relation to the stage of epidemiological transition. This variety of trends of the different major non-communicable diseases indicates that policy and health system interventions to tackle their increasing burden have to be informed by the specific trends in each state. (Ref : India : Health of the Nation's States – the study of Diseases Burden Trends in States of India 1990-2016).

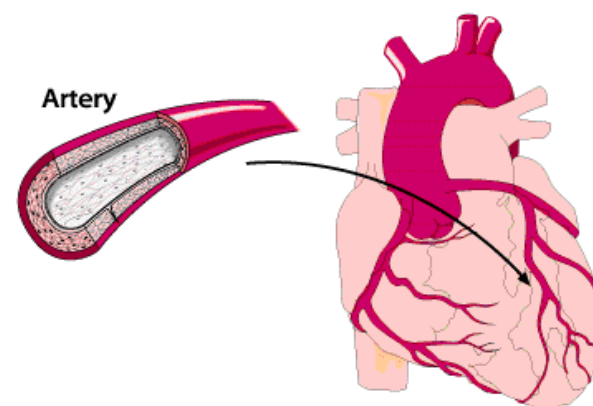
The patient with heart attacks reports to health system 4-11 hours later after the Chest pain in comparison to developed country caused the death. The other important cause of death due to heart attack is delayed referral, absence of thrombolytic therapy with local practitioners and absence of Cath labs in countryside.

Programme Description

There are two major approaches or therapy for treatment of heart attacks. One is Primary angioplasty and Second is thrombolytic therapy. Treating 100 heart attacks with primary angioplasty, instead of “clot-busting” (thrombolytic therapy) drugs will save 2 additional lives. When performed in a timely manner, primary angioplasty is better than thrombolytic therapy. But is it possible to

treat all the patient with heart attack in India through Primary angioplasty? Studies shows that it takes 8 -12 hours by patient (pre-hospital delays, referral – arrangement of vehicle, traffic jam etc) to contact health system and that delay is enhanced by health systems in diagnosing the patient and referring them to Cath Labs. It should be noted that there are 630 cath labs in India in 2015. But most of them are located in and around major cities, where only about 10% of patients are treated by primary angioplasty. While the US has >4 times as many cath labs as India has 84% of Americans live within a 1-hour drive of a cath lab. Timely primary angioplasty can be provided only if labs are operational 24/7.

How a heart attack occurs



The Second one is thrombolytic therapy by which 40-60% of people with heart attack receive treatment. Many of them reached health facilities beyond 6 hours after onset of chest pain and 30-40% of patients reached beyond 12 hours. The Main reasons for delay is Consulting a local practitioner (who does not thrombolysis); and also delay in transportation (Private - 63%, Public - 33%, Ambulance - 5%). Practitioners in periphery health facilities in India are willing to be thrombolysis. Therefore, adequate staff with thrombolysis skill may be placed in periphery health facilities. Study shows that 73 minutes (median) time is saved by paramedic administered pre-hospital thrombolysis in Rural Sweden.

Programme Outcome

The pre-hospital delays caused overwhelming death for heart attack patient in India. The reducing time to accessible to health facilities with thrombolysis skilled staff and timely treatment yield the greatest benefit and save the life. This can be encouraged if it will be objective of any policy level intervention.

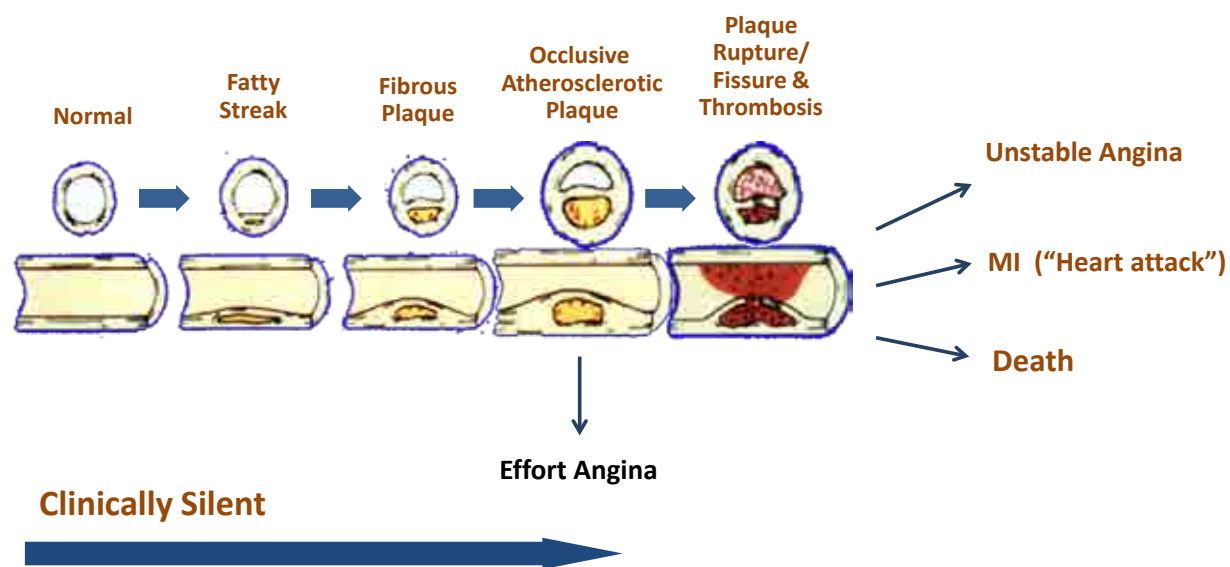
Scalability

The encouragement of Thrombolytic therapy in Peripheral Hospital and Pre-hospital thrombolysis will give overwhelming result in saving the life of patient with heart attach in India. Providing Primary angioplasty should not be in priority at this time, as it will be costly and impractical.

Contact

karthik2010@gmail.com

How heart disease happens

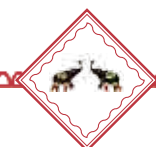


How long does it take to get to hospital in India?





INTEGRATED APPROACH TO ELIMINATION OF GRADE II DISABILITY DUE TO LEPROSY



Problem Statement

Disability Prevention, Management and Rehabilitation (DPMR) is an important component of NLEP; as in Leprosy, visible deformities i.e. grade II disability is the key factor behind stigma associated with it as well as the only morbidity attracting the highest concern for disease control, elimination or eradication.

Dadra & Nagar Haveli, having the highest disease burden in terms of PR and ANCDR in the country, has been trying its best to curb the Grade II disability due to Leprosy in the UT for last 2-3 years. All the components of DPMR were implemented by the UT and for the first time, RCS camp was organized in December 2015.

In the year 2015-16, 8 cases of grade II disability were reported among new cases. Although the absolute number was not high, 8 cases of G2D in a population of about only 4.2 lakhs is alarming situation indicating more hidden cases. In 2016-17 again 8 such cases were reported taking the grade II disability rate at the time of diagnosis from 1.88% in 2015-16 to 2.08% in 2016-17.

Program Description

On realizing that RCS is not the true solution for G2D but solution to prevent the development of disability is to detect cases early a new program

was launched in the UT. It was found that pure neural cases were being missed by the health staff including Medical Officers. Also, the working population was being missed in the active case finding campaigns (LCDCs or SAPs). To handle these issues, all the General Health Staff & ASHAs were sensitized to screen for sensory loss in addition to hypo-pigmented patch and visible deformity. Three rounds of active case finding drives (first round of active search by General Health Staff & two rounds of LCDC) and one round of Focused Leprosy Campaign was carried out. To screen the working population, male MPWs, PMWs and NMS were deployed for the evening time (6pm - 8pm) to screen out the suspects. Due to these measures, there was no G2D at diagnosis (during 2017-18) in the UT till 29th March 2018. A single case with Gr II disability was confirmed on 29th March 2018.

Along with active case finding measures, single dose Rifampicin prophylaxis is continuously being given to the healthy contacts of new cases and the UT has increased the number of contacts per Index case from 20 to 50-100 as per the population surrounding the index case.

Program Outcome

Although the UT marginally missed a year free from G2D at diagnosis, it has succeeded in

bringing down the G2D at diagnosis from 2.08% in 2016-17 to 0.36% in the year 2017-18.

During the year 2018-19, the UT set its goal to 'Zero Grade-II deformity due to Leprosy' in contrast to the All India goal of grade-II disability <1 per million population set by MoHFW, Government of India to be achieved by 2nd Oct 2019. As on date there has been "Zero" grade-I as well as "Zero" grade-II disability at diagnosis in the UT during this year.

Contact

nrhmdnhc@gmail.com







GUJARAT

COVERING PRIVATE SECTOR TB PATIENTS THROUGH PUBLIC HEALTH SYSTEM - Mehsana Model

Problem Statement

The State has a large Private Provider (PP) presence with around 18,000 members registered with the Indian Medical Association. Private Sector Engagement is one of the core components of RNTCP programme. However, previous engagement interventions have given modest incremental increases in TB case notification. A model of interventions was developed to leverage electronic health advances and free anti-TB drug vouchers to attract TB notifications, reduce patient out-of-pocket expenses, and improve the quality of TB care at scale with ownership of Government District TB Centre Team.

Program Description

The intervention started from 1st August 2014 wherein all private providers including chemists were mapped, prioritized and sensitized through one to one meetings and CMEs with involvement of professional association. A call centre helped for TB notification and issuance of e-vouchers for anti-TB drugs (prescribed as per Standards for TB Care in India) which TB patients redeem at private chemists. Notified patients were visited by program staff for public

health action in consultation with patients and private providers. Patients received adherence support through reminders from call centre, and then by program staff of non-reporting or missed follow up cases.

Program Outcome

From August 2014 to December 2017, out of 344 total PP, 312 were engaged at least one time and 130 (38%) notified; similarly, of 177 chemists who stocked anti-TB drugs, 102 (58%) redeemed e-vouchers.

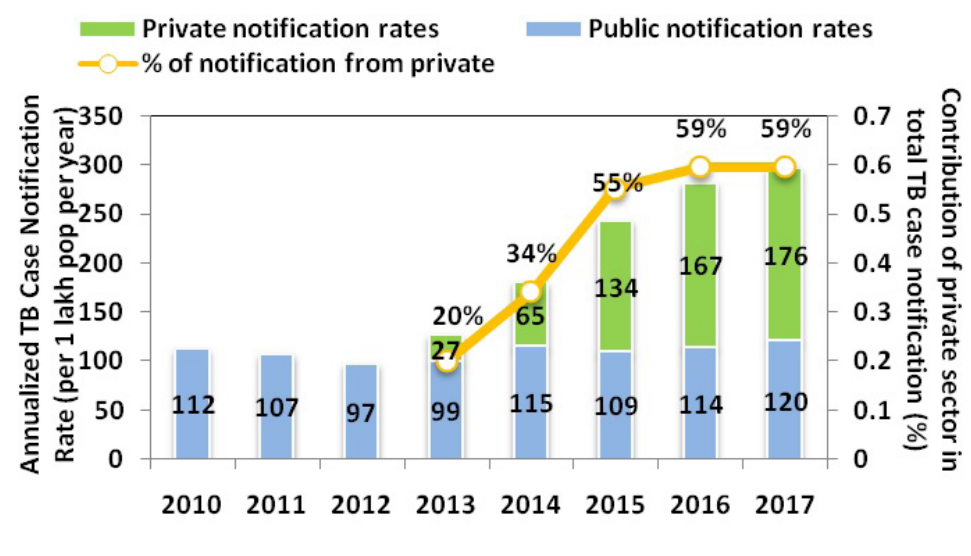
Total TB case notification rate contribution from private sector increased three times from 27% in year 2014 to 59% in year 2017. Total 40,151 vouchers of anti-TB drugs were validated and were reimbursed through partner organization. The treatment cohort show 72% patients completed treatment.

Conclusion

As per drug sales estimates, Mehsana could cover close to 95% drug sales through project interventions, largely through existing programme staff with free drugs and call centre as support. A strong public health system can deliver comprehensive universal access to TB patients in both public and private sector.

Contact

stogu@rntp.org







KERALA

NIPAH..... A Story from Kerala



Problem Statement

On 17th May 2018, the state was hit by NIPAH which triggered a scare not only in Kerala but also in other states when a private institute was first to report a about a cluster of 3 Acute encephalitis syndrome cases. By the next day evening, Manipal Center for Virus Research informed the Director of Health Services about a new virus detected from the samples. The information was shared with Principle Secretary (Health) immediately and the state was put on high alert and what followed has become a history in the annals of Public Health Measures of Kerala.

Elements in the outbreak response

1. Strong political will and leadership to address Public Health Emergencies.
2. High Quality leadership and managerial skills of Health and Civil Administration.
3. Health system's resilience to adapt to any emergency situation.
4. Optimum use of the Public Private Partnership in Laboratory surveillance in the state.
5. Commitment and result oriented approach to Hospital Infection control practices.

6. Community participation and co-operation during a critical situation.
7. Skilful management of the Media during outbreak situation.
8. Positive Response of the media persons in alleviating panicky moments.
9. Effective use of digital technology of Police department in responding to adverse social media reports.
10. Motivational skills of the health administrators to facilitate optimum functioning of the work force.
11. Tremendous support from Government of India , World Health Organization, Centre for Disease Control, Indian Council of Medical Research, National Institute of Virology , National Institute of Epidemiology, Chennai, and Department of Animal Husbandry and Veterinary Sciences University.

Closure of the outbreak

Active and passive surveillance continued for the next 6 weeks, and since no new cases were reported, with consensus from NCDC, the outbreak was declared closed on on the 25th June 2018. State is in continued vigilance to detect any recurrence. Life is back to normal in the affected areas.

Contact

idspkerala@hotmail.com







MADHYA PRADESH

BETUL INITIATIVE FOR TB FREE DISTRICT



Problem Statement

In 2016, District TB Centre, Betul in Madhya Pradesh, decided to conduct Active Case Finding (ACF) in Key Population groups in entire district. With this activity, district was able to reach a annualized TB case notification rate of 242 per lakh from 119 per lakh population. With sustained efforts, notification rate of the district began to decline from 4th Quarter 2016. The district decided to strategize its interventions by plotting the data block wise and village wise and bring them under surveillance to track emergence of new cases.

Program Description

Villages were classified based on total number of TB patients notified from Jan 2017 to June 2018 as notified into the RNTCP's Nikshay software as under:

- Villages with zero notification during the period – depicted as Green.

- Villages with 1- 2 TB Patients notified – depicted as Yellow.
- Villages with more than 3 TB Patients notified – depicted as Red.

The BMO, MPWs, ANMs, ASHA Sahyoginis and ASHAs were involved in the process along with RNTCP staff under the leadership of District Collector & CMHO. The district focused its preventive activities towards these villages and on a quarterly basis conducted house to house survey in 350 green depicted villages to find any new presumptive (symptomatic) or new case.

Program Outcome

Out of 350 villages, 102 villages were identified with either new TB Presumptive (symptomatic) or TB Patient detected during survey. 248 Villages have been identified as **Zero TB** applying the definition of 18 months and where not a single presumptive or new TB case was found on repeated survey.

The district managed to do this focused activity using existing resources available under the NHM and no additional financial implication was necessary. The State TB Cell also verified the data independently.

Conclusion

With strategic and focused activities concentrated on identified geographies, the district could demonstrate how to achieve TB free villages.

Contact

dtompbt1@rntcp.org







UNIVERSAL ACCESS TO TB CARE - Through Private Sector Involvement Under RNTCP



Problem Statement

State of Maharashtra has made significant achievements in case detection through public sector health facilities. Recognizing the need to reach to TB patients in private sector, the State of Maharashtra undertook three initiatives to increase access to free diagnosis and treatment to TB patients in private sector. Purpose of these interventions was to provide universal access to services, reduce out of pocket expenditure and reach out to large number of TB patients in private sector. The key features of these interventions are that they are supported through NHM resources and undertaken by existing general health system.

Program Description

- 1. Empanelment of private X-ray facilities for Augmenting TB Diagnosis in Mumbai**- NGOs have been selected through tender as per NHM/RNTCP Guidelines to operationalize the 'Empanelment of X-ray Facilities' for examination of presumptive TB cases.
- 2. Private Sector Engagement through Private Provider Support Agency (PPSA) for engagement, service provision and patients support in Mumbai**- An interface agency

known as public private support agency (PPSA) was engaged to provide services to private sector TB patients by facilitating free diagnostic testing from Public sector, free daily regimen Fixed Dose Combination from RNTCP for Drug Sensitive TB Cases along with ICT Enabled adherence monitoring through Nikshay, FDC supply through FDA Approved Retail Chemists and linking of Drug Resistant TB Patient to public sector for Free Second Line Anti TB Drugs under RNTCP.

- 3. Access to Free FDC to TB patients seeking care in private sector in Nagpur Municipal Corporation**- Nagpur Municipal Corporation engaged NGO (Disha Foundation) under RNTCP National Guideline on Partnership in April 2017. This NGO facilitates access to free FDC for TB patients in private sector along with notification of TB cases, sample transport and extend public health services.

Program Outcome

From February to August 2018 - **Total 30174 Presumptive TB Cases** from both Public and Private sector received Free Chest X-ray through 'Outsourced Private facility'.

- 7347/30174 (24%) of Patient's Chest X-ray have found to be abnormal.

- 2015 (27%) have been diagnosed TB and put on treatment amongst those with abnormal X-ray.
- Patients received free quality diagnostics closer to their residence and multiple visits to public health facility was avoided.

Provider engaged through PPSA was 385 Nursing Homes/Hospitals, 273 Formal Private Doctors, 1,584 Informal Private Providers, 177 X-Ray facilities and 198 Retail Chemists. TB case notification rate in Mumbai is now 418 cases per lakh per year (180/lakh from private sector).

Contact

dtomhbm@rntcp.org

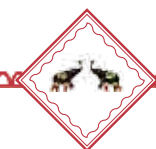






ODISHA

MALARIA CONTROL PROGRAMME - A Paradigm Shift



Problem Statement

Bulk of malaria reported from the North-Eastern States like Tripura and Meghalaya and from the peninsular states of Odisha, Chattisagrh and Jharkhand. Most of these states are characterized by widespread hilly, tribal, forested and conflict-affected areas which are also pockets of high malaria transmission. Presently, about 80% of malaria occurs among 20% of people classified as “high risk” in the above states. The State of Odisha contributes to nearly 40 percent of malaria and nearly 50 percent of deaths in India.

Program Description

Following activities were undertaken in the year 2017 for intensification of antimalarial activities were taken to tackle the malaria in the area:

- Identification of remote and inaccessible areas which get cut off after the monsoon.
- Increased surveillance of the community by means of mass surveys and identifying the malaria.
- Provision of rapid diagnostics for immediate results and treatment.

- Provision of 11.34 million Long Lasting Insecticides Nets (LLINs) to the identified population in high endemic areas.
- Promotion of IEC/BCC for utilisation of LLINs.
- Engagement of all politicians, local representatives, community groups, etc for use of LLINs and immediate reporting of fever cases.
- Community groups and volunteers took on themselves the task of promoting the use of LLIN by visiting the villages and requesting the community to sleep under LLINs.
- Accredited Social Health Activists (ASHAs) were used for fever surveys and mobilising the community.

Program Outcome

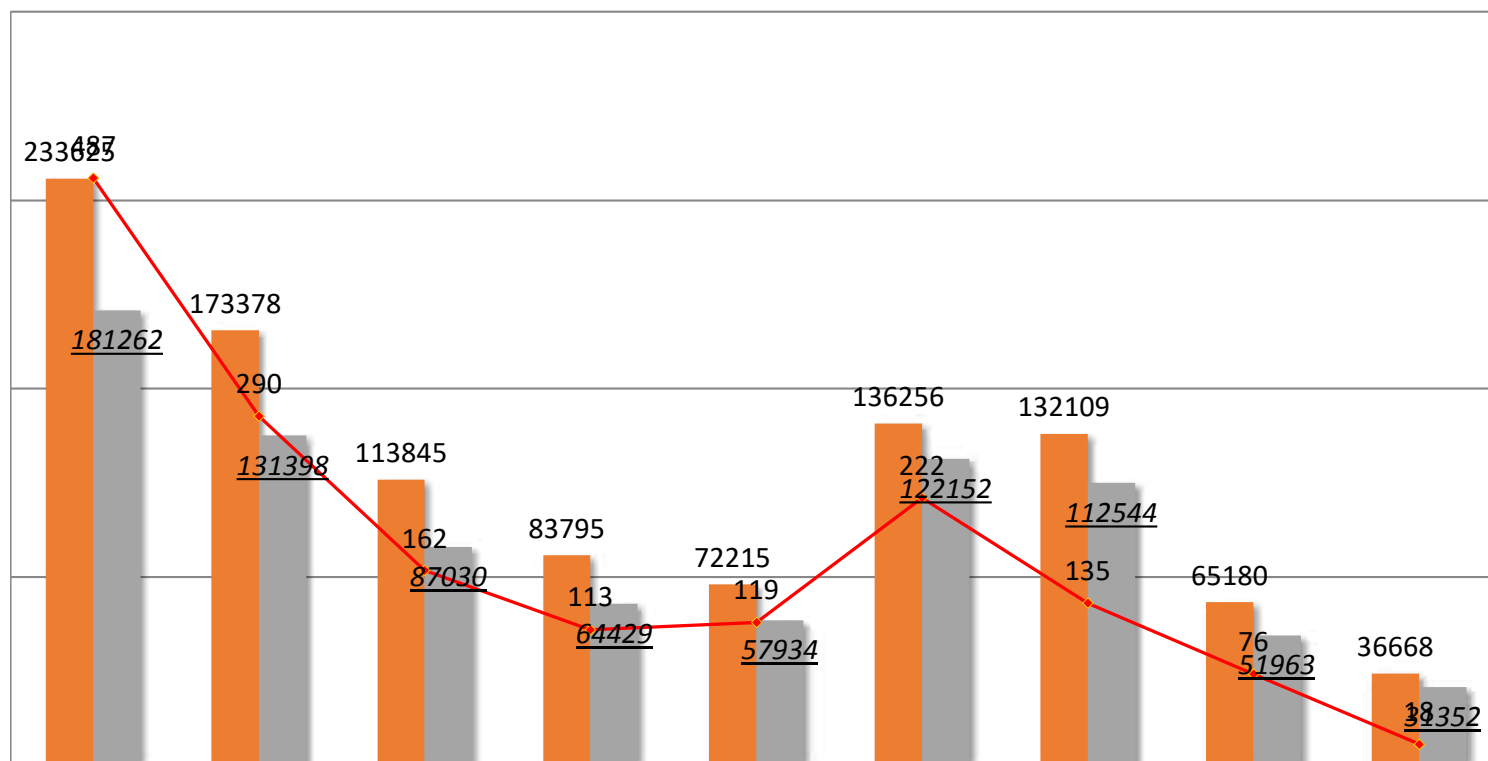
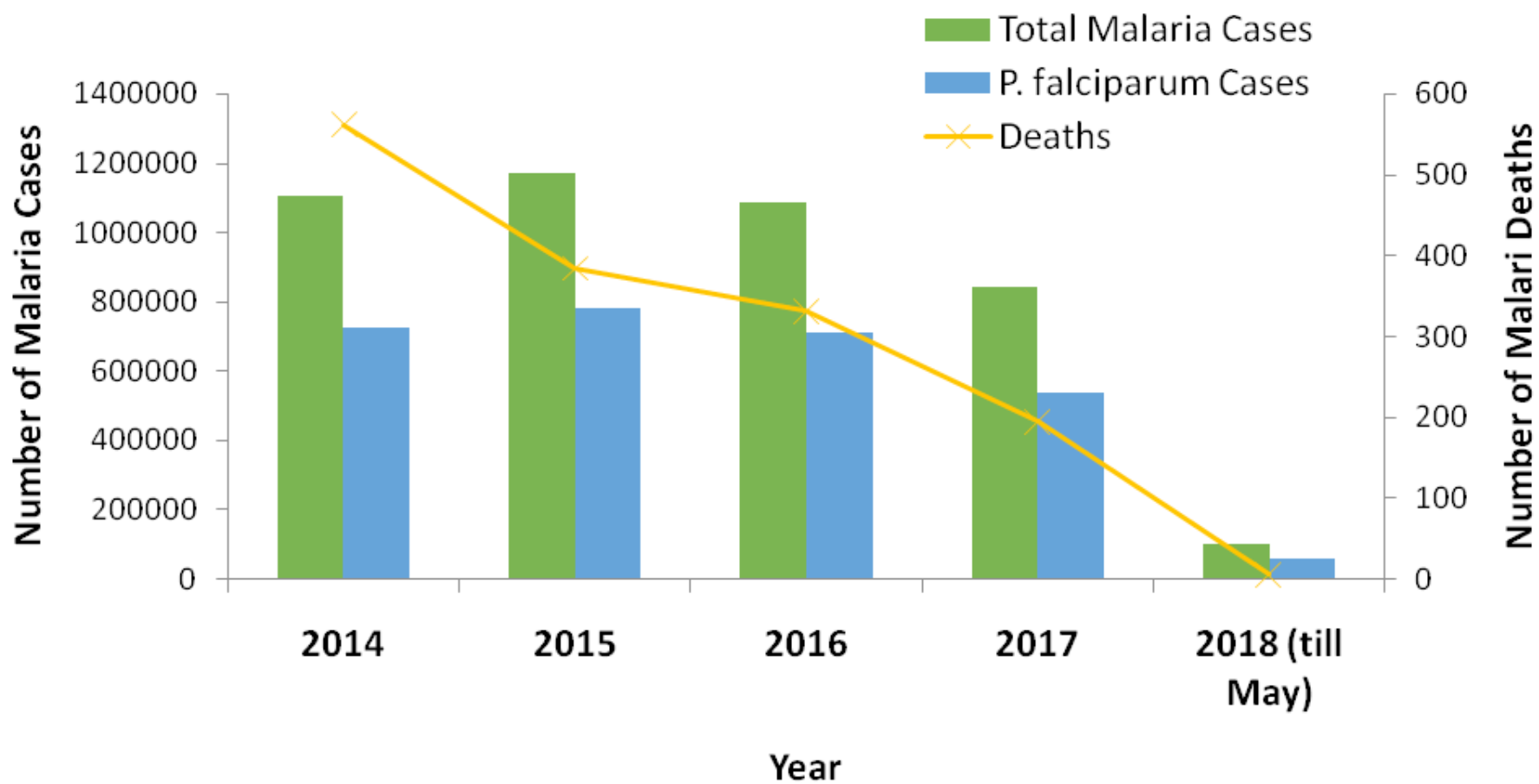
As a result of the above measures initiated in the months May and June 2017, malaria cases dropped by 50 and deaths by nearly 2/3rd as compared to the year 2016 during the months July to December which is evident in the graph given below:

Similar declines continues in 2018 also.

Contact

spmnhmodisha@gmail.com







TAMIL NADU

STEMI/NSTEMI PROGRAMME (An Initiative for Treating Heart Attacks by NHM - TAEI)

Problem Statement

ST Segment Elevation in Myocardial Infarction (STEMI), a grave type complication of Coronary Artery Disease (CAD) is a significant health care problem in India.

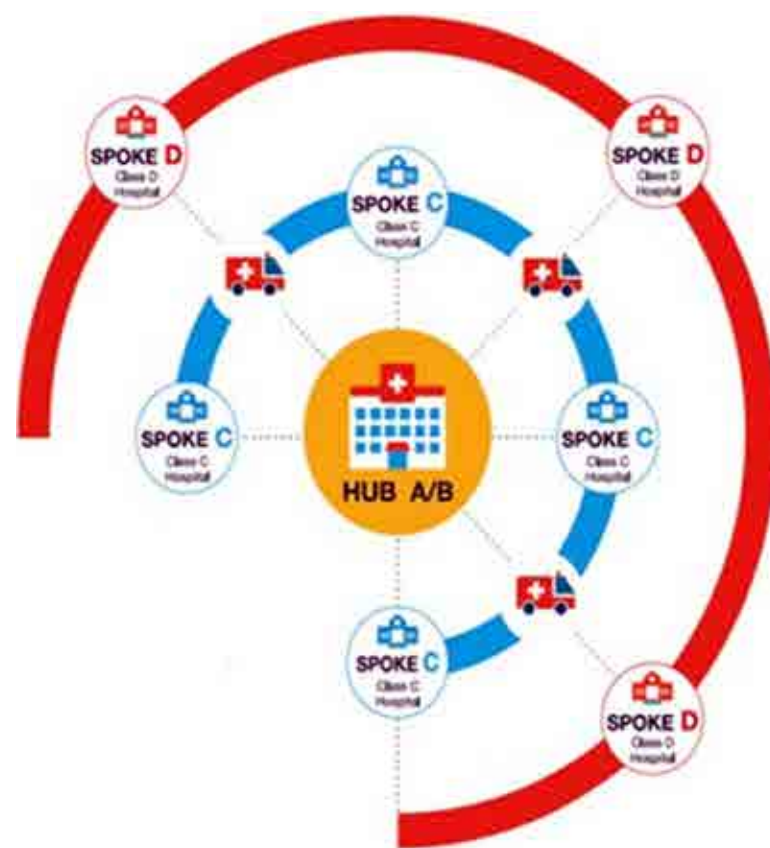
Programme Description

STEMI Programme (ST Elevation Myocardial Infarction) of Tamil Nadu Accident and Emergency Care Initiative (TAEI), Government of Tamil Nadu aims at Free and Prompt Treatment for STEMI. Under this programme:

- HUB and Spoke Model with 4 major components:
 1. HUB Hospital – having a Cath:
 - (i) A Hospital: has Cath Lab functioning 24x7.
 - (ii) B Hospital: has Cath lab functioning in Office Hours.
 2. Spoke Hospital:
 - (i) C Hospital: with ICU setting.
 - (ii) D Hospital: ECG facility within 30 minutes of reaching the HUB.
 3. 108 Ambulance Service – having facility to do an ECG and transmit to a HUB hospital for confirmation of STEMI.

4. Strategic purchase-National health Protection Scheme / State Insurance scheme. Drugs and Consumables under NHM for supplementing medicines, stents, consumables etc for STEMI cases.

- STEMI Kit Equipments which records ECG, Blood Pressure, SPO2 (Saturation of Oxygen) in Ambulance and transmit electronically to the Cardiologist in Hub / Spoke Hospital.
- Cath Labs to be established in 12 Hubs.
- Designation of STEMI coordinator in Cardiology Department of each HUB hospital.
- Establishment of console rooms in HUB hospitals to confirm the findings of ECG transmitted to HUB hospitals from 108 ambulance and provide immediate support to pre hospital phase.
- Training of Cardiologist, Physicians, Radiologist/Intervention Radiologist, staff



nurses and Cath Lab technicians in STEMI management protocol.

- Provision of STEMI kits and drugs to SPOKE hospitals for providing thrombolysis in the ST Elevation Myocardial Infarction patients.
- Implementation of STEMI protocol and training to reduce the door to balloon



and door to needle time in ST elevated MI patients by undertaking Primary Percutaneous Coronary Intervention (PPCI) and Pharmaco-Invasive therapy according to the need.

- Strengthening of CCUs in spoke hospitals to enable thrombolysis and stabilization.
- Linking Chief Ministers Comprehensive Insurance Scheme (CMCHIS) in Government hospitals by providing special STEMI packages.
- Putting in place quality checks and creation of registry.

Programme Outcome

- Daily Reporting

Implementing Partners

- 108 Ambulance Services: Provides emergency Ambulance service.
- Directorate of Medical Education: Runs Hub Hospitals.

- Directorate of Medical and Rural Health Services : Runs Spoke Hospitals.
- Chief Minister's Comprehensive Health Insurance Service (CMCHIS): Provides insurance support for the program.

Scalability

- Will be scaled to entire state.

Contact

rchpcni@tn.niv.in

STEMI/NSTEMI Daily reporting		
S.No	Particulars	06th Sep 2018
A	Total STEMI	29
B	STEMI Lysis done	13
C	Primary PCI	1
D	Pharmaco-Invasive Therapy	3
E	STEMI - Conservative treatment (No PPCI/Lysis)	15
F	STEMI death	0
G	STEMI transferred to HUB with Lysis	0
H	STEMI transferred to HUB without Lysis	0
I	STEMI not transferred/No lysis done	0
J	STEMI not transferred but lysis done	0
K	Total NSTEMI	4
L	NSTEMI Death	0
M	Total STEMI + NSTEMI	33
Total STEMI (A) = B + C + E + H + I		
Total STEMI + NSTEMI (M) = A + K		





आयुष्मान भारत

हेल्थ एण्ड वेलनेस सेंटर
हैदरनगर, पलामू





Non-Communicable Diseases



KARNATAKA

COMPREHENSIVE MENTAL HEALTH PACKAGE



Problem Statement

With effect from 2016, with the goal of Universalizing mental health care, all 30 districts in the state along with Bengaluru city is included under the District Mental Health Program. Apart from expanding to newer districts the mental health program in the state have undertaken several novel initiatives under the umbrella of “**Comprehensive Mental Healthcare Package**” to cater to the needy and under-privileged.

Program Description

- **Manochaitanya or Super Tuesday mental health care clinics:** This is a fixed day strategy to deliver mental health care akin to the Immunization services and Ante-natal care. The goal of this unique initiative of Government of Karnataka is to assure mental health care as near to the door steps as possible. Under this programme, on identified Tuesdays Psychiatrist from DMHP / District Hospital / Medical College provides specialist mental Health Services at the sub-district hospitals. Currently Super Tuesday Manochaitanya clinics are functional in 146 Taluka Hospitals and all District Hospitals of the State.

- **Assisted Home Care Services (AHC):** Generally, about 30 – 50% of patients seeking care drop out after registering under DMHP due to various reasons like financial constraints, inadequate awareness about the illness, duration of treatment, long term prognosis etc. It is critical that patients with severe mental illnesses do not miss treatment and take the treatment for the longer period of time. Since January, 2018, the DMHP Team members of Ramanagar District visit persons with severe mental disorders (schizophrenia and bipolar disorders) who have dropped / missed out of regular DMHP services at their homes, enquire about the reasons for the dropouts, provide psychosocial services, supply medications and try and ensure regular follow-up.
- **Manasadhara Programme:** The State is running Day Care Centre / Rehabilitation centre through an NGO in 14 Districts of the State.
- **E-monitoring District Mental Health Program in Karnataka:** Recognising the need for periodical good quality data, a web based Mental Health Program Management Information System (MHP-MIS) has been initiated across the 31 DMHPs in Karnataka

since December 2016 and has been fully functional with effect from April 2017. The software captures summary statistics of patient care from each of the health facility in the public sector under 5 different modules namely, patient care module, Training and events, Budget & expenditure Human resources and other data. The dash board provides the Program Officer and State Government Officials to monitor activities on a day to day basis.

- **Tele-mentoring:** By way of virtual learning, NIMHANS is providing training to remote health providers across the country i.e. the Medical Officers, Psychologists, Social Workers and Nurses for providing basic mental health services. With the help fo NIMHANS, Bangalore, the Govt. of Karnataka is offering **Tele-On Consultation Training (OCT)** to the Medical Officers posted at the Primary Health Centres. The PHC medical officers, while seeing their general patient pool, are offered guidance and training to identify and treat psychiatric disorders.

Contact

dd6mhkar@gmail.com

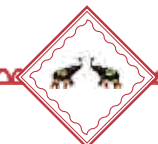






KERALA

INDIA HYPERTENSION MANAGEMENT INITIATIVE



Problem Statement

State of Kerala is currently in the highest epidemiological transition zone with the morbidity, mortality due to NCD surpassing the morbidity & mortality of communicable diseases & RCH combined. This is mainly due to the rampant modernization and urbanization of the population & the subsequent change in lifestyle. Studies have shown that over 34% of the total population is hypertensive, which is substantiated by the National Family Health Survey. The recent studies done by Achutha Menon Centre for Health Science Studies reveal that 1 out of 3 adults in Kerala is hypertensive and the control rates of Hypertension is 13% which is well below International Standards. It is at this stage that the State adopted IHMI Programme supported by WHO, ICMR & vital strategies, for effective management of hypertension in the State in four districts namely Trivandrum, Thrissur, Kannur and Wayanad.

Program Description

All patients above 18 years of age visiting any Health facility will be subjected to BP measurement. Health advice as per the protocol will be delivered depending on the condition of

the patients. Patients found to be Hypertensive will be registered under IHMI programme. The details of the patients will be documented in the treatment card and patient pass books. Advice on life style modification and medicines will be given during each visit as per the protocol.

Patients put on treatment will be subjected to follow up regularly. This will be done by ASHAs and field workers. The responsibility of BP measurement in PHC/CHC is given to the Staff Nurses and to the JPHN at the sub centre level. The follow up date will be given in the pass book along with the medicines and its dosage.

The treatment cards are stored in the Health facilities in a manner to facilitate identification of defaulters and lost to follow up cases. The defaulters will be identified from the treatment card kept in the hospital and alert will be given to the defaulters by followed by Home based tracking by field officers.

Program Outcome

As on October 2018 in Trivandrum district 6860 cases for Hypertension, 3454 cases for Diabetes Mellitus and 6617 cases detected for both has been screened and registered. In Thrissur district 10352 cases for HT, 3652 cases

for DM and 7760 cases with both DM and HT has been screened and registered. In Kannur district 15293 cases for HT, 2882 cases for DM and 7452 cases with DM and HT. in Wayanad district 4428 cases for HT is registered.

Training for 343 Medical Officers, 361 Staff Nurses, 838 field Staff and 358 Pharmacists on IHMI has been completed as on October 2018.

Implementation Partners

WHO, ICMR & vital strategies

Contact

arogyakeralam@gmail.com







PUNJAB

CORNEAL BLINDNESS BACKLOG FREE STATE



Problem Statement

It is estimated that about 1 lakh transplants per year is the requirement in India for tackling bilateral corneal blindness. As the population of Punjab is about 2.25 % of population of India the expected figure for Punjab is about 2250. Alternately, considering the population of Punjab as 2.80 Crores, 1.0% i.e 2.8 lakh are blind and about 1% of the total blind i.e 2800 are bilaterally Corneal Blind out of which 50% are having associated involvement of posterior segment so cannot be treated with Keratoplasty. About 400 new cases are added annually. Thus, this second method also shows approximately the same number of estimated optical keratoplasties required to be done to take care of the backlog of corneal blindness treatable by keratoplasty. So, there is a requirement of approximately 4000 corneas considering that 50% are worth utilization for optical purpose.

Program Description

Corneal blindness backlog free Punjab was launched by the department of health Aiming at making Punjab Corneal Blindness Backlog Free State to ensure that there must not be any patient in the State suffering from blindness because of corneal disease in both eyes to make it. Various activities were conducted under the program which included Eye Donation Fortnight is celebrated across all districts of the State where people pledged to donate their eyes and Statewide campaign is being organized in which a dedicated audio-visual awareness van visits all major cities and towns to motivate the people to donate their eyes. Road map concerning upgradation of the infrastructure of eye banks and capacity building of Ophthalmologists to achieve the target in a time bound manner was conducted. Also, special screening camps are being organized at district level to screen treatable

corneal blind patients who are interested in surgery and referring nearest Cornea Transplant centres.

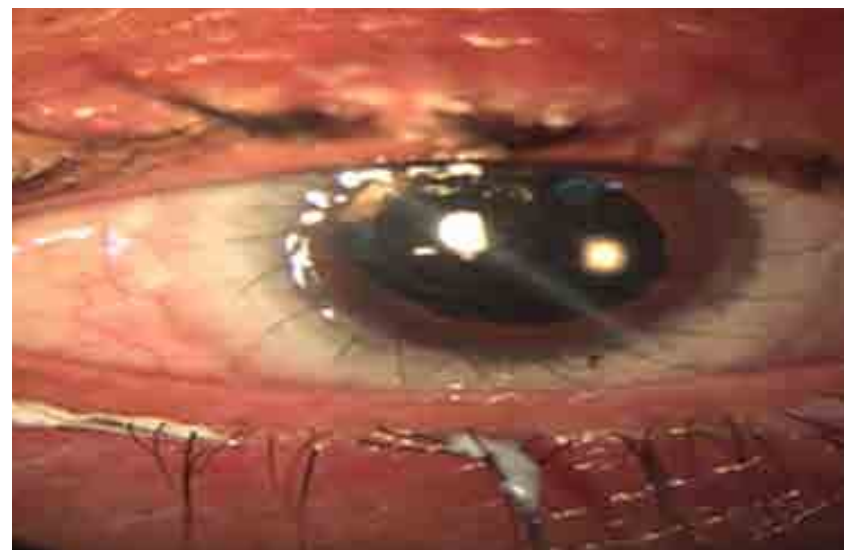
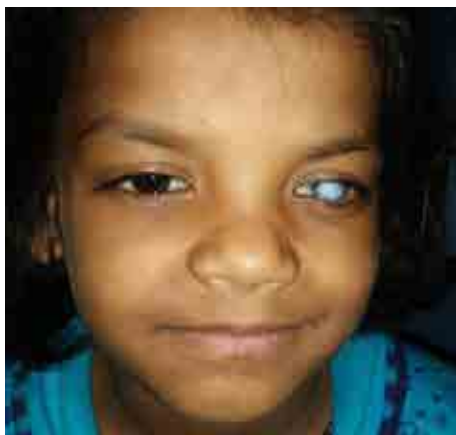
Program Outcome

More than 1,350 keratoplasties had been performed on patients between March 2017 and April 2018 for which 1,119 corneas had been procured and 735 corneal transplant surgeries had been performed at registered keratoplasty centers.

Contact

npcbpunjab@gmail.com







TELANGANA

KANTI VELUGU



Program Description

The department of Health Medical & Family Welfare under Government of Telangana basing on the results of pilot project taken up in association with an NGO in one of the district in the State has ventured upon enlarging the scope across State, for empowering the people with clear vision, through negating their blindness through an approach desired as avoidable blindness programme.

The Avoidable Blindness Free Telangana approach programme is basically attempting to screen all the deserving people through a camp approach, distribution of spectacles to those who are in need of prescription glasses and identifying those who need surgical intervention. The first step in the programme include dissemination of the camp details, need for eye screening and information on eye surveillance through IEC via., print and electronic media. Secondly, deciding on the number of paramedical ophthalmic assistants, ophthalmologists and sub-health staff needed for the camps that are planned across the State over a period of initially 6 months for saturation

of the approach across the State. Thirdly, training all those who are to manage the in screening camps, prescription and referral and documentation of ophthalmic cases. Fourthly, to equipping the camps and the Government hospitals with required screening, and surgical equipment and medicines. As a part of this, inspection of all those private hospitals who are networked into this approach for their readiness, and competence to be part of the programme.

The highlights of the programme include an AADHAR based data compilation of the patients who are screened, provided with prescription glasses and referred for surgical intervention and linked to the specially hosted website kantivelugu.telangana.gov.in. This is essentially needed to weed out the duplication and service the genuine patients.

The majority of the funds to the programme is through State budget, which essentially include training provision of medicine and essential equipment, prescription glasses to all the needy and reimbursement of surgical intervention fee.

Program Outcome

The latest statistics as on the date of the report (which changes every day as the programme is continued) is as follows:

Program has covered 33% of the population of the state across 2806 villages in 31 districts Out of the 900 camps planned 825 camps were conducted through which 62 Lakh population screened. 4 Lakh cases were referred for surgery in which 1 Lakh cases underwent surgical treatment. 10 lakh prescription glasses were ordered in which 5 lakh glasses were distributed.

Contact

jdnpbts@gmail.com







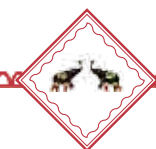


*P*MINCH+A



BIHAR

REDUCING NEONATAL MORTALITY BY ADDRESSING THE GROUP AT THE HIGHEST RISK: Implementing Simple Interventions to Identify and Support the Care of Preterm and Low Birth Weight Babies at State-Wide Scale



Problem Statement

India contributes to 27% of the total global neonatal deaths in every year. The preterm birth rate in India is between 12-14%. Annually 3, 80,000 babies are born preterm with low birth weight (LBW) in Bihar as per current estimate. Low birthweight and preterm birth are underlying causes in 70-90% of all neonatal deaths. Protocols for the identification and care of high-risk neonates at birth in the community (HBNC/C-IMNCI) and facility level (FBNC) exist, their implementation is variable across different states.

Program Description

Taking advantage of the relatively high institutional delivery rates in Bihar, it was decided to first introduce the identification and care of weak newborn babies in public hospital labour rooms and utilize ASHAs for supporting the continuing care of such babies at home after discharge from hospital.

The intervention for public facility births consisted of the following elements:

Identification of weak newborn babies born in government facilities and informing the

family that the baby is weak and needs careful attention to warmth (KMC, delayed bathing), cleanliness (hand-washing, cord care) and breastfeeding.

Offering referral to SNCUs.

Initiation of KMC in the hospital and counselling for continuing the practice at home.

Pre-discharge counselling, explaining to the parents the need for hand-washing before handling, dry cord care and frequent breastfeeding; and about danger signs suggestive of sepsis and where to seek care if and when they manifest.

Registration of the best available mobile phone number of the family.

Issuing a 'passport' (an identity card) to the baby, which can facilitate greater attention in case of referrals.

Notification of the ANM and ASHA of the village of residence of the weak baby. A full line list of weak babies maintained by the ANM.

ASHA to visit the family at least once daily for the first week, and provide support.

Telephonic follow-up of both, the family and the concerned ASHA by the respective PHC. Cross-notification of the birth of weak babies

by District Hospitals to respective blocks and across blocks where appropriate.

Program Outcome

The proportion of babies recorded as very low birth weight (<1500 gms) steadily increased from about 5% of all weak babies to about 20% over the four rounds, with a steep increase in this proportion between the last two rounds (11.6% in R3 and 19.9% in R4).

Birthweight adjusted rates of timely initiation of breastfeeding increased from 65% to 77% over the four rounds and KMC rates increased nearly four-fold to around 20% over the rounds.

Birthweight adjusted reported morbidity (any morbidity) reduced from 57% to 39% over the rounds.

There was no significant change in unadjusted mortality rates over the rounds, it remained between 16-19%.

Birthweight adjusted mortality rates reduced from 22.1% to 11.9% over the four rounds, a decline of around 46%.

Implementation Partner

The Technical Support Unit (TSU) headed by CARE.



Financial implication

The total cost of this project including Telephone costs and cost of printing is budgeted at Rs 42,00,000/- per annum.

Scalability

Already implemented at scale through public health systems.

Contact

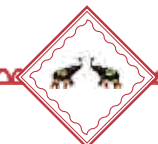
hshah@careindia.org





KERALA

SHALABHAM - Comprehensive Newborn Screening Programme



Problem Statement

Estimates shows that children living with CHCD in Kerala under the age group of 0-14 years is around 80,000 and there are about 4000 new CHD cases identified every year. Out of which 1023-1364 cases requires surgical treatment. The estimated surgical treatment coverage for CHD is around 34% in the state and the remaining cases are unaddressed.

Birth Defects usually manifest at birth and can be identified at the delivery points who are referred to higher centers for further evaluation and management.; however, some defects do not begin showing symptoms until a few weeks or months later would require further examinations.

Program Description

Govt. of Kerala launched the “Shalabham Programme” for ‘Quality of Survival beyond Survival’ for new-born by pooling funds from RBSK and Arogyakiranam. Under this initiative, a comprehensive clinical examination is to be performed on all babies, usually within the first 48 hours of life. This consists of a full physical assessment from head to toe, to identify any visible defects and also to reassure parents that their baby is healthy. The examination is to be performed by the Staff Nurse/RBSK

nurse, facilitated by the Pediatrician or Medical Officer. The Newborn examination is part of a range of post birth screening opportunities, which includes:

- a) Screening for Visible Birth Defects
- b) Pulse Oximetry screening for CHD
- c) OAE screening for hearing
- d) Neonatal blood spot examination for IEM.

Free treatment is ensured through the public health facilities and follow up is ensured through the DEICs. All delivery points are supplied with Tablet with internet connectivity and all RBSK nurses are trained.

Hridyam for Little Hearts

Hridyam is a web-based solution for system management of care of children with Congenital Heart Disease (CHD). This can be used as web based registry for CHD cases across Kerala, monitoring the progress of program envisaged for management of children with CHD.

The dashboard gives information on prevalence of low birth weight and Pre-term birth among babies born in public delivery points. As per the present system planned under ‘hridyam’ cases shall be registered from any location through web page hridyam.in by any target beneficiary

using internet. The case will be notified to concerned DEIC of the district where the child lives. During case registration immediately on filling the basic information the child will get an automatically generated unique register number which will be used as Case Number for the particular case. On getting alert on case registration DEIC will check whether all forms are filled. On completion of registration (completing all five steps of registration and verification by DEIC) the case will be categorized primarily into category 1, 2 or 3 and will be reflected on the table put in the dashboard.

Program Outcomes

Program started on June 2018 in all 99 Delivery points across Kerala for Visible Birth Defects (VBD), 49 Institutions for Pulse Oximetry screening (49) and OAE screening in 42 delivery points. As on date over 55000 children are screened and over 800 VBD identified.

Financial Implication: The budget for RBSK for this financial year for referral treatment is almost Rs 35 Crore and state has allocated Rs 35 Crore under Arogyakiranam.

Contact

arogyakeralam@gmail.com







MADHYA PRADESH

COMPREHENSIVE NEWBORN SCREENING IN DISTRICT HOSPITALS



Problem Statement

Birth Defects have been recognized globally as a major contributor to neonatal and infant mortality and disability. As per available estimates, 6% of children are born with serious Birth Defects every year worldwide. In India 7% of under-5 year deaths are attributed to congenital anomalies or birth defects, annually more than 17 lakh children are born with a Birth Defect contributing to 10% of neonatal mortality and 4% of infant mortality.

Visible birth defects are those that can be seen in infants, such as clubfoot, cleft lip and cleft palate, to name a commonly seen few. Birth Defects usually manifest at birth and can be identified at the delivery points.

Program Descriptions

Strengthening delivery of quality maternal & newborn services is one of the priority areas for National Health Mission of Madhya Pradesh. The state also took a visionary decision to ensure that all newborns born in public health facilities will be screened for various developmental diseases and birth defects within 48 hours of delivery across state. In first phase

all the newborns delivered at District Hospital are being screened for visible birth defects on 68 different parameters. As part of the NHM initiative in each district hospital team two or three staffs nurses of labour room & SNCU who have been trained in Comprehensive Newborn Screening. **NHM provides, a beacon of hope to improve survival of newborns delivering in public health of Madhya Pradesh making optimum use of existing manpower.**

Evaluation Result

Initially under RBSK program screening for defects done by RBSK mobile teams.

Currently comprehensive newborn screening is being done in all 51 district hospital with trained staff.

Training given to staff working in labour room & SNCU by state & National level trainers. Apart from that Skill Lab staff & Nursing Mentors are also being trained to further orient field staff on identification of visible birth defects.

Total 15 Medical Officers, 17 Skill Lab trainers, 29 Nursing mentors & 122 staff Nurses working in Labour Room & SNCUs are trained at State level.

Reports from all 51 District Hospitals are collected in specific reporting format.

Approximately 2% of newborns were identified for visible birth defects out of total newborn screened from May 2018 to September 2018.

IEC material (Charts developed by GOI for identification for Birth Defects) was displayed at Labour Rooms, SNCUs & Follow up OPDs.

Record keeping & reporting formats (Screening Record Register, Screening Charts & Monthly Reporting formats etc) developed in close coordination with State Government Officials & other technical experts.

Web based online monitoring system for Data analysis & android based mobile application for data entry is under development.

Contact

ddchnhm@mp.gov.in







MAKING OF A HUB : The Story of RKSK



Problem Statement

One of the key interventions under the RKSK programme is introduction of the Peer Educators (Saathiyas) who act as a catalyst for generating demand for the adolescent health services and imparting age appropriate knowledge on key adolescent health issues to their peer groups. As per the national guidelines, Saathiyas are expected to form groups of 10 -15 adolescents and conduct weekly meeting with the group. They are expected to use the RKSK modules to conduct these meeting, without any job aids. Several challenges for Saathiyas were observed in field such as complicated guidelines which were difficult for the Saathiyas for understanding, unavailability of time, lack of mentoring etc.

Program Description

To provide an enabling environment to Saathiyas for effectively and enthusiastically conducting monthly peer meetings, innovative solutions are implemented:

- Based on the findings regarding the user-friendliness of the RKSK module for conducting the meetings, simple and

innovative job-aids, in form of comics and animations, were developed and Saathiyas were trained on how to transact these within their peer groups.

- Topics were identified for a total 24 of comics. Already, 12 have been printed and remaining 12 are in the process of development.
- Co-ed groups were formed for conducting the meetings on general topic, while separate discussions were organised for boys and girls on topics which are sensitive in nature.
- It was decided to invest in developing the soft skills of the trained Saathiyas, especially to groom their leadership and communication skills for effectively conducting peer meetings.
- A mentoring chain was developed to overcome last-mile challenges. This chain serves a dual purpose: Firstly, it works as a cascade model for mentoring, and secondly, it forms a logistic chain to distribute a new comics, every month, at the village level.

Program Outcome

The comics were found to be useful for the Saathiya Brigade sessions. Regularity of

Brigade meetings has increased from 86% to 93% in 4 months, while attendance of members from 50% to 72%. The Saathiyas, and the Brigade at large, are now more confident and understand the process of physical and mental changes that happens in this age group. There is positive peer pressure among brigade members to address harmful behaviour and adopt healthy habits.

Implementation Partners

National Health Mission and UNFPA

Financial Implication

Annual expenditure is approximately Rs. 2,700/ village/month.

Scalability

The model can be replicated and scaled up in other parts of the country. The state governments of Odisha, Maharashtra and Rajasthan have adopted the comics, with Odisha translated the series into Odiya.

Contact

ddarsh2011@gmail.com







MAHARASHTRA

RESPECTFUL MATERNITY CARE (RMC) : Bringing About Changes in Clinical Practices



Problem Statement

In this modern era, despite the overall advances in maternal health outcomes/care, ensuring the women to have skilled and respectful care during delivery remains a challenge. In government facility, implementing RMC is a huge task. We have planned to implement the core components of RMC so that all women would be benefited by the process of humanizing labour there by decreasing maternal, perinatal mortality & morbidity.

Program Description

To address the ongoing issue of disrespect & abuse, we have implemented RMC to preserve the seven rights of labouring woman. We have implemented the following interventions Formulated Standard Operating Procedures (SOP) in OBGY:

- Providing birth companion
- Modifying the pre-existing beds to birthing beds at a minimal cost and allowing the mother to adopt the position of their choices.

- Specially designed personalized consents for each condition in labour room in local language.
- Triaging for treatment.
- Providing privacy by arranging curtains, soothing effect by music.
- Applying safe child birth check list in labour room and safe surgical check list in Operation Theatre.
- Curtailing the number of episiotomies.
- Caesarean audit by Robson's Classification.
- Provision of suggestion & feedback box.

Program Outcome

This project yielded better care. We have measured the impact at facility level. Decrease in caesarean section rate, decrease in unnecessary intervention during labour, early initiation of breast feeding & decrease in maternal morbidity and mortality is noted.

Financial Implication

RMC practices has led to save government financial resources. This has also reduced the

out-of-pocket expenditure from the laboring women and their families.

Scalability

- Sensitization workshops in collaboration with WRA for staff.
- Display of IEC material in antenatal OPD and wards to create awareness.
- Use of electronic media for promotion of RMC.
- Propagation of RMC at national, state and regional levels.

Contact

gadappashrinivas@gmail.com



सन्मान मातृत्व सेवेचा

Honour for Respectful Maternity Care



स्वच्छता अभियान अंतर्गत अखंड आणि अद्वितीय रुग्णसेवेच्या गौरवासाठी प्रथम पुरस्कार प्रसुतीगृह (Labour Room) दि. १५ ऑगस्ट २०१८

BEFORE



AFTER





RAJASTHAN

SYSTEMATIC ROLLOUT OF INJECTABLE CONTRACEPTIVE (MPA)



Problem Statement

Government of India launched the new injectable contraceptive (MPA) with the aim of expanding the basket of choices and address the unmet need of the beneficiaries. For a state as large and as diverse as Rajasthan, the introduction of any new intervention comes with its unique set of challenges as was the case with Injectables.

Program Description

The state decided to implement the services in a phasic manner and roll out the Antara programme in Bhilwara district, which has an unmet need of 12.4, out of which 5.7 is for limiting and 6.7 is for spacing. The Additional Chief Medical Officer of Bhilwara district was trained as a Master Trainer of Antara programme in order to cover all the technical aspects of the programme with in-house skilled personnel. Meticulous planning went into the pre-launch phase of the new contraceptive which included identification of facilities, staff to be trained and ensuring an adequate

supply. Over 1800 ASHAs were oriented on the Antara programme with particular attention to counselling aspects in order to prevent and deal with any associated misconceptions at the field level. Strong emphasis was also laid on the importance of timely administration of the subsequent follow-up doses.

Program Outcome

Total 17,525 doses were administered in District Bhilwara in 2017-18. Around 78% of the beneficiaries who had been administered the first dose returned for the second follow-up dose and a further 70% of beneficiaries who had taken the second dose returned for the third dose. Rajasthan State had administered a total of 34,479 doses in 2017-18, accounting for 23% of the entire country's share, which was highest in the country. Out of this, 52% of the doses were utilized by Bhilwara district alone. Till date in 2018-19, we have already administered 33,123 doses. These results can be attributed to the systematic planning, roll out and monitoring of the scheme. A software is also in the pipeline for real-time

tracking and monitoring of the Injectable contraceptive data. Therefore, the same model which has proven successful is being utilised to implement the scheme effectively across the state.

Implementing Partner

Government of Rajasthan has rolled out all the initiatives.

Financial Implication

The trainings of personnel, supply of Injectable contraceptive as well as printing of the MPA cards and registers are budgeted for in the Annual PIP.

Scalability

Roll out of Injectable in Bhilwara is a success story in the State and this model of implementation is been shared with each district for the same to be replicated.

Contact

projectdirector.fw@gmail.com

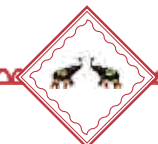






TELANGANA

SETTING UP OF A LABOUR DELIVERY RECOVERY ROOMS



Problem Statement

There has been an alarming decline in natural births and a constant rise in the C-Section rates in the country. This has therefore led to an increase in the demand of the skilled health care providers for necessary care. The C-section rate in the state is about 60%, highest in the country. This necessitates the initiation of program to fulfil the gap to meet the unmet needs of the population. Therefore, the state has made a provision for the initiation and scaling up of the midwifery.

Program Description

The objective of the program is to improve maternal health in the State, with a determination to make care more evidence-based, bring down interventions and promote Respectful Maternity care and thereby “Natural births”. The midwifery model of care is based on the fact that pregnancy and birth are normal life events, although complications can occur at any point in the childbearing cycle.

The state of Telangana Initiated Midwifery training programme on 1st November, 2017 at MCH KARIMNAGAR with 30 Staff nurses with experience of more than five years and 3 rounds

of selection which included test of knowledge, skill test and aptitude test. The training also included regular monitoring and technical support as well as sessions by national and international experts.

Program Outcome

Telangana state is leading in the country to take up the initiative of starting Midwifery programme and creating Professional Midwives:

- 126 Midwife posts have been created to provide dedicated Maternity services.
- The first 30 selected candidates are undergoing training. They will be trained for one year followed by 6 months internship.
- The training is as per seven competencies mentioned under International Confederation of Midwives (ICM) standards.

Implementation Partners

PPP between the Ministry of health and family welfare, Government of Telangana, Fernandez group of institutions and UNICEF for development of the Professional Midwifery skills of nurse.

Scalability

The State of Telangana has taken lead in the country to take up the initiative of starting Midwifery programme and creating Professional Midwives. 126 Midwife posts have been created to provide dedicated Maternity services.

With support of ministry to support scale up of Midwifery across.

Contact

cponhmts@gmail.com







WEST BENGAL

OPTIMAL CONTRACEPTIVE METHOD-MIX



Problem Statement

West Bengal houses 8% of India's population (Census 2011) and struggles with a high growth rate despite overall reduction in total fertility rate is 1.6 (SRS-2016). This is also compounded by a high teenage fertility rate which was affecting the overall maternal health. A qualitative and quantitative approach to contraceptive use helped in reducing the pace of fertility initially. However, a concomitant reduction in maternal and infant mortality could not be achieved and the state continues to grapple with a high MMR-101(SRS-2014-16).

Program description

The family planning program seeks to promote responsible and planned parenthood on a voluntary basis. Almost a decade ago, the state's goal was to reduce the growth rate which resulted in a skewed contraceptive method-mix leaning towards permanent methods. On the contrary, evidence says that a well spread out basket of contraceptive options in accordance with reproductive rights can lead to significant reductions in maternal

mortality, infant mortality and abortion rates. After detailed analysis we realized that the only way forward was to reinvigorate the hitherto dormant FP programme by making available the whole range of contraceptive choices and substantially increase our contraceptive uptake. Hence, the state effected a paradigm shift wherein focus was given to a well spread out basket of contraceptive method-mix. The state undertook systematic trainings, counseling, inclusion of newer contraceptives, strengthening of post-partum services as well as ensured the uninterrupted supply of contraceptives by the front line workers right down to the last mile and emphasized upon spacing methods with a focus on informed choice.

Program Outcome

As an outcome of these initiatives, the contraceptive prevalence (mCPR) has increased by 7% from 49.9 in NFHS III to 57 in NFHS IV and the share of spacing methods has increased by almost 30% from NFHS I to NFHS IV. With this result the state now boasts of contributing to the highest share of combined oral pill (23%), post-partum IUCDs

(17%) and post abortion IUCDs (13%). The state also has the highest PPIUCD acceptance rate of 40% while it ranks third highest in male sterilization services. West Bengal has a method mix which focuses equally on limiting as well as spacing methods and a balanced contraceptive mix is indicative of the improved access as well as fulfilment of reproductive rights. This is paying us rich dividends as all these efforts have led to the aversion of 46 lakh unintended pregnancies, 1.53 lakh unsafe abortions and 1500 maternal deaths in this year alone (Source: Track 20).

Inference

It is apparent that a low TFR has hardly any co-relation with the persisting high maternal mortality and morbidity.

A well spread out basket of contraceptives in accordance with reproductive rights can lead to significant reductions in maternal mortality, infant mortality and abortion rates.

Implementing Partner

Government of West Bengal has rolled out all the initiatives.



Financial Implication

The operational cost including the training components for the program is funded under NHM PIP.

Scalability

This program is very easy to scale and is set to expand further thereby reaching a much wider range of beneficiaries.

Contact

mdnrhm@wbhealth.gov.in

dhswestbengal@gmail.com





MUHM



MAHARASHTRA

MODEL URBAN PRIMARY HEALTHCARE PROJECT, NAGPUR



Problem statement

Improve access to primary health services to begin with and demonstrate a model where assistive technology, appropriate referral, better supply chain management will improve quality of diagnosis, treatment and treatment outcome. A baseline scoping study of the all UPHCs was done. As per results, it was perceived that there is scope of improvement in utilization of services. Further gaps in terms of access to doctors, appropriate diagnostic services, comprehensive medicines and most of the referral systems are not intact in terms of tracking the cases completely. Thus the project is designed to bridge the gaps noticed and demonstrate a model UPHC network.

Project description

The project intends to complement interventions for health system strengthening. The project aims to create a model for delivering smart healthcare services for the vulnerable sections of the society and is aspirational to all.

UPHC is nodal point for delivery of primary health care services in cities under the National Urban Health Mission. The model UPHC will strive to become a state-of-the-art facility that will offer holistic & comprehensive primary care services by leveraging human resources and supplies from NMC. It will create appropriate referral mechanism to address medical conditions requiring higher level of care. Further it will assist them in seeking diagnostic care, care at other facilities and referral services without hassles.

Key approach would be to demonstrate use of technology for enhancing access to 'desirable' quality of care.

OBJECTIVE:

- To demonstrate a 'model Urban Primary Health Centre' network catering to 'primary health care needs of urban poor'

Program Outcome

- Out of 26 clinics, about 8 clinics are transformed with infrastructure upgrade, IT system and training inputs.

- Nearly 24600 patient data is digitized and analysis being used by the clinics.
- Central Laboratory for the benefit of patients in all 18 UPHCs is operational with NMC rates. Till 26th September 2018 total more than 5000 tests were processed & results are sent to respective UPHCs.
- Targeted IEC through digital signages is being provided, evaluated by beneficiary's feedback.
- 10 clinics work in progress and will be completed by Oct 2018.

Implementing Partner

NUHM Maharashtra

Scalability

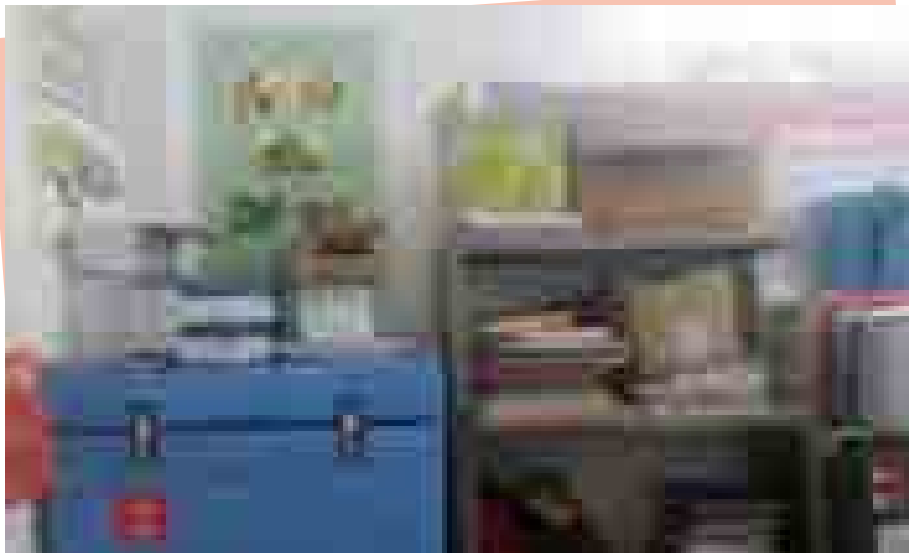
Can be scaled up in other corporations and councils.

Contact

shsrc.gom@gmail.com



BEFORE



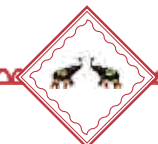
AFTER





ODISHA

AMA CLINIC: Our Clinic... Providing Comprehensive healthcare at UPSCs through engagement of specialists



Program description

Launched by Hon'ble Chief Minister of Odisha AMA Clinic launched on 19th December 2017 to extend need based specialist services on weekly basis in the urban areas by providing composite packages of specialist services, which will reduce out of the pocket expenditure of urban population. This reduces the burden of the district hospital and tertiary hospitals and to provide quality of the health care.

Weekly Specialist available in AMA Clinic

1. O & G specialist
2. Nutritionist
3. Pediatric specialist
4. Eye specialist
5. Medicine/Geriatric specialist
6. Skin-vd specialist
7. Psychiatric specialist
8. Physiotherapist
9. Counseling services

Program outcome

- Average patient received the specialist services per month is 44883 in 73 UPHCs.
- 2,41,967 patients have been received specialist services under AMA clinic from December 17 to July 2018.
- 73 UPHCs are providing the specialist services under AMA clinic out of 85 UPHCs.

Scalability

Keeping in view the success of AMA clinic, the same services can be extended to the institutions located other towns and rural areas. The secondary/ tertiary care hospitals and medical colleges can be mobilized to depute the specialists to periphery hospital.

Contact

spmnhmodisha@gmail.com







RAJASTHAN

NUHM- Mahila Arogya Samitis (MAS) Experience



Problem Statement

Communities play a vital role in promotion of healthy behaviours and prevention of diseases. Community possesses several resources – human and financial that can be used to enhance the quality of health care and effectiveness of health care services. Mahila Arogya Samiti (MAS) is one of the key intervention under National Health Mission aimed at promoting community participation in health at all levels. MAS is expected to take collective actions on issues related to Health, Nutrition, Water, Sanitation and social determinants at the slum level.

Programme Description

MAS Kota actively participates in the health-related activities of all the departments and apart from that they are also involved in other program like.

“Kishori Shakti Sanghthan”

An initiative to connect 4-5 adolescent girls (12-18 years) with MAS group to address concerns and raise awareness on management of menstrual hygiene, women safety in vulnerable population and to reduce school dropout rates among girls. Sanghthan provides regular updates to ASHAs and MAS on distribution of Iron tablets in schools, mid-day meal status,

sanitation status in schools and based on this feedback, NUHM district officials works with concerned department for improvement.

Behaviour Change Communication

Through awareness activities using medias like “Nukkad Nataks” focussing on issues related to Social Determinants of Health and on the various schemes and programs for health. MAS members discourage selling of tobacco products in slums by raising awareness among shopkeepers as well as among the community. During UHND, MAS members visit Anganwadi Centers and mobilize cases for ANC and Immunization. Exposure visits to health care facilities and Special Amavasya Drive for immunization of children of the vulnerable groups of labours are organized as part of the special drive.

Sanitation & Hygiene Practices

During the house visits MAS members educate and generate awareness among the community on proper WASH practices. This resulted in construction of 60 household toilets. They also regularly monitor Community Toilets (SULABH) of their slum areas for hygiene and cleanliness. MAS members were trained for solid and liquid waste management with the support from the local NGO, which they spread among the community and monitor the cleanliness of the community.

Programme Outcome

Convergence Actions

MAS members are working in close coordination with other departments like ULB, ICDS, PHED etc with the help of ASHA & PHM. As a result of regular follow ups with Ward Corporator they have constructed Roads in their Slum.

Livelihood

NUHM has provided special trainings to MAS members to prepare environment friendly sanitary napkins with the support of NGOs. This has empowered them to support their families financially. Some areas in Kota are also linked with National Urban Livelihood Mission where MAS members are part of Self Help Groups and have received various vocational trainings.

Scalability

This state experience highlights the effects of an active MAS committee on the community. Similar activities can be conducted by other MAS committees in different regions of the country for context specific solutions to health issues and contribute to the well-being of the community.

Contact

md-nrhm-rj@nic.in







TAMIL NADU

GIS MAPPING VULNERABILITY ASSESSMENT in UPHC of Madurai Corporation under NUHM



Problem Statement

Area demarcation in urban area and peri-urban areas are of high task. During Madurai corporation expansion 33 HSC area were converted to 28 wards, which resulted in many no man land coverage area developing many hamlets, increase in poor family planning, maternal death due to dual control service.

Programme Description

Geographical Demarcation Mapping for the vulnerable population was a done through a well-trained survey team and uploaded in **MAPinr app**, a user friendly software capable of data capturing and location point of interest (vizlatitude and longitude). The maps are developed with the details of slums and vulnerable area and population identification with Vulnerability Assessment index ie. Residential Vulnerability, Social Vulnerability, Occupational Vulnerability, Health Related Vulnerability. Available health facility with buffer of Vulnerable area mapped <1, 1-2, >2 Km

and are super-imposed, digitalized and plotted on GIS map. GIS mapping helps in intersectional coordination of various departments like NULM shelters, Socio Economic cast census under Ayushman Bharat Yojana, Town planning department, Integrated Child Development Services department.

Programme outcome

- a) Reduction in MMR – pinning the location of the no man area and continuous monitoring of mothers in that area.
- b) Reduction in Dengue fever cases – source identification and reduction.
- c) Planning - Mission Indradhanush, Muthulakshmi Reddy Maternity Benefit Scheme – ANC care coverage.
- d) Town planning - Reduction of overcrowding in the Madurai Corporation.
- e) NULM location identification and utilization (basic medical care and shelter) in urban areas for the needy.

Implementation Partner

Corporation of Madurai, Tamil Nadu, India

Financial Implication

National Health Mission - Project cost of Rs. 8 lakhs, as a pilot project.

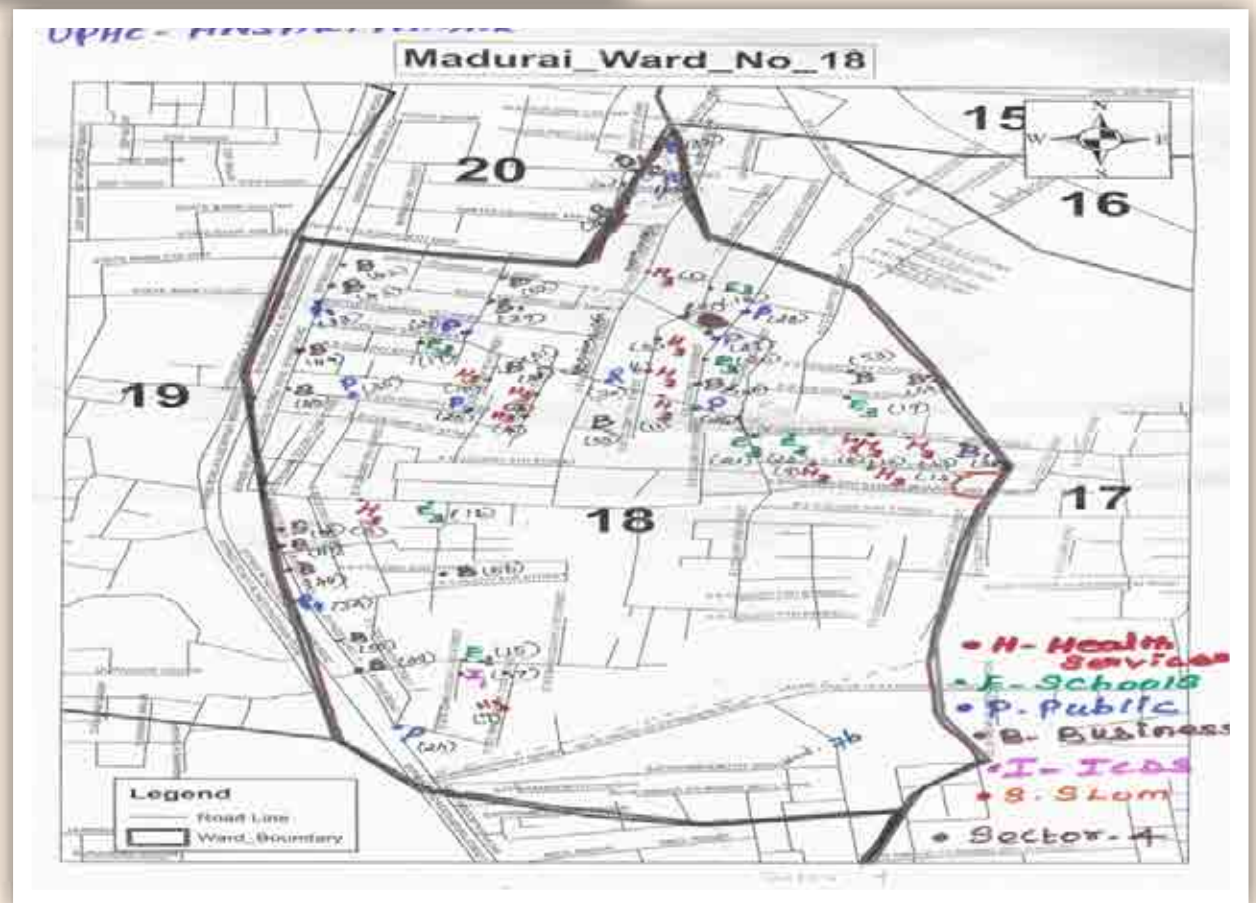
Scalability

Can be scalable to entire state with multiple programme/ department compatibility.

Contact

nuhmtn@gmail.com









 E-HEALTH



ASSAM

SWASTHYA SEWA DAPOON - An Integrated MIS-GIS System



Problem Statement

State has implemented online “Health Management Information System (HMIS)” from 2008 and “Mother & Child Tracking System (MCTS)” from 2011. In addition to regular data collected through HMIS and MCTS, tones of additional data collected through Excel and other formats as all required data are not captured through HMIS and MCTS. All systems were running in silos and there was no correlation between the systems. Compiled report from two systems was not possible. There was specific gap of information collected for HR data, ASHA related activities, VHND monitoring, financial monitoring, Health infrastructure development etc. In fact there was no concrete HR database and for every instance, separate reports were collected from districts based on which decision of posting and transfer were done which often resulted erroneous decisions.

Program Description

To overcome the gaps, National Health Mission, Assam started development and implementation of Integrated MIS GIS System (Swasthya Sewa Dapoon) in phase manner. The system has been developed using in-house

capacity of NHM Assam and it is hosted in NHM own server. Main objective is to develop and integrate all health related databases in a single platform so that, data can be shared between the systems.

Following strategies adopted during implementation of the system:

- i) Single Database Structure: The system was developed in single database structure. All modules shared the same master tables which make it easy to integrate the system and share data between different modules.
- ii) Single entry: In the entire system, one data will be entered only once. If one data is captured in one module, then the same data is shared with other systems and it will not be entered second time in other system to avoid duplicate data which resulted error in data.
- iii) Open Source Technology: The system has been developed using open source technology.
- iv) Use of in-house capacity: The system has been developed using in-house capacity of NHM, Assam and the system is also hosted in the Server of NHM Office.

Outcome of HR-MIS System

- i) Entire HR database of Health & Family Welfare Department is available on a click of the mouse.
- ii) Centralized salary disbursement of 100% NHM employees within the last week of every month which has increased the motivational level of employees.
- iii) Salary linked with grading of performance appraisal.
- iv) Faster recruitment process by using online application module which also helped for sorting eligible candidates.
- v) Online transfer and posting for both employees under State health service and under NHM which helped real time updating of information.
- vi) Transparency of system by publication of HR database in public domain.
- vii) Transparent posting on merit basis through counseling and on the spot distribution of appointment letter.

Contact

spm.nhmassam@gmail.com



Major modules under Swasthya Sewa Dapoon



SWASTHYA SEWA DAPOON NHM, ASSAM (Integrated MIS-GIS System)



About Integrated MIS-GIS System

Integrated MIS-GIS System has been developed by integrating all the programmes under one roof. The Objective is to get the information of different programmes in a single window. The system has been developed in open source technology using the in-house capacity of National Health Mission, Assam.

Dashboard :

	Maternal Death
	Infant Death
	X-Ray Services
	CT-Scan Services
	Laboratory Service
	Mobile Medical Unit
	Drug Stock Availability



Maternal Death



Infant Death



Civil Works



Inventory Management System



Health Service Monitoring System



HR-MIS System



ASHA Payment & Performance Monitoring System



NPCDCS



GIS



Drug Stock



VIIND



Financial Monitoring System



Complaint Redressal System



e-CRS



Activity Management



Wage Compensation System

TECHO+ (Technology for Community Health Operation)

Problem Statement

There is a remarkable gap between time of service delivery and given service data entry in e-Mamata. Above all, the data entry operator at the PHC has the responsibility of other work as well as has only basic knowledge of computer and not fully aware of significance of various health elements which also results in data errors. Only 40 to 45 percent of the given services are recorded within 15 days of the service delivery. Thus, it is necessary to ensure realtime data entry in the beneficiary tracking system.

Program Description

TeCHO+ is a mobile & web based application which works as a job-aid for health workers and administrators for improving coverage and quality of maternal, newborn and child health services. TeCHO+ application provides name based tracking of pregnant women and children using mobile phones along with Aadhar authentication. Considering the limitations of the real-time data entry in e-mamta and encouraging results of the ImTeCHO project by the Health and Family Welfare Department has decided to develop and implement upgraded version of ImTeCHO covering 7/11 indicators as TeCHO+, which is launched for implementation in by Hon. Prime Minister in entire state.

Updation of Family Health Survey (database of all the person residing in the state) using TeCHO is in progress in the entire state. Additionally, all ASHAs of Bharuch, Narmada and Valsad districts will be provided with mobile phone by the end of 2018 to realize the objective of AAA.

Program Outcomes

- Real time data entry by service provider at point of service delivery so that real time tracking will be possible for the services of the beneficiaries.
- Digitalization of various Register, Records and reporting.
- TeCHO+ will play an important role in improving the health indicators like the MMR IMR and TFR, etc.

- In future based on symptom, probable diagnosis and possible treatment will be provided for ANM, facility for scheduling doctor's visit will be included in TeCHO, which will increase the value of health worker.

Implementation Partners

- Department of Health, Gujarat, SEWA rural, and GVK EMRI

Scalability

- The program is being scaled up to the state level.

Contact

dassrathpatel55@gmail.com

Table: Program outcome of ImTeCHO

Indicators	ImTeCHO area (%)	Non Project Area of District (%)
Early registration of pregnancy within first three months	82	57
Visited at home by a ASHA at least 3 times during last pregnancy	90	57
Early initiation of breast feeding	90	73
Exclusive breast feeding during first six months	44	23
At least 5 home visits by a ASHA within the first month of delivery AND 2 home visits within the first week	56	10
Sought help from ASHA for neonatal complication	78	27





MADHYA PRADESH

E-VITTAPRAVAH: A Budget & Fund Management System

Program Description

e-Vittapravah is a web-based online application is also used as a platform to devolve financial powers till block level and expedite payment processing through e sanctions using Aadhar based biometrics.

The sanctioned activities along with the budget in the PIP is mapped DDO wise in the software by the planning division at the state level. Once the DDO wise and activity wise budget allocation has been done, the funds are released by the Finance Division of the state office. The fund released is done as per the tranches received from GoI and has been categorized into 3 broad groups of (i) Untied (ii) Beneficiary oriented and (iii) NHM universal. The DDOs starts making expenditure against the activity wise budget allocated to them. e-Vittapravaha therefore ensures quick dissemination of PIP, budget allocation and funds to field level offices.

At the DDO level, each node has a maker, verifier and approver role for fund disbursement. Once the payment has been made by the maker with relevant document uploads, which is mandatory, it goes to the verifier login and then to the Approver login. The system limits the usage of funds to the level of budget allocated. The payment approval is done using the Aadhar based biometric devices of the approvers. Upon

approval, an excel format is generated and needs to be uploaded in the PFMS login of the DDO using a Digital signature through the excel bulk load facility of the PFMS. This excel currently acts as a payment request file for PFMS. The payment request file uploaded in PFMS triggers the debit from the parent account at state level for crediting the requested amount to the DDO . It also enables the direct and timely devolution of untied funds to the CHC, PHC, SHC and VHSCNs level. The untied funds can therefore be disbursed by the respective BMOs in the first quarter of the financial year.

Program Outcome

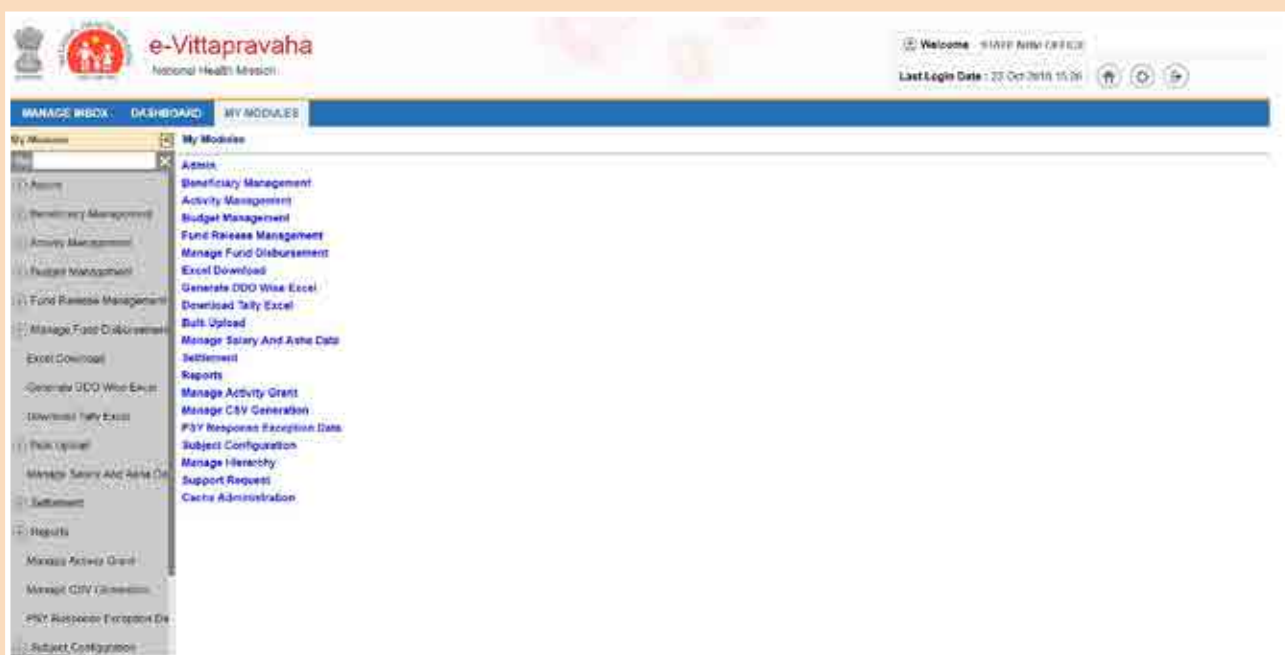
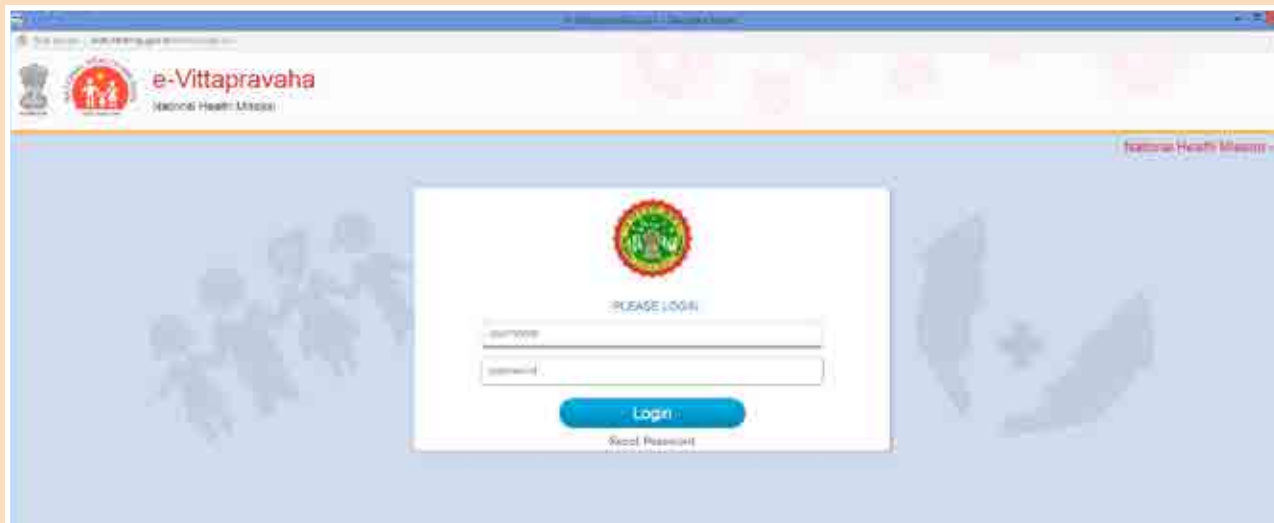
e-Vittapravaha went live on 13th July 2018 there are approximately 1400 users. The system is being used by 72 types of office bearers who have been assigned the role of maker, verifier

or approver. The users of the system have increased from 34,578 to 66,747 from June 2018 to September 2018. As on date, payment has been initiated on e-Vittapravaha of INR 128.5 CR for the state scheme of PSY and INR 251 CR for NHM scheme. Payment to 9.37 lakhs beneficiaries out of which 77.5 thousand have benefitted from NHM scheme. 17.4 thousand vendors have been paid till now an amount of INR 128 Crores. As of now 5.20 ASHA incentives have been disbursed amounting to INR 38.14 Crore over a period of 2 months. 2.06 lakhs JSY benefits have been disbursed amounting to INR 28 Crores; 34 thousand Family planning beneficiaries have been paid a total of INR 5.9 CR; and 25.2 thousand individuals have been paid salary amounting to INR 53.5 CR.

Contact

drectorfinance.2017@gmail.com

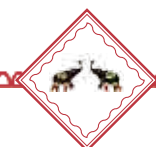






RAJASTHAN

DAKSHATA - Mentor Application



Problem Statement

Rajasthan has been one of the states that have pioneered the successful implementation of Dakshata under NHM. First large scale evaluation of Safe Childbirth Checklist was done in Rajasthan. Learnings from this study paved way for conceptualizing DAKSHATA initiative at National Level. 'Dakshata' is a strategic initiative by the MoHFW, GOI to improve the quality of care at the delivery points which comprises of a concise training package for competency enhancement of Medical officers, Nurses and ANM. Dakshata mentors have been performing onsite-mentoring visits in the target facilities and are currently collecting information through 'Paper based format', which is shared for action to address the gaps, both at district and state level. Tracking these visits, timely compilation and getting meaningful and standardized analysis has been a challenge. Need was therefore felt for developing a mechanism to monitor the visits conducted by mentor and get key actionable points for facility district and state.

Program Description

NHM Rajasthan decided to streamline this process with the support of Jhpiego by developing the **Dakshata mentor App**. Dakshata Mentor Solution has two components; mobile app and online application. Mobile app is designed to report data from facility immediately after the assessment and the online application on the server is empowered to manage this data, and generate actionable analysis.

The key activities done are illustrated below:

1. Data collection format designed and aligned with Dakshata Mentor Package.
2. To provide real-time results by aggregating and extracting value from all the data collected by mentors, following dashboards were developed which includes
 - Facility Level Dashboard: Comparison of Essential Resources, Practices and LR environment in last six visits.
 - District level Dashboard: The district dashboard will enable comparison of

individual facility with overall score of district for key aspects of labor room quality of care.

- State level Dashboard: State dashboard was designed to enable last six month's comparison of individual facility with corresponding district and overall score of state for Status of practices in labor room, Labor room environment and Facility resource availability.

Financial Implication

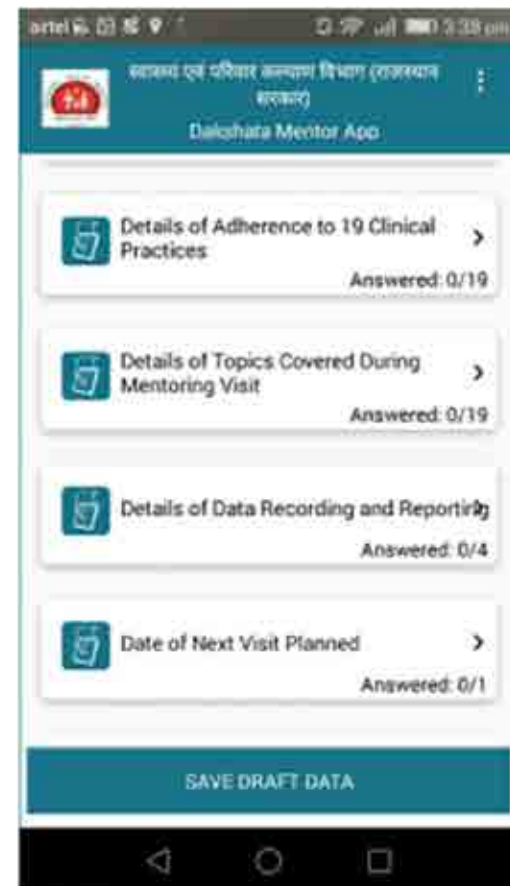
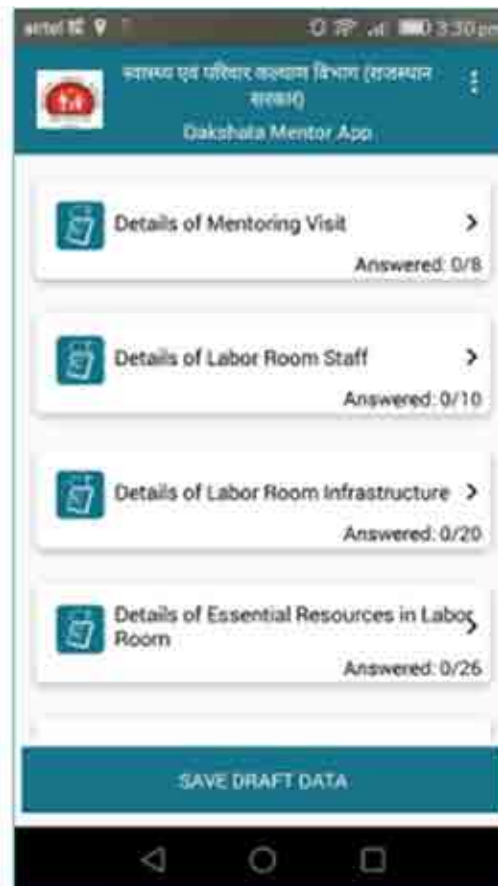
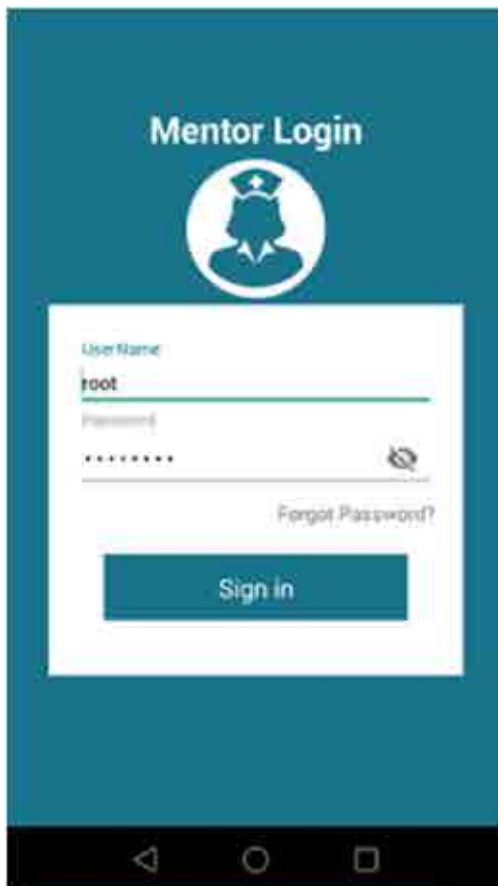
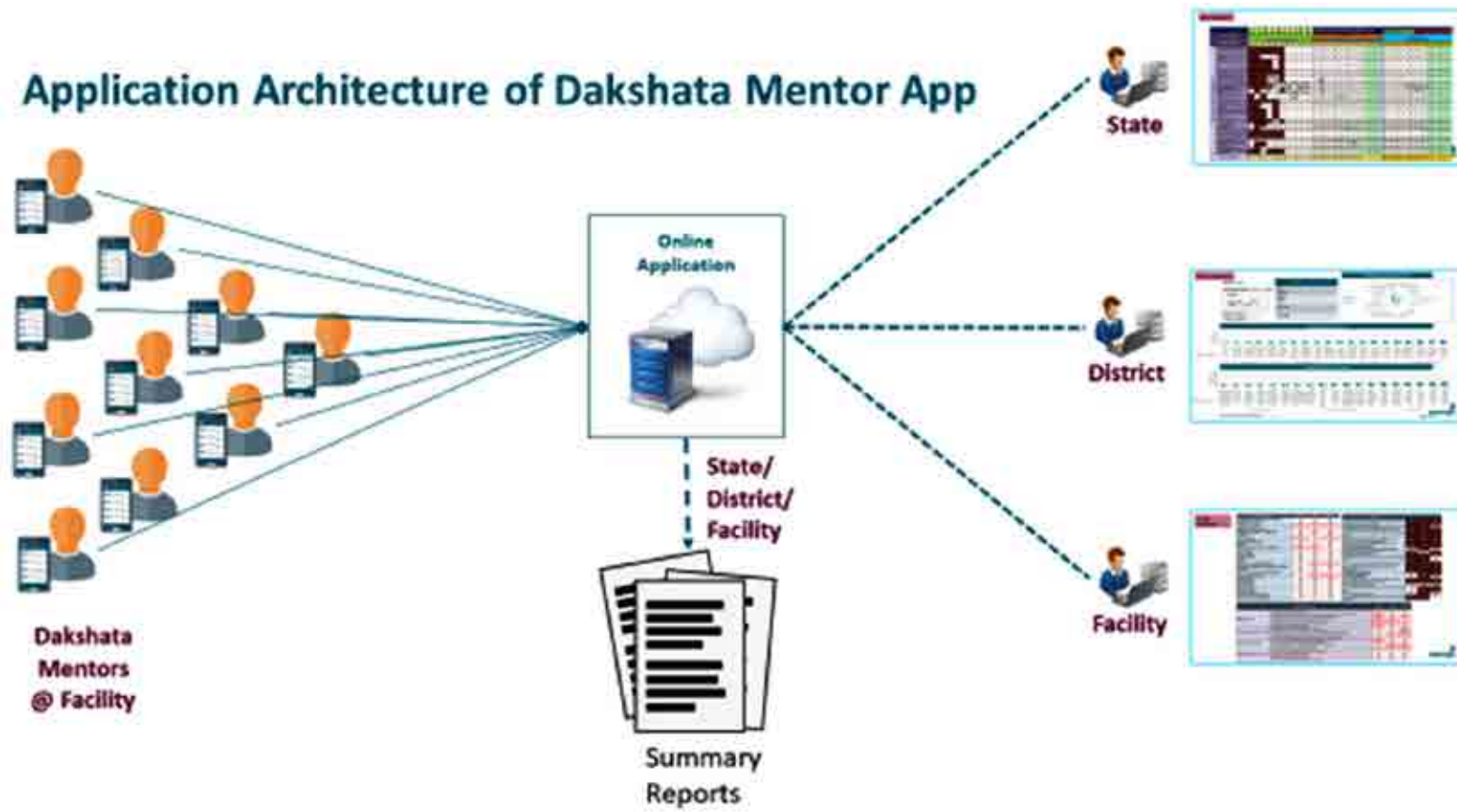
The App is readily downloadable at Google play store and is free to use. The App needs to be hosted on the server which will incur one time deployment cost, which may not be required if hosted on in house server. An annual maintenance cost would be incurred as for other Apps. There are no additional costs.

Contact

spm_raj.nrhm@yahoo.com



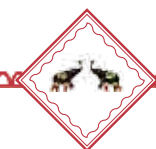
Application Architecture of Dakshata Mentor App





TAMIL NADU

LINKAGE OF PICME (MCTS) & CRS - Pregnancy & Infant Monitoring & Evaluation an Civil Registration System



Problem Statement

There has always been a lacuna in the collection of data of pregnant mothers and the infants both from government facilities and the private facilities. There was a gap in interlink between various data collection software and in the registration under Pregnancy Infant Cohort Monitoring and Evaluation which led to difficulty in tracking of high risk mothers availing health services in private facilities, higher order birth mothers, etc. In order to capture all Antenatal mothers of all Socio-economic status in early Pregnancy and to bring them under continuous monitoring a centralized system -Pregnancy Infant Cohort Monitoring & Evaluation Version 2.0 software (PICME 2.0) software has been developed in the year 2016.

Programme Description

PICME 2.0 software has been developed and used by Public Health Department with the objective of capturing all pregnant mothers, delivered mother, infants, children and the MCH services rendered to them. This will serve as Mother & Child registry for the State of Tamil Nadu. The Unique RCH ID of all pregnant

mothers and infants generated from PICME 2.0 software is essential to obtain Birth certificate. This software has been linked to Civil Registration system Software to issue free birth certificates. Effective Civil Registration Software linkage has ensured that all private deliveries are also entered in the Maternal Child Tracking System portal. Provision for pre registration through common service centers /102/institutions/self online registration has been made, providing easy accessibility for the Antenatal mothers to get registered early. Aadhar Authentication/Visitor mother registration/Institutional Delivery entry has been made mandatory. All Migrant mothers' i.e mothers from other States and Mothers who are Non Residents of India are also being captured.

Programme Outcome

- Continuous monitoring of AN mothers has contributed in the decline of MMR of Tamil Nadu to 52.61 (Apr 18-Aug 18) when compared to the previous year (73.52 in Apr 17- Aug 17) per 1 lakh live birth.
- All birth occurring in the state have been registered.

- RCH ID made mandatory for Birth certificates. Therefore Mothers of high Socio-economic group has also been included under continuous follow up through PICME 2.0 Software.

Implementing Partners

National Informatics Centre, Ezhilagam, Chennai; Greater Chennai Corporation- Civil Registration System Software linkage; Tamil Nadu e-Governance Agency; State Data Center-Perungudi, Chennai.

Financial Implication

Cost of developing the software, procurement of IT devices, capacity building and recruitment of HR is approximately Rs. 4,69,46,500.

Scalability

Similar programme can be rolled out in other states as well for efficiently tracking the high risk mothers to deliver efficient health care.

Contact

rchpcni@tn.nic.in





EMERGING INITIATIVES

Health Systems Strengthening



HEALTH BULLETINS

*Problem Statement*

There is a paucity of health information related feed-back loops in which health information data collected, collated and reviewed by the state is disseminated back to health services staff (so that information informed health care planning takes place) and to the public (to raise awareness about health related issues). This initiative attempts to address these two areas.

Programme Description

This initiative uses health data collected by the states Knowledge Command Centre to produce monthly health related bulletins for the state, districts and villages in the state. Launched in March 2018, it contains information on the health related Programmes of the government (with a special focus on non-communicable diseases and seasonal illnesses), the best and worst performing health indicators at state level, health services and facilities available at district and village level and information on the disease profile of that area (illnesses and number of cases). This is distributed to the CMHO of the district and from there to all public health facilities (CHCs, PHCs, MMUs

and other health administrative offices). This initiative covers 13 districts and 18,000 villages of the state.

Programme Outcome

This initiative provides health officials with information about management of non-communicable diseases and to plan for containment of seasonal illnesses. It also provides them information on focus areas to improve health outcomes and on the performance of public private partnerships.

The bulletins provide information to the public about the free health Programmes being provided by the state, raises awareness about prevention of non-communicable diseases through lifestyle modifications and provides health promotion messages for mitigation of seasonal illnesses.

An independent evaluation of this recently launched initiative will provide further information on its effectiveness.

Implementing Partner

This is an initiative of the state government through the data collected, collated and analysed at their Knowledge Command Centre.

Financial Implication

Not specifically provided, but it is assumed that only modest financial support will be needed to ensure its sustainability as the information is already being collected and reviewed by the state. Funds will be needed for the production of the bulletin and its distribution, dissemination and awareness raising.

Scalability

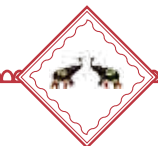
This intervention has been rolled out across the state. As other states will also have this information collected, replicating this practice so that planning and action is informed on the basis of information and evidence collected will be feasible for other states too – with modest financial inputs.

Contact

ddmiscfw@gmail.com



FEEDER AMBULANCES (108 BIKE)



The Government of AP taken up an initiative to provide the feeder ambulances to the interior and remote ITDA areas as many habitations are not having good road connectivity.

Feeder ambulance shall transport shortest possible time with advanced ICT for providing quality Emergency Response Services to the tribal People on 24x7 basis with tele-liaisoning with main ambulance service provider call centre (108).

Reach time is less than 60 minutes on call landing and they are available in the field round the clock to transport all emergencies.

12 category of medical equipment, 5 category of lifesaving drugs, 32 category of consumables are available in Feeder Ambulances.

Operation and maintenance of Ambulances services include the

- Maintenance of Medical, on Medical and ICT equipment in the ambulances and replace with the new one in case of permanent nonfunctional of equipment.
- Providing medical consumables, surgical consumables etc required in ambulance from day to day.
- Trained manpower 24X7 bases. with specified medical equipment and treatment

that will stabilize the patients and then transport them to the nearest health facility within the shortest reasonable possible time with support supervision.

- Obtain insurances, licenses and permits as required by the law from the respective competent authorities.

Providing advanced Information and Communication Technology includes.

- Provision of GPS devices to all the ambulances for tracking and monitoring.

- All the data (including Voice calls), arises from receipt of call to call centre, dispatch ambulances, post transport follow up and feedback shall be stored in exclusive data base centre.

- Provided with tab/mobile phone with appropriate software application for capturing the details of services provided to the patient in the ambulances and details of health institution to where patient is transported.

Periodical trainings to the Drivers, EMTs, and management staff and call centre staff. Periodicity shall not exceed quarter. Training action plan, training material, methodology are being approved by Government.

Regular real time feedback from the beneficiaries through IVRS and Service provider is responsible for all the legal disputes arising out of transportation of medical emergencies.

Shall conduct quality audit on biannual basis through an independent agency identified by the Government.

Contact

ddmiscfw@gmail.com





AMANAT - JYOTI : A Nurse Mentoring Intervention



Problem statement

In the year 2011, the quality of service delivery and the range of services to be provided under the RCH Programme at the district and block level, was not at par with the national standard. Other than having lack of infrastructure, the prime concern was lack of knowledge and skill of the service providers working in maternity wing.

Programme Description

To improve capacity building of frontline workers such as doctors, nurses and midwives in all public health facilities, Mobile Nurse Mentoring and Training (MNMT) pilot phase was conducted during 2012-2014, which covered 8 districts of Bihar, covering 80 PHCs, 7 District Hospitals and 1 subdistrict hospital. The experiences of the pilot phase have been used to scale up the intervention. Apatkal in Matrutvaevam Navjat Tatparta (AMANAT) started in January 2015 to cover 320 Block PHCs in four phases over the next two years.

Components

AMANAT Programme was divided into two sub-Programmes, AMANAT-V (vyapak)

catering the requirement for Comprehensive Emergency Maternal and Neonatal Readiness and AMANAT- B (buniyadi), catering the Basic Emergency Maternal and Neonatal Readiness. Hence, AMANAT-V was covering the CEmONC centres like District Hospitals and FRUs and AMANAT-B was covering the other BEmONC centres like Block PHCs and non FRU SDHs.

Programme Outcome

The quality of services at the facility for CEmOC & BEmOC obstetric care were improved. Indicators such as Delivery conductors did practice Hand-wash & gloves (both) improved from 30.5% to 75.4 % at the end of the training and many other changes have been bought into practice. Amanat Jyoti has been started only a few months back. Till now, only the first module is recently over and data analysis is going on.

Financial Implication

Current Programme is supported by Care India for payment of salaries of Nurse Mentor Supervisors, CEmONC Obstetric Nurse Mentors, OT mentors and Paediatric mentors, lodging, boarding and travel. Around Rs 14, 04,00,000/- will be spent over from

December,2017 to May, 2019. When this Programme will be implemented by government of Bihar, the cost of the Programme will reduce to Rs 60, 00,000/- per annum.

Scalability

The Government of Bihar has already started implementing this intervention at scale through public health systems.

Implementing Partner

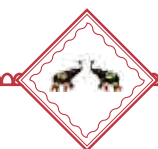
Care India, Bihar

Contact

hshah@careindia.org



A STRATEGIC APPROACH TO IMPROVE QUALITY FACILITY BASED NEWBORN CARE SERVICES



Problem Statement

As of today, out of 25 sanctioned SNCUs, only 18 SNCUs are functional and sometimes these units too face issues of deviation from standard norms of Facility Based new-born Care (FBNC) prescribed by MoHFW, GoI. One of the main reasons is struggle of state in recruiting adequate skilled and trained human resources despite repeated recruitment drives. In addition, maintenance of equipment is a major constraint towards optimal functioning of SNCUs. The SNCUs equipments need to be maintained through proper mechanism for equipment maintenance.

To sort out the above mentioned issues of Human Resource and Equipment maintenance, NHM has done MOU with UNICEF and EKAM foundation, Chennai December 2015 for operationalization and strengthening of SNCUs in the State.

Programme Description

The objective of the partnership is to operationalize and strengthen functioning of all the SNCUs in the State and ensure the quality of care through trained health human resources. Terms and conditions are as follows:

- Recruitment of Doctors, staff nurses and Data entry operator for SNCUs in the State.
- Maintenance of SNCU Equipment.
- Training of Doctors and Nurses.
- Microbiological Surveillance of SNCUs.

Programme Outcome

With this partnership eighteen (18) SNCU have been made operational in the State, and three are going to be started soon, thus ensuring facility based new-born care in these districts.

Leveraging resources, health professionals, and infrastructure from both the public and

private health sectors in order to meet the health-related need, especially 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.

Scalability

This partnership is one of the most successful mechanisms for providing quality facility based care. This helps to provide quality care from public health institutions thereby making the health facilities functional as per standard norms.

Contact

office.mdnrhm@gmail.com





HEALTH CARD - A comprehensive index of 50 indicators to assess the health condition of district



Problem Statement

All the National health Programme are Implemented under the umbrella of National Health Mission. All The Programme are monitored by specific indicators of the Programme. There is a requirement of a comprehensive index to measure the implementation status of national Programmes at district level. Individual monitoring of Programmes was unable to make comprehensive picture of national health Programme implementation status at district level.

The primary purpose of the score card based monitoring is to provide district's health score and rank based on composite score in compare to other districts of the state. This is very brief document to take review of Programme implementation for state and district authorities especially Mission Director, Director Health services, Collector and Chief Medical and Health Officer.

Programme Description

To measure the implementation status of National Health Mission rigorous consultation was done with the different national health Programme division. After 4 rounds of

consultation 50 indicators has been chosen by experts. These 50 indicators are related to RMNCH+A, communicable diseases, non communicable disease, hospital quality, health system strengthening, finance accounting and more. Selection of indicators are based on all important activities/ Programmes implemented under National Health Mission, Chhattisgarh and which are responsible to impact on health status of the state. Idea is to select minimum indicators represent maximum Programmes. Indicators are selected on the SMART (S- Specific, M- Measurable, A- Achievable, R- Realistic, T-Timebound) basis. Total 50 indicators has been selected in 9 groups. Indicators has been given weightage based on Programme's importance like Maternal Health has been given 20% and NCD Programme has been 21%. Financial utilization must be correspondence to the physical achievement so financial expenditure has been given 20% weightage.

Those indicators which are available online like HMIS, NIKSHAY, PMASMA, RBSK, SNCU and FMR. Total 33 indicators are available on online reports and 6 NCD indicators will be available soon through NCD app which is launched for Health & Wellness Centre recently.

On the basis of weightage over all score of 100 points has been defined for implementation status of NHM at district level. The score of district against 100 points will present the status of implementation of NHM at district level.

Programme Outcome

Health score card will help to effectively measure the status of implementation of national health Programme at district level. Monitoring of all the national health Programme will be effectively done through this health card.

Implementing Partner

Monitoring and evolution division of NHM will develop the health score for districts with the coordination from national health Programme division.

Scalability

At national level, and other state can develop health card for states and district. This health card will help to comprehensively monitor the of implementation status of National Health Mission at State and district level.

Contact

office.mdnrhm@gmail.com

DIGITIZING HOSPITAL AND LINKING WITH MERA ASPATAAL-PANCHKULA - Use of Technology for Patient Safety and Quality Care in Public Healthcare Facilities

Problem Statement

Quality of care is often compromised at District hospitals because of the inefficient processes like poor system of crowd management leading to long waiting times, difficulty in tracing the health records, variations in clinical processes due to absence of clinical protocols, difficulty in measuring patient satisfaction manually, frequent stock-outs and expiry of drugs etc.

Programme Description

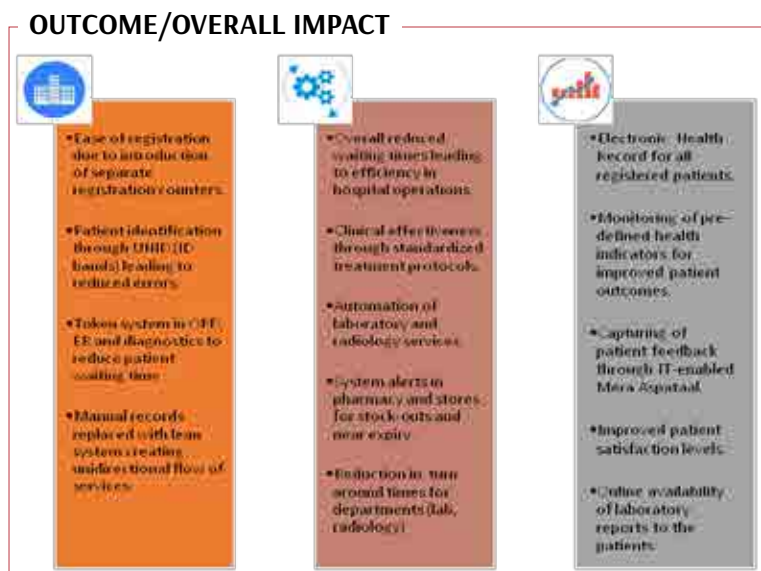
The state of Haryana in an endeavour to find out the e-Solution to all the above stated challenges took the initiative to implement the following:

- Hospital Information system - e-Upchaar.
- Use of Token system and electronic display for streamlining the patient flow.
- Generation of Unique Health ID (UHID) for every registered patient with bar coding for ensuring traceability and continuum of care.
- Integration of district hospitals with 'Mera-Asptaal'.

- Automation of laboratory services and Integrating with HIS.
- Integration of radiology equipment with Picture Archiving and Communication System (PACS)
- Optimal utilization of human resources through HRMS (Human Resource Management System) module of the application.

Programme Outcome

The impact of all the above interventions have been observed in various areas as described in the table below:



A time motion analysis was conducted for 5 district hospitals to see the effect of interventions on waiting time.



Scalability

The interventions done by the state are indeed impactful and hence should be replicated and scaled up to cover upto CHC and PHC level. The whole process of patient information and record generation can be linked to Aadhaar number (UIDAI). These interventions over the period shall be able to not only improve utilisation but will increase the patient satisfaction.

Contact

domainexpert.hshrc@gmail.com



INITIATING AND ACCELERATING QUALITY IMPROVEMENT FOR PUBLIC HEALTH FACILITIES

Problem Statement

Haryana initiated their efforts to ensure Quality in care provided at state's public health care facilities in 2014 with implementation of NABH standards in 5 DH and 8 PHC and out of these 4 PHC reached the accreditation status in 2014.

Programme Description

After the launch of National Quality Assurance Standards (NQAS) for public health facilities, in 2015, 328 healthcare facilities including DH, SDH, CHC, PHC were taken up for Quality Improvement. Evaluation of gaps was carried out and an action plan was developed to fill the gaps.

Infrastructural modifications like zoning of OT, emergency, labour rooms and in-patient wards were taken up. Support services such as CSSD, laundry, kitchen and medical record rooms were also set up. Appropriate approvals for; handling Bio-Medical Waste, Atomic Energy Regulatory Board (AERB), NOC for fire and license to operate lifts were obtained.

Efforts were made to improve the processes and service quality by working on parameters such as, reduction of waiting time, timely reporting of investigation results, ensuring cleanliness, strengthening up Infection Control Measures, channelizing the inventory processes etc.

Figure 1: Compactors were installed in 21 Civil Hospitals in Medical Record Department



Documents like Standard Operating Procedures, Standard Treatment Guidelines, Accident & Emergency Care Services Module, Housekeeping & Laundry Manual and Dietary Services guidelines were prepared by SHSRC.

Efforts for health care providers' capacity building have been made. Trainings have been provided for common emergency management (clinical pathways and Medico-legal concepts). By now State has 120 ACLS trained doctors and 269 Doctors & 998 nurses have been trained in BLS. Accident and Emergency Simulation lab has been operationalised at SIHFW for imparting hands-on training. More than 1000 healthcare professionals have been trained under NQAS.

Programme Outcome

In 2015, Civil Hospital Panchkula became the first NQAS certified District hospital. Till date, 21 facilities (4 district hospitals, 1 CHC, 1 UPHC, 15 PHCs) have received National Certification.

The improvement of hospital services has led to improved patient and employee satisfaction, Queue management, online reporting, picture archiving for better access, digitization of patient records, reduced errors and improved efficiency. All these efforts have led to improved productivity, reduced costs and time to deliver services. Digitalization of radiology has reduced the cost by 65% saving Rs. 1,50,660 per district hospital.

Scalability

The project is replicable, standardized processes and documents can be implemented in all the facilities.

Contact

edhshrc@gmail.com

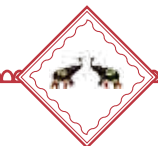
Figure 2: NQAP certified facilities status





HARYANA

SENIOR CITIZENS' CORNER WITH "SAARTHI" SERVICE



Problem Statement

The number of senior citizen has increased as life expectancy of the people has increased. The senior citizen needs care at home and outside home porticularly health facilities while they visit.

Programme Description

The Senior Citizens Corner started in Civil Hospital Panchkula having a registration cabin, nurse's cabin, doctor's cabin, physiotherapy & dietician cabin and examination cabin.

Arts and commerce Graduates and Post Graduates get registered with employment exchange department of Haryana. Those who don't get employment are given work for 100 hrs a month for 3 months a year under the Saksham Scheme. The payment is done by the employment exchange department and they are deputed to various departments.

A batch of 20 joined civil hospital Panchkula in the month of January, 2018. For the optimum utilization of these graduates and full filling the needs of the Senior Citizens gave birth to the Senior Citizens Corner with SAARTHI service in Civil Hospital Panchkula on 7th of April, 2018.

The aim of this corner is:

- Shifting from the concept of separate line to NO LINE for Senior Citizens.
- Minimum movement of Senior Citizens
- Assistance to Senior Citizens in hospital
- To make the experience of public health facility comfortable and satisfying for that age group in which a person makes maximum visits to a hospital.
- NCD Screening of Senior Citizens at its best.

When a patient visits the Senior Citizens corner he doesn't stand in line. SAARTHI gets the formality of registration done and the patient sits in the nurses cabins and gets his weight, BP, pulse, SPO2 and refraction screening. After that the patient moves to the cabin of the Doctor. The Doctor advises him blood tests and/or Radiological investigation and/or specialist consultation and/or prescribes medications. For the blood tests the patients moves to the next cabin. For medicines the patient sits in the waiting area and the SAARHTI arranges the medicines from the pharmacy. For radiological investigations and specialist consultations the SAARTHIs take them on a wheel chair, get the things done and bring them back.

Register is being maintained in Senior Citizen corner from day one. The beneficiaries are

comfortable as most of the things are done in that corner itself. There comments reflect that it is very satisfying experience especially for those Senior Citizens' who come alone to the Public health facility.

Programme Outcome

Senior Citizens' corner is populastic idea. It is simply rearrangement of existing things and presenting the service in colorful, friendly and satisfying way. The Senior Citizens have a feeling that they are now getting the respect and preferential treatment which they deserve at this age. The NCD screening and amendment of this age group has improved.

Scalability

This concept is a requirement in every district hospital and is easily scalable. No additional human resources and infrastructure is required. It has only to design and make it look colorful. Saarthi's can be taken on contract basis or by involving the local social organizations. Rests of the things are already available in a district hospital.

Contact

trehanlaparo@gmail.com





INTER-STATE EXPOSURE VISIT AS A MEASURE OF QUALITY IMPROVEMENT

Problem Statement

NQAS Programme was launched in Year 2013 by MoHFW, and J & K was one of the late adopter of this Programme in October 2017 and decided to implement NQAS in 5 District hospitals. After awareness and internal assessor training organised by NHSRC in collaboration with NHM, J&K, state official felt that standards of NQAS are very difficult to implement in the State. State nodal officers received feedbacks from the facility about how to initiate NQAS in the facilities. The health facilities raised concerns and constraints in the implementation of the Programmes in various areas- administrative,

resources and logistics which required appropriate managerial interventions. The facilities required hand holding, & a sample to be witnessed and replicated.

Programme Description

After a detailed brain storming session at SQUA, State decided why not to made a visit to the State, which are performing well in NQAS. Then an exposure visit was planned and proposed in State PIP 2017-18. After approval, State with the help of NHSRC, planned a exposure visit to State of Haryana (Performing excellent in NQAS) with all 5 selected DQT members.

During this visit State and DQT team met with State officials of Haryana and visited Civil Hospital Panchkula and raised there all concerns, clarified their problems, learned best practices and gain experiences of Haryana during NQAS journey.

Programme Outcome

- Substantial Improvement in NQAS scores from baseline in all facilities.
- Improvement in trends of all 30 Key performance Indicators were notice from the facilities.
- Average scores of Patient Satisfaction were also increased in these facilities.

Implementation Partners

MoHFW, NHM J&K, NHM Haryana, and NHSRC

Scalability

The initiative involved can be implicated in slow performing States in NQAS Programme.

Contact

pmqualityjk@gmail.com





JHARKHAND

RECRUITMENT OF SPECIALIST MEDICAL OFFICER THROUGH BIDDING PROCESS



Problem Statement

Jharkhand accounts for more than 40% of the mineral resources of India, but it suffers widespread poverty as 39.1% of the population is below the poverty line and 19.6% of the children under five years of age are malnourished. The state is primarily rural, with only 24% of the population living in cities. Quality health care is a major challenge in Jharkhand considering the dearth of medical officers and especially Speciality Medical Officers (SMO).

Programme Description

NHM Jharkhand has its regular recruitment process for selection of Specialist Medical Officers but getting and moreover retaining SMO's was major issue. Due to difficult geographical area Specialist Medical Officers were unwilling to render their services in remote places. NHM Jharkhand came up with an innovative idea of providing best medical services in remote areas by allotting the facility on choice through bidding process. Through this, Specialist Medical Officers can apply for their facilities of preference and compensation expectation. These facilities will be allotted to the Specialist Medical Officers as per lowest bid for a particular facility. For Specialist Medical Officer negotiable salary has already been approved in ROP 2017-18.

Conditionality

- Interested candidates can bid for advertised posts only.
- The selected bidders have to provide their services as per prescribed TOR and defined responsibilities.
- Interested candidates can submit their bid in the prescribed format.
- This bidding process is being done on ad hoc basis till the regular / contractual appointment against the said facility is done.
- Candidate can submit their bid for particular facility.
- Allotted facility will be non-transferable.
- Candidate has to bid with financial expectations along with educational qualification.
- The lowest bidder shall be offered the quoted facility. In case of similar quoted rates JRHMS will decide allocation on the criteria based. The lowest bidder shall be offered the quoted facility. In case of similar quoted rates JRHMS will decide allocation on the criteria based

Financial implication

In the bidding system bidders had quoted INR 56700.00 to 300000.00 /per month. NHM

Jharkhand has made policy that over price bid will be rejected, bid price along with bid place will be reviewed by a competent committee so that additional financial burden will not impose. Under this policy NHM Jharkhand had rejected 4 bidders who had quoted high rates in urban area. In the bidding process NHM Jharkhand able to engage SMO in remote and hard to reach area in the allocated fund allotted by GOI.

Programme Outcome

The recruitment success rate was 95%. The innovation was successful & 22 Specialist Medical Officer joined in their preference place with their desirable salary.

It is not just the lowest quote that will get the job but NHM also has a scoring system for performance. For example, for an obstetrician, the number of check-ups, normal deliveries and elective caesarean section deliveries that he/she has conducted among some other parameters will evaluate his / her performance. The issue is not only about money but also about infrastructure, work atmosphere and these need to be addressed at the earliest.

Contact

nrhmjharkhand3@gmail.com





DIGITAL NERVE CENTER (DiNC)

Introduction

The Government of Karnataka has collaborated with Tata Trusts to overcome the issues plaguing the healthcare service and fulfill its vision of meeting the healthcare delivery needs of the citizens.

Objective

The objective of the transformation initiative is to strengthen the existing delivery capabilities with imaginative technology application and processes techniques, steering immediate, visible results.

The transformation Programme aims to address healthcare delivery challenges including lack of awareness amongst the population about availability of health care services and healthcare Programmes at different levels

Digital Nerve Center (DiNC)

Is a people centric - service led platform model that facilitates to & fro communication between patients, hospitals, and doctors irrespective of their geographical location. The DiNC platform manned by medical experts helps in planning and managing patient journey throughout the treatment cycle. This involves in transformation

of primary health care, Aiding in quality Services of Secondary and tertiary Health Care through empowering people Creates a new paradigm in public healthcare delivery by empowering patients to easily access quality care services with technology intervention.

The Digital Nerve Centre enables delivery of virtual care with consistent and continuous communication using clinical intelligence. This innovative model from TATA Trust connects three crucial elements—rural or remote healthcare center, a nerve-center, and virtual network of care providers—underpinned by technology, people and processes. Thus aided, patients from remote villages are able to access top quality medical consultation without travelling long distances.

Health Seeker's Advantage from DiNC

- Consistent and continuous real time communication between Doctors, Patients and Healthcare Workers, at all levels
- Brings together everyone in the Healthcare Ecosystem, to deliver reliable and effective healthcare service - Right treatment at the Right time through the Right provider.

- Patient has to only visit the nearest Healthcare Centre or Call up a Toll Free DiNC number, for effective healthcare delivery, & care continuum

Architecture / Approach

The Phyigital Approach

Leverages human or physical element of compassion and empathy to manage patient needs through Patient Care Coordinators & Managers The digital and network technology opens new touch points of communication for Clinicians/Specialists/ Healthcare workers and Patients to connect with each other on real time basis.

The DiNC setup manned by Technical and Clinical experts uses clinical intelligence to digitally connect all crucial elements—Healthcare Centers, DiNC Command center, and Care Seekers & Care providers.

The Deployment of Patient Care Coordinators & Managers (PCC & PCM) helps overcome one of the key constrains of technology aided healthcare service - 'Touch & Feel'

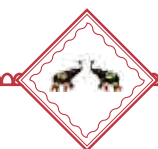
Contact

dhoklr@gmail.com



KARNATAKA

HEMOGLOBINOPATHIES AND HEMOPHILIA CARE



Problem Statement

- Only 6 treatment centres were working for blood disorders in the state.
- Earlier there was no registry for Hemophilia and Thalassemia patients.
- Irregular procurement for Anti Hemophilia Factors. No free Blood Transfusion and Iron Chelating Agents for Thalassemia and Sickle Cell Anemia cases.
- No training for treating doctors for Blood Disorders.

Programme description

State Blood Cell was established on Jan 2017. The Programme delivers Anti Hemophilia Factor's, Iron Chelating Agents and Blood Transfusion Free to all the Blood Disorder's

Patients including both APL and BPL. Under this Programme, a Day care centre was started in all 30 districts and Medical Colleges and Hospitals. Karnataka Hemophilia registry has already become functional and Thalassemia and Sickle Cell Anemia registry will be started in the state. Capacity building of Doctors for treating and managing Hemophilia and Hemoglobinopathies is being done. Patient Rehabilitation workshops are also being conducted for Hemophilia and Thalassemia patients at division level.

Programme Outcome

Free treatment for Hemophilia led to an increase in number patients availing services at Government Hospitals. The number of treatment centres in the states have been increased to 30, earlier only six centres were

available. To reach the last mile, screening for Sickle Cell Anaemia is being conducted in the tribal districts of Karnataka and more than eight thousand people are screened and about 173 suspected cases have been detected.

A two day workshop, Karnataka State workshop Management Workshop 2017 (KSHEMA) was conducted where Pediatrician, Pathologists, Resident Medical officers and Physicians of all DH participated to discuss and learn about Hemophilia. Division wise rehabilitation workshops for Hemophilia patients and their families were also conducted in the year 2017-2018.

Contact

statebloodcellkar@gmail.com





UPGRADATION OF REMOTE PHC THROUGH e-HEALTH



Problem Statement

PHC Noolpuzha is located in Wayanad district of Kerala, the district geographically backward in terms of healthcare infrastructure. PHC was facing critical and serious healthcare issues as Noolpuzha is bordering Karnataka and Tamil Nadu as well as it is second largest tribal Panchayat in Kerala. Although Noolpuzha did not have much developed public or private healthcare, it had OPD of approx. 50 patients per day. The biggest challenge for PHC was to create environment of trust, Quality and patient friendliness.

Programme Descriptions

To address the identified issues and create an environment of trust various intervention was taken by dedicated staff of PHC in collaboration with Local Panchayat and State National Health Mission. The intervention includes initiation of National Quality assurance Programme, installation of e-health system, telemedicine and Gothra Sparsham (Tribal antenatal healthcare Programme).

Assessment under NQAS Programme helped facilities to identify their gaps regularly and take actions to address them. To eliminate the

obstacles of access, reducing waiting time, afford ability, tracking the disease burden and monitoring of health entitlements etc.

E Health Programme covers online medical consultation, medical records and medicine supply management etc. A comprehensive Electronic Health Record (EHR) with details of all the treatments patient has undergone are available in this portal for the registered users. The system also supports HL-7 encoding interface with other hospital management systems, which will help in improvement of continuity of treatment.

Telemedicine OP has been started in the PHC on every Wednesday with the help of community technology NGO without any third-party network which avoided recurring cost

Gothra Sparsham (Tribal antenatal healthcare Programme), bring all the antenatal from tribal community to the hospital for routine ANC check-up on every month in a particular day in the hospital vehicles to provide the essential treatment

Programme Outcome

As on September, 2018 around 65947 patients registered in outpatient department .The more

than 100 patients were treated in 14 sessions through tele-consultation

Malnutrition issues among the AN mothers and newborns in tribal community were addressed through Gothrasparsham Programme and was able provide ANC to more than 800 women as well as to prevent home deliveries in the tribal community.

Under NQAS in the beginning we are getting only 77% of overall score & during our National Assessment we are able to achieve 98% which is highest among all the PHCs in country.

Implementing Partners

State NHM, and Panchayat.

Scalability

The hospital is upgraded from a remote village primary health centre into modern hospital unit by effectively using Govt. grants, schemes and support of local Panchayat.

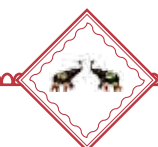
Contact

phc.noolpuzha@gmail.com



MANIPUR

BEHIANG PHC - Twice Kayakalp Awardee and Best Hill PHC Awardee



Problem Statement

Located at 67 km from Churachandpur town of Manipur & being the last village of Indo-Myanmar border, Behiang village was always crowded with people from Myanmar. Inaccessible villages, roads filled with potholes which gets worse during rainy season used to affect the healthcare in all folds resulting in high Maternal & Child Mortality Rate. The villages along this international boundary solely depend on this PHC for all kind of health services which had no Lab Technician, Pharmacist, Driver & no moreover no source of water.

Project Description

The present MO I/C took the matter seriously and held series of meetings with fellow doctors,



staffs, village chiefs, local church leaders, local organizations and domain experts and seek the help of local representatives like Autonomous District Council Members, MLA, Contractors etc. In November, 2014, a visit of Director, Manipur Health Services highlighted the issues faced by the facility staff.

Winning Kayakalp incentive award twice enabled the Quality improvement of the facility by Use of Myanmar bike for reaching the unreachable Locally prepared wooden IV Stands and Staff Quarters with Solar lights Well-equipped IPD Ward Other activities including purchase of water pump for pumping water from river, installation of RO machine for safe drinking water, building guest room for visitors, badminton court to promote physical activity, Intercom facility, antenna, router for WiFi, cellular phone connection made available, frequent cleanliness drive conducted with support of local youth club, police & students, health camps with support of Assam Rifles (supplied oxygen and anti-venom etc.) have been executed with the Kayakalp incentives.

Project Outcome

The joint efforts resulted in conversion of a two roomed PHC into a 24X7 bedded PHC equipped

with equipment like Generator & USG making it first of its kind in history amongst PHC located in hilly region and has become the best hill PHC awardee.

Various interventios undertaken by the team has led the following results:

Implementing Partners

Manipur Health Services, PHC Staff, Local Leaders & Representatives including Autonomous District Council Members, MLA, Contractors, Village Chiefs, Local Church Leaders, Local Organizations, Domain Experts

Scalability

Team work with good leadership and determination to serve the humanity can bring major achievements. With provision of more staff and complete diagnostic equipment, more referrals can be catered and all the National Health Programmes can be implemented successfully with ultimate goal of improving Quality of Care of Public Health Facilities.

Contact

smd.manipur@gmail.com





CREATING SAFE AND ENABLING ENVIRONMENT Through Assessment and Facilitating Improvements of WASH in Health Institutions in Selected District



Problem Statement

It is estimated that 68000 infants die within the first month and about One lakh die within the first year from birth in MP every year. MIS data from Specialized Newborn Care Units (SNCUs) from 53 units in Madhya Pradesh and from 6 states suggests that 17% of the new born deaths are caused because of sepsis. All these issues raises concern over the quality of care being provided at the Govt Health facilities of MP especially in terms of Health Care Associated Infection (HCAI) which contributes to early neonatal diseases particularly sepsis. However HCAI is not only the cause of IMR and MMR in the country, but the intervention on WASH compliances can address 10 percent of deaths caused due to sepsis.

Programme Description

UNICEF Madhya Pradesh in collaboration with Quality Assurance Unit of NHM has carried out assessments and WASH improvement plans in 148 healthcare facilities (Seven District Hospitals, 43 CHCs& 98 PHCs) and Nutrition Rehabilitation Centers (NRCs) in 7

High performing districts of Madhya Pradesh. The selected facilities are accountable to conduct more than 70% of the total deliveries conducted in the districts with an ultimate objective to develop greater understanding, generate knowledge, and to create infection free environment and build appropriate responses on WASH in healthcare. A pre tested comprehensive assessment and improvement planning tool with a Star Grading tool (SGT) app was used by the health professionals and mentors to assess real time WASH imitative implementation status of healthcare facilities. A separate dashboard ODK collect was also created and used for ease of data collation, interpretation and analysis.

Programme Outcome

As per NHM-MP (Nutrition Cell) data compiled in a period of 2 years (2016-18), recovery rate has drastically changed and reduced in 7 WASH intervention districts of MP. During the year 2017-18, total 51 health facilities awarded by Kayakalp and out of these 24% declared from WASH in Health intervention districts as more than 65% indicators are related to WASH improvement.

Implementing Partners

UNICEF, NHM, and IIMRU.

Financial Implication

As per the allocated budget to different level of health facilities under untied funds 16% funds were mainly utilized WASH interventions (78,02,215.00 out of 46.50 lakhs).

Scalability

Based on the evidences and its improvement throughout these years the project is now being replicated in two more tribal districts namely Alirajpur, Jhabua, and 24 Aspirational Districts within the state. Also State Govt of Chhattisgarh has shown willingness to adopt the model in their state in collaboration with UNICEF Chhattisgarh. DOHFW Assam has also expressed their willingness to test the feasibility of the Programme in their state through brainstorming sessions.

Contact

kayakalpmp@gmail.com

HEALTH BULLETINS - Implementation of Out Patient Opioid Assisted Treatment (OOAT) for Drug-Deaddiction in the Public Health Facilities

Problem Statement

There are dissimilarities in the number of patients availing health services under Drug-De Addiction Programme and actual number of patients who wish to get-rid-of the addiction. There is an extra expense on the medicine purchase as the medicines are prescribed to ghost patients.

Programme Description

OOAT is OPD based treatment of substance abusers by empowering Medical officers posted at CHC, drug de addiction centre and rehabilitation centre. The main features of this Programme are the Central digital recording of individual patients along with generation of

unique identity number. Unauthorized access of the data is prevented by a three-layer security. Another added feature of this web portal is that it is platform and device independent with minimum bandwidth requirement of 512 kbps. The target population of this Programme are the substance users.

Programme Outcome

With the implementation of CRS, sharp decline in patient registration for treatment has been noted. The reason behind the decline in number of patients is a removal of duplicate/ghost patients and impact of this system is further visible in consumption of medicines. There is an evidence of 25% decline in expenditure on purchase of medicine too.

Implementing Partner

This is an initiative of the state government (Department of Health and Family Welfare).

Scalability

Out- Patient Opioid Assisted Treatment Programme along with CRS system initially launched as a pilot project in three districts of Punjab namely Amritsar, Tarataranand Mogaon 26th October 2017, later scaled up in May 2018 to all Community Health Centre. This plan can be rolled out in other states as well.

Contact

chi@punjab.gov.in





ADARSH PHC

Problem Statement

For strengthening primary health care services, there is a need to create models from the perspective of availability of staff, drugs, tests and infrastructure, across the state that deliver healthcare of the highest quality to the rural population.

Programme description

The Adarsh PHC Yojna was launched on 15th August 2016 with a total of 295 PHCs (1 PHC per block) with a focus on providing adequate staff, increasing drug and investigations availability, adequate equipment and supporting infrastructure. The primary objectives of this initiative were to reduce out-of-pocket spending, strengthen services available to the community and improve clinical outcomes and reduce burden at higher institutions such as CHCs/ DHs.

Programme outcome/evaluation

Since the launch of Adarsh PHCs the state has seen an improvement in OPD numbers by 30% and deliveries by 4% at the identified PHCs. The success of the first phase led to the decision to add another 600 PHCs under the

scheme. 286 PHCs out of the selected 600 were launched as Adarsh PHCs in the second phase on 11th, July 2017.

Scalability

The government plans to add another 314 PHCs under the umbrella of Adarsh PHC Yojna in the

next phase. These PHCs have also been developed into “Wellness Centers” by posting Ayurvedic Medical Officers, and ensuring availability of Ayurvedic medicines and Yoga services.

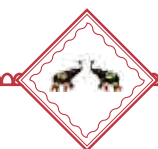
Contact

spm_raj.nrhm@yahoo.com





INNOVATION IN HC DELIVERY Training Need Assessment



Problem Statement

To improve the skill of our Hospital/ Department Doctors, Staff nurse and workers in effective Health care delivery and increasing their competence

This Laqshya initiative at GH sholinghur quality circle has made a tremendous impact on the way our HCO employees execute their work with skill and confidence, thereby gradually improving the patient and employee satisfaction.

Programme Description

- The results of medical and nursing audit death audit and prescription audit were analyzed in the quality circle meeting of labour room and OT.
- Training need assessment done as per daily rounds findings.
- OSCE analysis for each category of staff.
- Focused one to one training and inclusion of the needed subjects in the annual training plan was done.
- TRAINING CELL has been formed in the hospital including one obstetrician, one pediatrician and Hospital Infection control nurse, Quality Nodal Officer and Quality Nodal Nurse.

Solutions Arrived

- The area/ward staff nurse will orient the patient how to use the suggestion box to voice her complaints with confidentiality assured.
- The printed patient feed back forms covering the areas of service delivery, facility management and dignified approach by health care workers will be hung below each suggestion box.
- Patient or attender is encouraged to fill the forms and add their opinions in the end and put the forms in the suggestion box.
- Head nurse/matron entrusted with the task of opening the box and submitting the filled forms to the concerned HOD.
- These points will be discussed in the weekly quality circle meetings of the hospital every Thursday.



Programme Outcome

The Retest showed a marked improvement in competence level. The skill empowerment reflected in the results of health care delivery.

- Better wound healing-staff nurse training in hand hygiene
- Cleanliness of patient care areas-workers training in three-bucket system/ unidirectional mopping/mop disinfection
- Correct method of clinical application and State of the art management DOCTORS training

Cost

Minimum cost involved for printing OSCE assessment printing. No additional manpower required

Scalability

Can be applied in all hospitals. Quality is a continuous process; this method will be applied every six months to fine-tune the skills of all our employees

Contact

rhcpci@tn.nic.in





QUALITY IMPROVEMENT IN LAB SERVICES IMPLEMENTATION & IMPACT OF EXTERNAL QUALITY ASSURANCE SCHEME (EQAS)



Problem Statement

Medical errors can be clustered into categories like errors of diagnosis, treatment, prevention, and miscellaneous. Approximately 60% to 70% of medical decisions are related to laboratory diagnosis. Right investigation reports are important for right diagnosis, right treatment and right clinical outcome of the patient. To improve the precision, accuracy and to reduce the variation in laboratory results it is required to have robust internal Quality control and external quality assurance of medical laboratories.

State of Uttar Pradesh has initiated implementing of National Quality Assurance Standard in 2014 and during its internal assessment it was found that none of the facility was performing internal & external Quality control Programme. Lack of any Quality control Programme in hospital labs. lead to inaccurate results of both haematology and biochemistry tests and it ranged out of its two & third standard deviations* from 17% -44% and 22% - 52% respectively.

Programme Description

To address this issue state has decided to take up action and empanelled RML Mehrotra pathology, a non-government accredited EQAS service provider for ensuring External Quality Assurance Scheme (EQAS) in the state. Project started in the FY 2016-17 for Haematology tests of 40 District Hospitals and was extended to cover both Haematology in 40 hospitals and Biochemistry tests in 24 hospitals in the year 2017-18.

Based on initial reports a drive was run to strengthen the system and root cause analysis was done and to identify critical to quality issues and measures were taken.

*The results falling between two standard deviations (SD) are considered to be precise.

Programme Outcome

Regular root cause analysis follows up and feedback for corrective action was done and it

led to the improved results in the subsequent cycles. Duration for Intervention for EQAS has been taken here from September 2016 to September 2018.

Under Haematology for Hb, RBC, MCV & MCH there is 11, 17, 12 & 12-point improvement from baseline. While under Biochemistry, for Bilirubin, Creatinine, Glucose, HDL, Uric acid there is 31, 31, 35, 17- & 19-point improvement noticed from baseline.

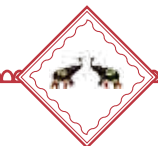
Contact

qanhmup2018@gmail.com



STRENGTHENING QUALITY OF MNCH DATA UPHMIS

Results from 2nd Round of Data Quality Audit and Feedback in 148 Priority Facilities



Problem Statement

Use of govt data for Programme review and planning is a key challenge due to poor data quality of HMIS/MCTS, in Uttar Pradesh. Every year large numbers of Programme managers, service delivery professionals and data entry operators are training on HMIS/MCTS but the success is limited due to several reasons. UoM/UPTSU has adopted a number of interventions such as inclusion of data quality index in the district performance ranking, regular analysis of data quality and feedback and supportive supervision, which includes joint data audit with facility staff and hand holding for data improvements.

Programme description

In order to improve the data quality of HMIS (UPHMIS), UPTSU adopted a strategy where a TSU team (M&E and clinical) works with

facility level staff to systematically audit data, identify reasons for data gap, provide on site solutions (if feasible) and prepare action plan for data quality improvement. A field team is constituted by TSU to qualitatively understand the reasons for high performance vis-à-vis low performing facilities. The qualitative methods such as in-depth interview and discussion with the facility staff to understand the pathways of change in facilities which improved their performance and those who did not. The initial findings suggest that facility level ownership is one of the factor for improving the data quality.

Programme Outcome

The mean score of proportion of data elements matched with source registers have increased from 49 to 70 ($p < .001$), the increase is high in district hospitals (47 to 72, $p < 0.001$) followed by block level CHCs. There

is substantial decrease in the heterogeneity in the poor performing districts, as 28% of the poor performing facilities have improved their performance in terms of data consistency with source register. Almost 15% of the facility remains poor performing after the intervention. Based on these findings National Health Mission constituted seven teams to periodically conduct data audit in 75 districts, which will be further increased subsequently with engagement with division and district team.

Supportive supervision is one of the critical interventions for improving the data quality of HMIS, as it increase facility level ownership.

Contact

mdupnrhm@gmail.com

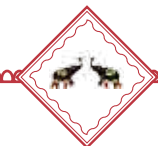


EMERGING INITIATIVES

Health Care Technology



BEMPU Hypothermia Monitoring Device



Problem Statement

Neonatal hypothermia and infection are among the top causes of newborn death and illness in low-resource settings, especially in Lower birth weight and pre-term infants. Newborns with hypothermia can experience consequences like hypoglycemia, hypoxia, and poor weight gain. In premature infants, hypothermia increases morbidity and mortality. Hypothermia may be purely environmental or represent intercurrent illness (eg, sepsis). Hypothermia can result in poor growth, poor organ development and death. Hypothermia is affecting up to 85% of newborns globally and approximately 4-12 million Indian newborns yearly.

Programme Description

BEMPU could be a bracelet that can detect hypothermia early and alerts the mother with an intuitive audio-visual alarm. This enables the mother to perform Kangaroo Care thereby preventing hypothermia. Up to 2.6 million babies die within their first year. Hypothermic babies are two times more at risk than average rate as much as 2/3 of these deaths could be prevented



Methology Of Bempu

BEMPU flashes a blue light when the BEMPU flashes orange and alarms when the baby is at a normal temperature baby is hypothermic

The mother does kangaroo care. Once the temperature returns to normal, BEMPU Flashes blue again.

Programme Outcome

- It can facilitate improved thermal care of newborns.
- The device could be simple to use, safe, fits low-to-normal weight infants, and can promote kangaroo care in home setting.

Pilot

The Programme has been piloted by Rajasthan government

Financial Implication

Price of bracelet at current scale with Programmematic intervention Rs. 2,000

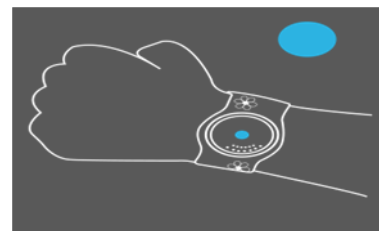
Scalability

It could be used in Public Health system

Contact

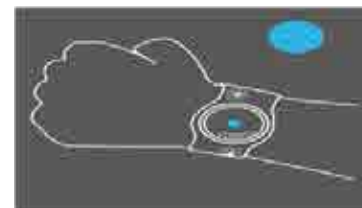
<https://www.bempu.com>

BEMPU flashes a blue light when the baby is at a normal temperature



BEMPU flashes orange and alarms when the baby is hypothermic

The mother does kangaroo care



Once the temperature returns to normal, BEMPU Flashes blue again.





Touch HB

A Non-Invasive Anaemia Screening Device



Problem Statement

According to Global Nutrition Report 2017, 51% of Indian women aged 15-49 anemic. In 2016, the report showed that nearly 48% of women in India were anemic. Anemia is typically diagnosed on a complete blood count.

Programme Description

TouchHb is a non-invasive anemia screener which mean it detects anemia without a needle poke by identifying the presence of pallor in conjunctiva. The main focus of TouchHb is on the easy functionality factor and the affordability factor.

The camera captures an image of the conjunctiva of the eye. This image is sent to the smart phone over Wi-Fi. The TouchHb app processes this image, runs image processing algorithms and calculates the Hemoglobin (Hb) of the patient. It uses the method of reflectance photometry to estimate the hemoglobin content in blood in grams per deciliter. It is recommended that the subject look straight or upward while the screening test is performed.

Programme Outcome

Hemoglobin estimation (Hb) is one of the basic tests recommended in Free Diagnostics initiative guidelines under National health mission up to subcenter level. TouchHb is a portable device and could be carried by ASHA worker.

Pilot

TouchHb has been piloted by some Government hospitals of Rajasthan and Maharashtra.



Financial Implication

Cost of TouchHb is Rs. 18,548 per device and it uses non-invasive conjunctival imaging-based method which costs 0Rs/- per test. As TouchHb do not use electricity or chemical to perform test, it does not involve any direct cost per test.

Scalability

Measurement of blood Hemoglobin (Hb) is a common indicator for the diagnosis of Anemia. Hemoglobin test is one of the recommended tests in Free diagnostics initiative guideline at PHC level. TouchHb could provide a scalable solution.

Contact

yogesh@biosense.in



ANDHRA PRADESH

TruNAT MTB AND MTB-RIF: Diagnosis for Mycobacterium Tuberculosis



Problem Statement

Tuberculosis is an infectious disease caused predominantly by the bacillus Mycobacterium tuberculosis. It typically affects the lungs but can affect other sites as well. In India, an estimated 27.9 lakh patients were suffering from TB in 2016 and up to 4.23 lakh patients were estimated to have died during the year.

Programme Description

TRUNAT MTB is an open system – the DNA is first extracted and the testing is carried out using a portion of that DNA. The remaining DNA can be used for any other molecular confirmatory test



or for testing rifampicin resistance if the test result is positive for TB. Drop-outs can be avoided since TRUNAT MTB does not need two samples.

MTB TRUNAT™ MTB and MTB-RIF Dx is a Chip-based Real Time PCR test for quantitative detection of Mycobacterium tuberculosis and Rifampicin resistant Mycobacterium tuberculosis respectively in human sputum specimen. MTB and MTB-RIF Dx aids in diagnosis of tuberculosis infection and Rifampicin resistant Mycobacterium tuberculosis infection respectively

TRUNAT™ MTB and MTB-RIF Dx runs on the Truelab™ Real Time micro PCR Analyzers.

Addition of 5 ml of DNA to TRUNAT MTB chip
PCR SUITCASE

Innovation Outcome

- It will only test for rifampicin resistance when samples are tested positive for TB. Thereby, the use of reagents may be reduced and will help make testing cheaper.



PILOT Product is yet to be piloted in Public Health Facilities

Financial Implication

Cost of test TRUNAT™ MTB including TRUNAT™ MTB – RIF Dx for all positive cases is Rs. 800 per test

SCALABILITY It could be done at a primary healthcare centre without electricity, as the portable machine is run by a battery

Contact

bc@bigtec.co.in





TECHNICAL GUIDEBOOK ON MAINTENANCE AND REPAIR OF MEDICAL DEVICES

Problem Statement

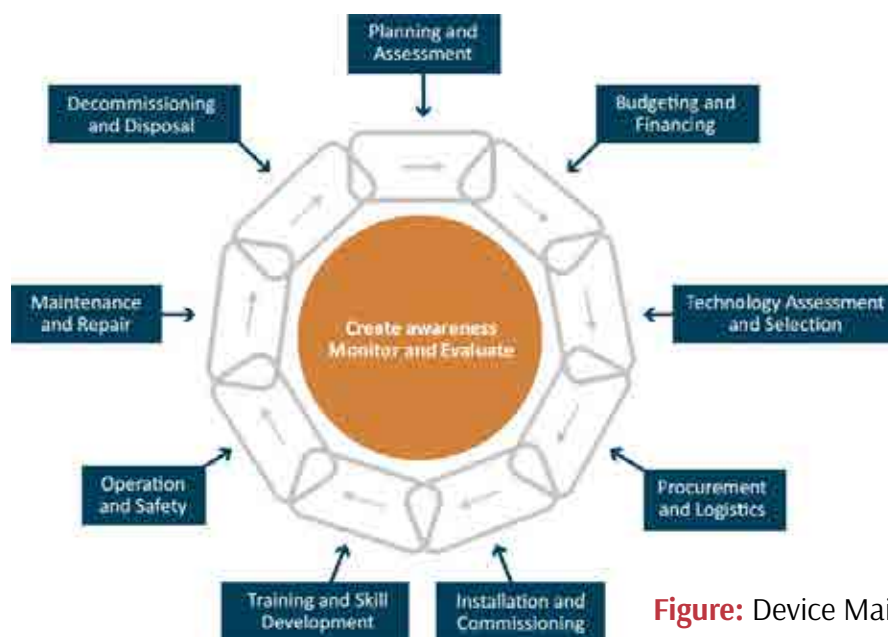
Optimal use of medical equipment is when safety and accuracy is ensured and expected results are obtained in right time. Many quality standards such as USFDA/CE/BIS/UL/EN/ISO/IEC are followed for ensuring optimal manufacturing of medical devices ensuring safety, accuracy and robustness along with ease of device operation by end users as required. The primary function of any healthcare facility is to keep medical equipment in good working condition and in optimal performing condition to ensure provision of quality services. The guidebook on preventive maintenance of equipment is generally prepared for easy reference of users and technicians of devices.

Programme Description

This manual is intended to be a guide for the medical equipment user to carry out basic maintenance tasks. As the majority of equipment problems are either simple or user-related it is the aim that the better care and regular maintenance enabled by this manual will have a significant positive effect on the delivery of healthcare across India.

- Tasks that can be done by the user of the equipment

Figure: Equipment maintenance life cycle



- Tasks that take place at the point of equipment use
- Tasks that do not require the opening of the main body of the equipment

Programme Outcome

The guide book will be helpful in user preventive maintenance of medical equipment at all levels of public health facilities.

Financial Implication

As this guidebook is developed by state it will be freely available either through states or another website.

Scalability

As this is a guidebook it could be scaled to all levels of public health facilities.

Figure: Device Maintenance in progress

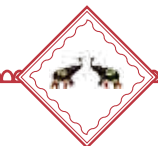


Contact : missiondirector@nic.in



TELANGANA

DIAGNOSTIC SERVICES-HUB & SPOKE MODEL



Telangana Diagnostic project is a State initiative to build in-house capacity to provide Quality Diagnostic services, free of cost to the public. It aims to fulfill this need using HUB and SPOKE model. A Dry-Run was initiated in January 2018 where 50 Centers in and around Hyderabad were identified and were included in Dry-Run in a phased manner. Currently a total of 126 centers have been made operational under this project which includes 5 Area Hospitals, 1 District Hospital, 3 Wellness centers, 2 Basthi Dawakhana, 1 Civil Dispensary.

52 different types of investigations are being performed at the central lab

126 centers which are currently operational in Dry-Run are divided into Hubs & Spokes.

- Spokes - 109
- Mini Hubs - 8

Spokes include 1 District Hospital, 5 Area Hospitals, 3 Wellness Centers, 105 UPHC's and 9 UHC's. The samples transportation is accomplished through Dedicated Transport System

Contact

arunchinta@yahoo.com



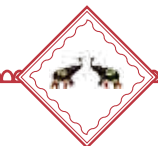
EMERGING INITIATIVES

D
DCPs & NCDs



ASSAM

TOBACCO FREE VILLAGE, JORHAT



Problem Statement

Tobacco free Village concept is to reduce the health hazards of Tobacco consumption (mostly from chewing form; to prevent Cancer, Cardio vascular diseases, TB and other tobacco related diseases) for the first time in India at Jorhat district of Assam, where the Tobacco consumption is higher than the National Average of India (As per GATS study) and the religious & social acceptance is much more higher than the other part of India. Concept of Tobacco Free Village was adopted in a Cost effective way under NTCP Assam.

- Cancer (Mostly Oral), Cardiovascular (CAD) premature deaths along with other Tobacco related deaths are very common in this part of the country.
- Tobacco use and offering of dried Tobacco (Man Sada) with areca nut, beetle leaf and lime paste is a classical social custom of Assamese villagers.
- Children adopt Tobacco chewing habit of tobacco at their own home rather than after a peer stress of society or in school environment.
- The School Health Programme of NTCP alone cannot provide safe guard to our

future generations unless we educate the villagers.

- Concept of creation of Tobacco Free village is one of the best policies to educate about the ill effect of tobacco to our future generation.

Programme Description

We have adopted following steps in tobacco free village projects

Selection of the villages in consultation with local prominent public leaders.

- Third party pre-evaluation (Survey) of the Tobacco use pattern. (Optional and newly introduced)
- School and Village level Interventions with audiovisual Programme.
- Multispectral approach with generation of different parallel orders, gathering supports from other government departments.

- Involvement of local volunteers and NGO leaders.
- Group discussion with involvement of “self-helps groups” (SHG) and student bodies.
- Special De-addiction Camps & awareness campaigns were organized with street play.
- Personal relationship was developed with Hard core Tobacco Users.
- Mass Oath Taking Ceremony was conducted in the premises of the Village NAMGHAR
- Visit of District Administration (DC) with ceremonial appreciation.
- Ceremonial Declaration
- Training of Various women specially the Self Help Groups
- Celebration of World No Tobacco Day
- Special House to House to Campaign

Contact

spm.nhmassam@gmail.com





INTRODUCTION OF NEW DRUG (BEDAQUILINE) WITH CENTRE - STATE PARTNERSHIP to Improve Treatment Outcomes of Drug Resistant TB Patients



Bedaquiline – a new anti-TB drug was introduced in the country in conditional access Programme at selected Drug Resistant TB Centres. Government Medical College, Guwahati in Assam was the first DR-TB Centre in the country to enrol drug resistant TB patient and initiated on Bedaquiline containing treatment regimen. Documentation of preparation and outcome of introduction of Bedaquiline containing regimen will be provided in detail.

Contact

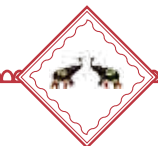
spm.nhmassam@gmail.com





ANDHRA PRADESH

SYSTEMATIC MEDICAL APPRAISAL AND TREATMENT (SMART) - Mental Health Project



Problem Statement

Only about one in every four mental health patients receive appropriate health care in India. Stigma, lack of adequate mental health professionals and mental health services account for this treatment gap, which is worse in rural areas.

Programme Description

This Systematic Medical Appraisal Referral and Treatment (SMART) mental health project evaluated task shifting and mobile-technology based electronic decision support systems to enhance the ability of primary care health workers to provide evidence-based mental health care for stress, depression and suicidal risk in 30 remote villages in Andhra Pradesh between May 2014 and April 2016. 21 ASHAs and 2 primary care doctors were trained to use an electronic decision support

system; over 5000 eligible individuals were screened and 238 identified with common mental disorders needing referral and further management. A pre-post evaluation using mixed methods assessed the change in mental health service utilization by screen positive individuals.

Programme Outcome

There was a significant reduction in the depression and anxiety scores between the start and end of the intervention among those who had screened positive at the beginning. Stigma and mental health awareness in the broader community improved during the project duration. The intervention led to individuals being screened for common mental disorders by village health workers and increase in mental health service use by those referred to the primary care doctor.

Implementing Partner

The George Institute for Global Health India

Financial Implication

The model was deemed feasible and acceptable.

Scalability

The effectiveness of the intervention needs to be demonstrated using more robust randomized controlled trials, while addressing the issues identified during the project that will facilitate scale up.

Contact

pmaulik@georgeinstitute.org.in





TB MUKTA VAHINI NETWORK

A Community Led Response for TB

Programme Description

TB MUKT VAHINI (TMV) is a network of TB Survivors cum Champions. Initially, 13 TB Champions underwent the capacity building workshop arranged by REACH formed the network which is now having more than 200 members.

The members of the networks are from different sectors-like farmers, taxi driver, private teachers,

law Student, gramin chikitsak, self-employed, and social sector.

They are motivating to people through sharing their own stories to fight against TB. The network coordinates with each other at different level. The members of TB MUKT Vahini are conducted several advocacy meeting with Policy makers-elected representative (Ministers/MLAs/MLCs/MPs) to bring the political commitment in TB and PRI members for

making 'TB Free Panchayat'. They are member of Programme Committees. It has formed it social media account at FB page, twitter & whatsapp and supporting & motivating people through sharing their routine activities at social media.

Programme Outcome

The network contributed through

Patient counselling – 286

Referral – 400

Diagnosed among referral – 72

Contact

tbmuktvahini@gmail.com





REGAINING THE LIFE : Leprosy Post Exposure Prophylaxis

Problem Statement

Despite a national elimination status in 2005, leprosy continued to be a public health problem in Dadra and Nagar Haveli. Increasing prevalence rate (PR) and ANCDR reflected high and active transmission of Lepra Bacilli in its population. Proportion of child cases was also rising.

Programme Description

To curb the menace, an innovative concept of “Post-Exposure Chemoprophylaxis Project” was launched with two pronged approach to eliminate leprosy from Dadra and Nagar Haveli. Prompt referral of symptomatic persons and prophylactic drug administration to contact persons. Intensive surveys are carried out periodically to identify persons having symptoms of leprosy. They are promptly referred to a health facility for multidrug therapy (MDT). All the contact persons of symptomatic person are identified. They are offered a post-exposure prophylactic drug administration, which comprises of a single dose of rifampicin. This cuts down their risk of developing leprosy by 50-60%.

Programme Outcome

- By end of March 2018, Contacts of 1574 index cases of leprosy, 3930 were screened

and 28139 contacts were administered single dose of Rifampicin PEP (Post Exposure Prophylaxis).

- PR of leprosy declined from 6.77 in March 2015 to 4.5 in 2018.
- MB cases have started declining
- No new Grade II disability found
- Acceptance of PEP and Awareness among people for leprosy has being increased.



Key Challenges

- Repeated visit to contact house
- Difficult to convince contacts in Urban areas
- Difficulties in covering social contacts in school
- More number of forms (Excess paper works)
- Difficulties in understanding the codes in contact list

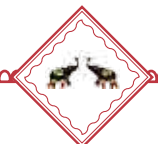
Contact

nrhmdnh@gmail.com





SPECIAL ROUTINE SURVEY (SRS) CONDUCTED AT THE DANGS UNDER NLEP



Problem Statement

National Leprosy Eradication Programme (NLEP) was introduced in Gujarat in 1983 in phased manner and the whole was covered by MDT in the year 1991. The goal of NLEP was to reduce the prevalence rate to less than 1 per 10,000 populations by 2005 which was achieved in Oct-04 and reduced PR 0.95 at State level.

Programme Description

To achieve the objectives of the plan, the main strategies to be followed are:

- Integrated leprosy services through General Health Care system.
- Early detection, prompt & complete treatment of new leprosy cases.
- Carry out house hold contact survey for early detection of cases.
- Involvement of Accredited Social Health Activist (ASHA) in the case detection & completion of treatment of Leprosy patients.
- Strengthening of Disability Prevention & Medical Rehabilitation (DPMR) services.
- Information, Education & Communication (IEC) activities in the community for improve self-reporting to Primary Health Centre (PHC) and reduction of stigma.
- Intensive monitoring and supervision at block, Primary Health Centre, Community Health Centre.

Special Routine Survey was conducted between September 5, 2018 to September 21, 2018 in The Dangs District which is Southern district of Gujarat with the objective of District level elimination (Prevalence Rate < 1) by the end of the Year and Reducing the rate of new cases with grade-2 disabilities (Grade 2 disability Ratio) per 1,00,000 population

After routine Leprosy Case Detection survey, The Dangs districts required thrust through special plan with more focused and systemic approach.



Programme Outcome

Out of the 637 total suspected cases, 119 cases were detected for NTD, 28 cases for MB, 91 PB cases and 17 children cases

The identified new cases were put on treatment and the further management has been planned in case required hospital admission.

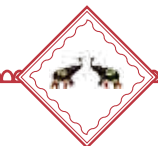
Contact

pvdave1@gmail.com



GUJARAT

AADHAAR - A Mental Health Helpline and School Outreach Programme



Problem Statement

The Helpline provides help and support to the persons with mental illness and generate awareness on mental health issues. The Helpline also arranges free Ambulance services to the families who are unable to bring their family members suffering from mental illness for treatment at State run mental health establishments at Ahmedabad, Vadodara, Jamnagar and Bhuj.

Programme Description

The Control Room of the helpline has been established at Hospital for Mental Health, Ahmedabad. The Counsellors attending the calls identify the crisis or problems and provide telephonic counselling and if needed refer to treatment facility. The Helpline also provides free Ambulance services to the families who are unable to bring their family members/

friends/relatives for treatment at Ahmedabad, Vadodara, Jamnagar and Bhuj. For Destitute persons with mental illnesses the helpline team rescue the person with help of Police and admit them in the mental health establishments with Judicial Orders. On an average, the helpline received about 25-30 calls a day during which the callers are provided with general information on mental health, telephonic counselling and referrals to treatment centres. Through the helpline, more than 3600 destitute mentally ill have been rescued, treated and after recovery, about 3200 of them have been re-united with their families across the country.

The Government of Gujarat initiated the School Mental Health Programme to recognize mental health issues in children from preventive care perspective by bringing awareness amongst Teachers on a large scale.

Programme Outcome

Mental Health Screening has been included in the school health check-up Programme run by the Public Health and Education Department of Gujarat. The State has prepared training modules including life skill education for Teachers which incorporate identification of mental health issues, counselling, referral to DMHP/Psychiatry Dept./Hospital. The State has conducted training and sensitization of Teachers through BISAGE (Satellites) on a larger platform covering almost 42,000 schools and is running Child Guidance Clinics at 18 Districts. The State has also developed Pediatric symptom checklist and child behavior checklist (Parents and Teachers version used for screening purpose) and conducts regular awareness activity for Parents.

Contact

md-nrhm@gujarat.gov.in





“E- HEALTH CARD” - A Digital Solution for Prevention and Control of all common NCDs



Problem Statement

Himachal Pradesh with a population about 7 million achieved a high level (40%) of opportunistic screening of +30 population for Diabetes & Hypertension in the year 2016-17 under NPCDCS. About 9.13 lakh persons were screened and 11.35 %, 10.29 % were suspected for diabetes and hypertension respectively [Annual NCD report 2017]. The prevalence could not be assessed since the same person could have been screened multiple times or at many places.

Programme Description

In order to collect the reliable information of the entire +30 population and to address all common NCDs & risk factors, the digital health promotion approach has been adopted covering all common NCDs like Cancers, Diabetes, CVDs,

Stroke, COPD, CKD, Blindness, Deafness, Mental illness, epilepsy and associated NCDs risk factors, the **Electronic Health Card (EHC)** has been developed in the state.

The strategy is as per the GOI – NPCDCS guidelines but the innovation is coverage of more than 10 NCDs, 15 risk factors and individual empowerment through access to the OTP protected data and SMS reminders for services and follow-ups. The ASHA does the population enumeration and collects the data about the risk factors and common signs and symptoms from individual. ANM uploads the observations through the Anmol tablet in the Health Card application. The information is available to patient and to the service providers immediately. ASHA ensures the monthly follow-up visits and provides information to the ANM for further uploading in the portal.

Programme Outcome

Details of more than 3.6 lakh persons has been enrolled in EHC till September 2018. The follow up of identified cases are ensured

Scalability

The state of Himachal Pradesh will soon cover 18-30-year populations under this strategy as Mukyhamantri Nirog Yojna. GOI has also launched the NCD application in India in 2017-18 which covers few risk factors and diseases like hypertension, diabetes and 3 common cancers. The data from the E Health card can be easily migrated to the GOI application.

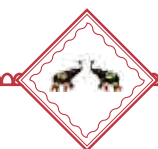
Contact

osdncdhp@gmail.com



JHARKHAND

mSAKHI FOR NON-COMMUNICABLE DISEASES (NCDs) : A Digital Solution for Coordinated NCD Management



Problem Statement

Over the last decade, there has been an increase in the prevalence of NCDs in India. In Jharkhand, NCDs account for 48% of the total disease burden. NCDs pose a new array of challenges such as the sheer numbers of people who will need monitoring; the high cost of treatment, and the chronic nature of the conditions.

Programme Description

mSakhi for NCDs is a digital health tool for frontline health workers to help them counsel, screen, refer and track patients – and at the same time record data about coverage of the Programme. There are separate applications for ASHAs, ANMs (ASHA supervisors) and a web-portal, so supervisors and Programme managers can track key indicators on a real time basis.

Programme Outcome

Earlier diagnosis and initiation of treatment of patients.

The automatic scoring feature for CBAC has helped the ASHAs to identify high- risk individuals while ANMs are able to prioritize screening and follow up for high risk individuals.

mSakhi has reduced the work load for ASHAs and ANMs by reducing paper work.

Evaluation Result

A qualitative assessment conducted in Kanke block, Jharkhand district in June 2018, found that mSakhi has improved assessment skills and knowledge about NCDs among FLWs as well as the community.

Financial Implication

Implementation cost of implementing mSakhi in four HSCs and one CHC having 51 ASHAs, 04 ANM and 01 GNM at CHC was borne by Intra Health.

The implementation cost of replicating mSakhi in one block with an average size of 20 Health Sub Centers is approximately INR 8,968 per AHA for the first year with a yearly recurring cost of INR 2,104 per ASHA and ANM while for Clinical staff is estimated to be INR 12,741 and INR 1,843 respectively.

Conclusion/Lessons Learnt

m-sakhi has demonstrated high level of acceptance of digital tools among Frontline workers by enabling reduction in work load and



improving the follow up of individuals at high risk for screening.

Implementing Partner

Intra Health International, Inc.

Scalability

The m- sakhi application can be integrated with the NCD- CPHC application being rolled out at the HWCs after technical review.

Contact

mdnrh@jharkhand@gmail.com





ASSISTED HOME CARE TO THE MENTALLY ILL



Problem Statement

Despite efforts made under District Mental Health Programme (DMHP), about 30% of patients (living in communities) have sub-optimal outcomes. A sizeable proportion of persons affected by Severe Mental Disorders (SMDs) remain out of reach of treatment. The factors for dropping out include, stigma and lack of awareness, cost factors due to distance between community and District hospitals etc. Community based interventions for (SMDs) have been proved to be beneficial and cost-effective.

Programme Description

It is a pilot Programme involving home visits for persons affected with SMDs who have dropped out of treatment. Home visits are done by PSW/NURSE under supervision of Psychiatrist. During the visit, screening of reasons for drop out with the objective of bringing people back into the fold of treatment is done and psychosocial counseling is provided.

Programme Outcome

In both Urban and Ramanagar District together, in the past four months, about 40 among the 60



registered cases have been brought back under the AHCs treatment umbrella. In fact, during home visits, some new cases of SMD have also been identified. Psychosocial interventions in home/community settings, provides a much better and nuanced understanding of a persons' psychosocial needs and social and family dynamics. It is easier to also counsel the family. Patients and family have received the home visits well. There are challenges with regard to maintaining confidentiality that need more attention. The pilot is still in data collection phase. Independent evaluation shall be done in next two months.

Implementation Partners

AHC pilot project started by GOK-DMHP in collaboration with NIMHANS and BMCRI

Financial Implication

Need to be assessed once pilot study is over.

Scalability

After the pilot Programme the services can be scaled up to more districts, especially where DMHP is being implemented. The draft CPHC guidelines on mental, neurological and substance use disorders, also propose home visits and community based psychosocial interventions, support and follow up, to be carried out by ASHA/ANM under supervision of the MLHP at HWC or MO at PHC.

Contact

dd6mhkar@gmail.com





KERALA

STEWARDSHIP BY THE LOCAL SELF-GOVERNMENT IN TB ELIMINATION



Programme Description

TB Elimination taskforces are formed in all of the 1034 LSG bodies chaired by the head of the LSG. The TB elimination task force is a group of responsible citizens and public servants organized under the leadership of the LSG specifically to achieve the goal of TB elimination in the population stewarded by that LSG. The taskforces decide on local adaptations of generic protocol of Kerala TB Elimination mission.

One of the various activities of TB Elimination mission in Kerala initiated by the LSG stewarded TB elimination taskforces is mapping of TB vulnerabilities of all individuals under the LSG. A team of 2 trained health volunteers visit a block of 200 serially numbered households at a rate of 10 houses per Sunday, with a questionnaire to assess 13 TB vulnerabilities of each individual member of the household. In addition, they impart TB awareness to all individuals in the households and refer identified TB symptomatic among the vulnerable individuals for testing.

Programme Outcome

78,000 trained health volunteers have visited 7,80,000 households of the state, meeting 3,41,00,000 individuals and assessing 13 vulnerabilities of each individual. Currently



the data is being digitalized. This data will be used for periodic surveillance for TB symptoms among the vulnerable individuals for a period of 4 years. In addition, 38,000 TB symptomatic

were referred for testing and 383 new TB cases were diagnosed.

Contact
stoke@rntcp.org





CATARACT BACKLOG FREE

Objective of Programme

An initiative to create cataract Backlog free Madhya Pradesh under National Programme for Control of Blindness and Visual Impairment (NPCB&VI).

Strategy

- To do the line listing of patients by ASHA.
- Mobilizing cataract patients to Public Sector Hospitals and NGOs through ASHA.
- Implementation and training of ASHA through Deputy DPMs.

Human Resource Involvement

- Identification of ASHA with their villages.
- Identification of PMOAs with their area allotted.
- Identification of Deputy DPMs (Best PMOA of the district).
- Identification of DPMs.
- Identification of NGOs.

Training

- Training of Deputy DPMs and DPMs by State Programme Officer.



- Training of PMOAs by Deputy DPM & DPM.
- Training of ASHAs by Ophthalmic Assistant.
- Training of Ophthalmic Assistant to train ASHA.

Activity

- ASHA doing survey of their village and preparing the list.
- The lists prepared by ASHA to be collected by ASHA Sahyogi/ANM/MPW
- Examination of list of patients by PMOAs at village level/PHC and making route chart for transportation (Pickup, Followup and Drop of patients by a vehicle).
- Submission of list of final patients to Deputy DPM.
- MOU with NGOs by DPM.

- Preparation of Camp calendar for cataract operation for the Public Sector Hospital and NGOs.
- Dissemination of dates for examination and operation.
- Transportation of patients to Public Sector Hospital and NGOs.
- Followup of operated patients by PMOAs.

Contact

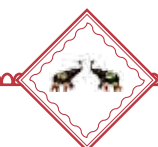
blindnessbhopal@gmail.com





RAJASTHAN

MOBILE DENTAL VAN



Problem Statement

Oral health although neglected is an important part of general health, affecting not only the individual, but also the broader health system and economy. Presently, assured delivery of oral health care in India is mostly available at tertiary level which also is mostly concentrated in urban areas. This leads to a huge gap between demand and availability of services.

Programme Description

Rajasthan has launched Mobile Dental Vans under RBSK with an objective to provide oral health care services including diagnosis and treatment to children below 18 years in hard to reach areas.

7 Mobile dental vans have been deployed for divisional Headquarters to cover all districts (34 in number) under them. Each Mobile Dental Van consists of one vehicle for movement of dentists and paramedical staff (dentist-2, dental technician-1, helper-1, driver-1) equipped with diagnostic facilities like dental chair, dental X-Ray and other equipment required for basic dental procedure/investigations.

Programme Outcome

From October 2017 to January 2018, 250 camps have been organized where 28006 children have been screened. 18% cases have had fillings done and 38% have undergone scaling. Rest of the procedures include Root Canal Treatment, Extraction, pulpotomy and referral to CHC or DH.

Implementing Partners

- GVK Telangana- Bharatpur, Bikaner and Udaipur
- Maharaja Vinayak Dental College, Jaipur- Jaipur

- Vyas Dental College, Jodhpur- Jodhpur
- SantokabaDurlabji (SDMH), Jaipur- Ajmer and Kota

Scalability

Practice can be replicated in states with far flung hard to reach areas on fixed day basis till integrated services become available.

Contact

spm_raj.nrhm@yahoo.com





SCRIPT PROGRAMME

(Stroke Care and Rapid Intervention with Plasminogen Activator and Thrombectomy)



Problem Statement

Every year, Stroke causes 55 Lakh deaths across the world, of which around 10 Lakh deaths occur in India. Stroke usually affects individuals later in life though it does not spare any age group. Presently it is also being observed in the younger population, mostly due to unhealthy lifestyle, raised blood pressure or diabetes which occur due to stress of the modern day life.

Programme Description

SCRIPT Programme (Stroke Care and Rapid Intervention with Plasminogen Activator and Thrombectomy) of Tamil Nadu Accident and Emergency Care Initiative (TAEI), Government of Tamil Nadu aims at Free and Immediate Medical, Surgical and Interventional Treatment for Stroke. Under this Programme:

- Emergency Medical Technician is trained to identify Stroke using the FAST Scale, Patient is shifted at once by Ambulance to designated Stroke Centre (with required facilities)

- Coordinate with Mobile Apps with the Stroke Centre about the patient and time of arrival
- Multi-disciplinary Stroke Team of Stroke Physician, Neurologist, Stroke Nurses, Radiologist and CT technician are ready at the Stroke Centre to receive the patient and start immediate Management.

Programme Outcome

- An initial pilot study was conducted with Rajiv Gandhi Government General Hospital (RGGGH) as the hub and Thiruvallur District Headquarter hospital, Kanchipuram headquarter hospital and Chengalpattu government college and hospital as the spokes.

Implementing Partners

- 108 Ambulance Services : Provides emergency Ambulance service.
- Directorate of Medical Education : Runs Hub Hospitals
- Directorate of Medical and Rural Health Services : Runs Spoke Hospitals

- Chief Minister's Comprehensive Health Insurance Service (CMCHIS): Provides insurance support for the Programme

Financial Implication

- CT Scans
- Biplanar Cath Labs
- Consumables for Cath labs
- Equipments and Consumables in ER
- Training of Hospital and Ambulance Health Care Workers

Scalability

- The standard operating protocols are being developed for stroke thrombectomy with the team of experts in Neuro-Intervention across the country. Bi planar cath labs are being installed in major hubs and neuro intervention training is planned for neurologists in the government service.

Contact

<http://www.nrhmtn.gov.in/>
www.taeionline.com
traumatnhsp@gmail.com



RNTCP FOR BETTER PERFORMANCE

The two Mobile CBNAAT Vans supplied from Centre was effectively utilised by the State with system strengthening.

- Tour schedule was prepared by allotting the vehicle for a week for each district.
- Communications were sent to all the District Collectors on schedule of Van.
- The Van covered District by district and screened the vulnerable populations, especially in the identified Blocks and towns for TB Free initiative.
- The District Collector flagged off the vehicle on Mondays in each of the district.
- Human Resource of the concerned districts were utilised for operating the CBNAAT machine and driving the vehicle.

The outcome (3 months) is as follows:

- Number of tests – 14354
- Number of TB patients diagnosed – 1009

Contact

rchpcni@tn.nic.in





NIKSHAY POSHAN YOJANA ZERO TO UNIVERSAL COVERAGE IN ASPIRATIONAL DISTRICT - NADIA



Documentation of NIKSHAY Poshan Yojana through Direct Benefit Transfer for TB patients in the Aspirational District. The Scheme launched in April 2018 and in the period of April and May 2018, 90% coverage was achieved during Extended Gram Swaraj Abhiyan.

Contact

mdnrhm@wbhealth.gov.in



EMERGING INITIATIVES

NUHM



THE URBAN PHC (UPHC) - The New Makeovers

Programme description

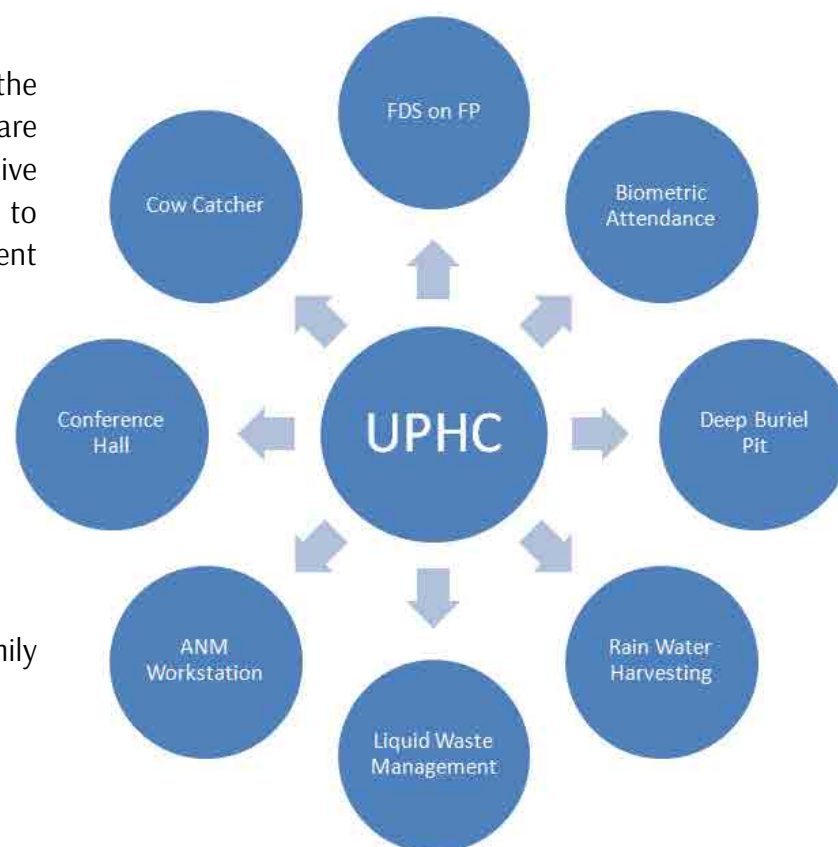
Urban Primary Health Centre (UPHC) is the hubs of preventive and basic curative care for urban population. Various innovative approaches have been taken in the UPHC to create conducive environment for the patient as well as service providers.

The following activities were undertaken:

- Liquid Waste Management
- ANM workstation
- Conference hall/ Meeting hall
- Cow catcher
- Fixed Day Static (FDS) Approach in Family Planning Services in UPHCs
- Bio metric attendance
- Deep Burial Pit
- Roof Top Rain Harvesting Structure

Programme Outcome

- Infection management and ensure contamination of water through liquid waste management
- Created conducive environment for the ANMs to work in the UPHC
- Restriction of entry of the animals to the UPHCs
- Good response of Urban Population on FDS
- Check attendance of the service providers through bio metric attendance



- Proper bio-waste management
- Water preservation through roof top rain harvesting structure

Financial Implication

The financial implementation for each initiatives is very less in terms of the benefit, the resources can be mobilised from the Urban Local Body or other local sources.

Scalability

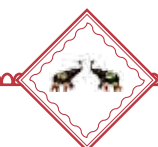
Keeping in view the success of different initiatives in the urban PHC, same can be extended the institutions located in the urban areas.

Contact

spmnhmodisha@gmail.com



A CONVERGENT APPROACH FOR PROMOTING OVERALL HEALTH STATUS : Involving the Line Departments and Urban Local Bodies



Programme Description

The City Co-ordination Committee/ Urban Health Advisory Committee is envisaged as an apex body at the city level for the convergence of various line department and stakeholders involved in the planning and delivery of maternal, newborn, child health and nutrition (MNCHN) and water, sanitation and hygiene (WASH) services to the urban poor.

CCC/UHAC are constituted taking the lead officials from Health & FW Department, Women & Child Development, School & Mass Education Department, Housing & Urban Development Department, Civil society and ULB as well as the NGO partners, representative from civil societies and health bodies like FOGSI, MAS etc. The body was constituted joint chairperson of Municipal Commissioner of the ULB/Executive Officer of Municipality and CDM & PHO of the district.

Role and functions of UHAC

- Identify various health, water, sanitation and nutrition related issues/problems and health resources of the city/Urban slums and to come out with workable solutions

for addressing those through the joint collaboration of the stakeholders.

- Identify the gaps & bottlenecks of the implementation mechanism and advice the appropriate mechanism to overcome those bottlenecks –if any by the fund utilization through different departments / Institutions.
- Arrangement for referral of pregnant women and malnourished children belonging to poor family of the ward to appropriate public health institutions.

Programme Outcome

Quarterly convergence/coordination meetings held with involvement of various departments & stakeholders and various issues/problems related to health, water, sanitation, and cleanness were identified & discussed .

City level stakeholders sensitized on the city-level health status and the related schemes of NUHM, ranging from the community level UHND sessions to the facility-level OPD and specialized services, including infrastructure, quality assurance and FP/MNH services

Integration/co-ordination established with various line departments and other stakeholders and monitoring plan got evolved to ensure the shared responsibilities for better outcome of Health Programmes for the Urban poor.

Quality of services improved and the functionaries have become more responsive.

Financial implication : No Financial Implication are involved. The respective department may implement decision .

Scalability

Keeping in view the success of CCC/UHAC in Puri, Rourkella & Berhampur Cities , it is planned to replicate other 10 cities/towns which will be ensured through various line departments and other stakeholders. The cost involvement is very less for replication.

Contact

spmnhmodisha@gmail.com





SMALL INTERVENTION-BIG EFFECT- Mahila Arogya Samiti (MAS) contribute for achievement of Measles Rubella vaccination in the Urban slums

Problem Statement

Creating health awareness to improve health services seeking behaviour is very challenging especially among the migrant population and heterogeneous groups with different cultural and behavioural factors.

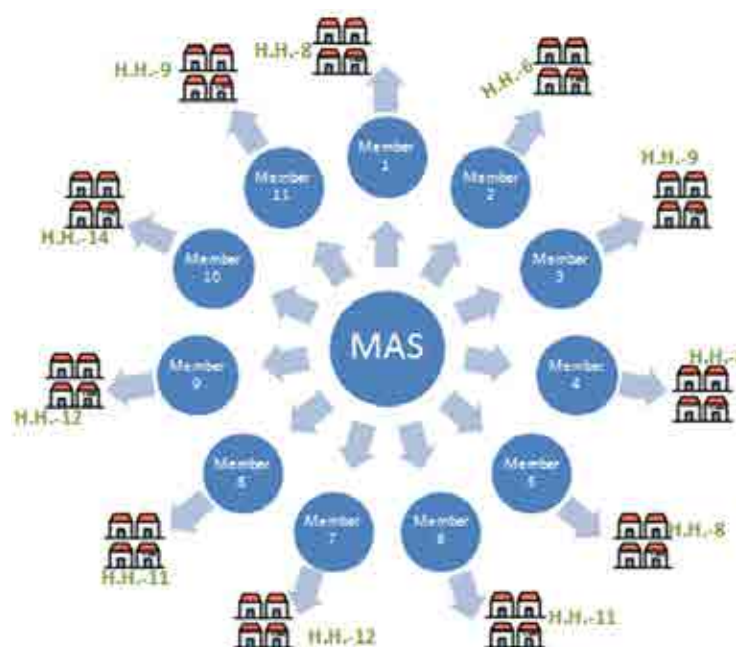
Programme Description

The Measles-Rubella (MR) campaign was implemented from January 2018 to April 2018 as part of global and nation-wide efforts to eliminate measles and control rubella. Mahila Arogya Samiti (MAS) in Odisha has been proactively engaged during the community phase of MR campaign

Distribution of Households among the MAS members during the MR campaign

Dhobasahi MAS, Cuttack City, Total House hold = 108 Nos: Each MAS member was assigned number of households and was responsible for motivating the identified children to attend the immunisation sessions.

The household resource map was prepared by MAS members and ASHAs for identification of children and to prepare a due list for vaccination during the campaign period. BINDI was used as



a symbol for depicting the beneficiaries on the Map. In addition, MAS members used the green card and red card to demarcate the houses for beneficiaries.

ASHAs and MAS members played a massive role in mobilizing communities for vaccination drive by various means for instance organizing a mass rally, local folk show and slum meeting

Programme Outcome

Mahila Arogya Samiti team reportedly played a significant role in this massive campaign in

Urban Odisha which helped the State achieve an overall immunization rate of 98.2% and an urban immunization rate of 95.7%, making it one of the highest performing State in the country.

Implementing Partner

Mahila Arogya Samiti (MAS), Health & Family Welfare Department, Govt. of Odisha.

Financial Implication

The financial involvement of this initiative was very less in comparison to the outcomes achieved. Budget was mainly required for regular hand-holding support and capacity building budget.

Scalability

Keeping in view the success of MAS involvement and contribution towards achieving MR, same initiative can be replicated in other areas.

Contact

spmnhmodisha@gmail.com



OUT-REACH CAMPS IN URBAN AREAS FOR VULNERABLE POPULATION



Problem Statement

Raising awareness and demand for health interventions at urban public health facilities is sometimes a challenge. Innovative methods are needed to ensure that vulnerable and marginalized communities have access to high quality low cost health interventions.

Programme Description

Over a three year period, increasingly larger health camps have been organized in urban areas with provisions for screening of the vulnerable and marginalized (including sanitary workers and construction labourers). Those needing further management are

referred to neighbouring UPHCs where they are registered on-line to facilitate further follow-up. During year 2017-18, mega camps have been organized by clubbing weekly camps and increasing access to specialists; 3208 camps with 4,60,532 people screened (and an average OPD load of 150-200 per camp) have been organized so far.

Programme Outcome

This approach has led to greater numbers of vulnerable and marginalized populations to be screened in urban areas. An independent external evaluation of this initiative will provide better evidence of its effectiveness.

Implementing Partner

This initiative has been provided by the state NUHM department.

Financial Implication

Not provided.

Scalability

While the camp approach will increase awareness and access for the urban marginalized, concurrent efforts should be made to integrate service access to the health system through routine outreach and service delivery at UPHCs.

Contact

nuhmpunjab@gmail.com





DOMESTIC BIO GAS PLANT IN UPHC

Problem statement

K.Pudhur, Madurai an Urban PHC catering a total population of 52,785 with an average OP of 200-250 per day which can produce both solid and liquid waste in the Urban PHC. An extrinsic and effect management needed for the waste management for the UPHC.. The solid waste collected from the UPHC and co-locating area of the PHC about 3-5 tons of solid waste, thus such quantity of waste may be utilized as an energy resource forming a BIOGAS PLANT.

Programme description

Biogas plant has been implemented from June 2017, in K.Pudur Urban PHC, Madurai Corporation, Tamil Nadu with all sustained safety measures. Plant Requires Fibre Reinforced Plastic tank, PVC pipe/GI guide Pipe, Biogas stove, Gas tube, brass connector, safety valves, pit, water seal. Expected biogas produced – ANAEROBIC FERMENTATION – Methane, CO₂, Hydrogen sulfide, Oxygen & Nitrogen. From 50 kgs of waste approximately produces 3-5kgs of Biogas. Bio-gas production is directly proportional to anaerobic waste deposited. Waste products from the biogas plant - water let out through UGD and solid as manure.



Programme outcome

Low cost nutrition supply with high cost effectiveness in Amma unavagam for cooking purpose. Biogas plant saves a monitory cost of 5 x Rs.1600 (per cylinder cost). Furthermore K.Pudur UPHC is in verge of converting to UCHC, this biogas plant shall cater to the needs of the UCHC.

Implementation partner

Corporation of Madurai, Tamil Nadu

Financial Implication

National Health Mission – at Project cost of Rs.3.5lakhs, with a maintenance cost of Rs.1000/month on a pilot basis.

Scalability

Can be scalable to entire state based on the need

Contact : nuhmtn@gmail.com



EMERGING INITIATIVES

COMMUNITY
PROCESSES



SWASTHYA SETU



Problem Statement

Important indicators such as Infant Mortality Rate, Severe Acute Malnutrition, Pre-term Deliveries and full Antenatal care checkups along with counseling on proper diet, nutrition, breastfeeding practices, etc. are some of the major issues which necessitate quality training, orientation and sensitization of ANMs, ASHAs & AWWs.

Programme Description

Swasthya Setu was launched on 23rd March 2018 aimed to motivate and increase co-



ordination amongst all the three core grass-root level functionaries to work together as a team to improve the quality of care.

Programme Outcome

Following the launch of the Programme, the AAA is better trained to handle their responsibilities and are actively sharing the data gathered by them. It has further enhanced coordination and ensured non duplication of work which in turn saves time and enhances service delivery. Joint awareness Programmes and meetings are conducted for exchange of information.

The ASHA and ANM are playing an important role in identification, screening and provision of services to Antenatal, Post-natal and nursing mothers. The increased coordination between the ASHAs, ANMs and AWWs was further evident during the recently announced Poshan Awards, wherein, One of the Triple A Teams of Daman and Diu has

been selected for their exemplary performance during Poshan Maah. These combined efforts of field data sharing plays an integral role in reaching the desired goal of Malnutrition free Daman and Diu.

Financial Implication

Apart from the amount spent on developing of MAA booklets for sensitization, no major expenditure was borne. If cost-benefit analysis is done, the gains far outweigh the expenditure incurred.

Potential for scale: Extension of Inter-sectoral Convergence and linkages with other departments like NGOs, Panchayats, Education, water & sanitation and so on, for intensified counselling and awareness generation at village level for a stronger impact in the community is already being undertaken.

Scalability

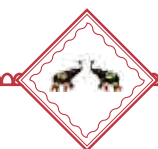
The same can be replicated across other states and UTs for eliminating malnutrition including anemia and achieving the health targets under Sustainable Development Goals.

Contact : dpodaman@gmail.com



JHARKHAND

SAHIYA SANGI PORTAL FOR TRACKING HBNC (PLA)



Problem Statement

In Jharkhand, there are 38% of home deliveries. There is a need to improve identification and tracking of high-risk newborns for effective provision of care.

Programme Description

Sahiya Sangi- An IT initiative, started in November 2016, to strengthen the HBNC activity for saving New bornsto support Sahiyas (ASHA) for upgrading their skill, supporting DPCs for reporting and monitoring.

The application sends regular reminders to Sahiyas thus improving the identification and tracking of the high risk newborns. A Dashboard is available where the higher officials can monitor the progress and activities at the District level which include parameters such as training, automatic, follow up reminders, unique ID, financial analysis and random data validation.

Programme Outcome

The Programme data shows :

- Increase in number of ASHAs doing home visits from 71% in 2016-17 to 92% in 2017-18.

- Increase in newborn follow up from 37% to 57% over a period of one year
- Three fold increase in follow up of high risk newborns.

Financial Implication

In the first year, maximum cost utilization was focus on dashboard development and capacity building including report generation and hands-on training. In second year, maximum use of cost in upgradation of dashboard up-to block level and compatible to NIC for hand over and sustainability.

Lessons Learnt

The Sahiya Sangi has emerged as a useful tool for easy tracking and maintaining the progress of a child, increasing the follow-up of high-risk newborns and real time tracking of monthly/yearly expenditure District/Block Wise.

Implementing Partners

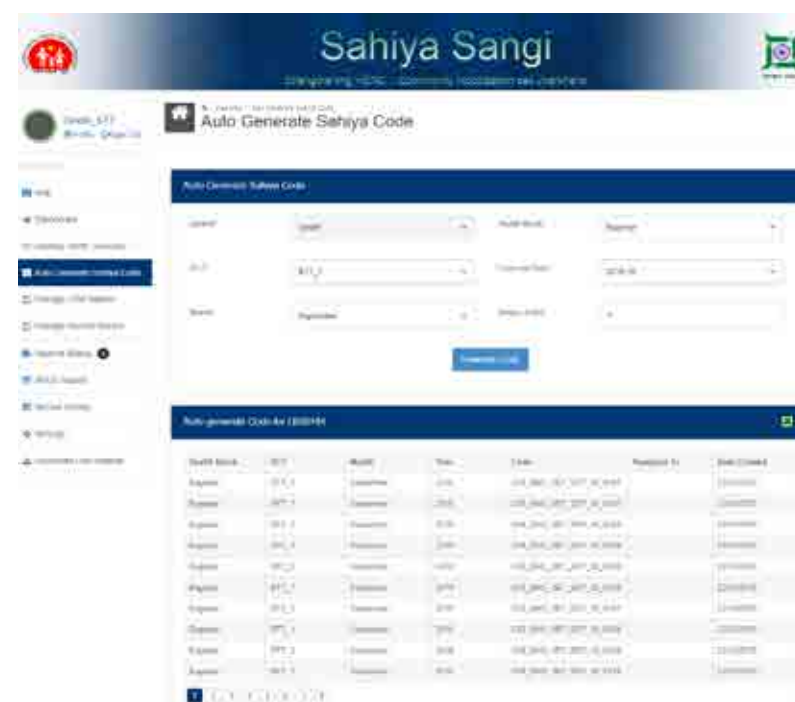
NHM, and UNICEF, Jharkhand.

Scalability

MIS is already implemented in all 24 districts of the State and scaled up further.

Contact

mdnrhmjharkhand@gmail.com





EXPLORING THE ROLE OF SAHIYAS IN PREVENTING VIOLENCE AGAINST WOMEN USING PLA APPROACHES



Problem Statement

The fourth National Family Health Survey data has shown that about one in three married women in rural Jharkhand face spousal violence. The incidence of physical, sexual, emotional and economic violence among girls and women is even higher. There is currently no scalable community intervention model for primary and secondary prevention of violence against women in rural Jharkhand.

Programme Description

A pilot test was done in Jharkhand using the Participatory Learning and Action approach to increase awareness on gender-based violence in the community and to plan strategic actions to address these concerns at the individual and community level.

Monthly meetings of women's groups for PLA approach, usually involves a group of 20-30 women, who work through a meeting cycle with four phases. In the first phase, groups identify and prioritise important social and health problems faced by women in their community. In the second phase, they discuss and prioritise strategies to address the problems. In the third phase, groups implement their chosen

strategies and in the final phase, they evaluate the process. By 2020, an estimated 32,000 women's groups facilitated by Sahiyas and the Sahiya Sathis will be formed in Jharkhand.

Programme Outcome

To evaluate the preliminary benefits and outputs of this approach, Ekjut team conducted cross-sectional baseline and end-line surveys with members of the 39 groups taking part in the intervention across 22 villages of Chakradharpur and Bandhgaon blocks in West Singhbhum District.

The results shows that the proportion of women reporting violence as unacceptable in seven scenarios proposed to them increased from 74% at baseline to 83% at end-line (adjusted $p < 0.001$). In one year, psychological violence by husbands decreased from 67% to 56% (adjusted $p < 0.001$). Help-seeking for past one-year psychological violence by husbands increased from 28% to 46% (adjusted $p < 0.001$). One year psychological violence by family members decreased from 66% to 50% (adjusted $p < 0.001$), as did the prevalence of past year physical violence by family members from 27% to 12.1% (adjusted $p < 0.001$). The proportion of women seeking help for violence by family members

increased from 35% to 66% ($p < 0.001$). A small proportion (5%) of women also sought help from health, legal or police services available for action on any form of violence.

The pilot showed promising reductions in the acceptance and incidence of psychological and physical violence in women and also showed increase in help seeking by survivors of violence within the family and friends.

However, less than 5% of women sought help from health providers, the police, or a legal aid cell. This builds a case that sensitising local governance systems through Mundas (headmen), investing in public services to make them more responsive to survivors, and creating better linkages between other community-based groups and Sahiyas are required for improving help-seeking.

Contact

mdnrhunjharkhand@gmail.com



EMERGING INITIATIVES

COMPREHENSIVE
PRIMARY HEALTH CARE



INTERNAL BRANDING OF HEALTH AND WELLNESS CENTRES UNDER AYUSHMAN BHARAT



Introduction and Rationale

MoHFW, GoI developed a standardized external branding for all the Health and Wellness Centres across the country to make the centres appealing.

The State Government of Chhattisgarh decided to extend this external branding within the facility and develop comprehensive internal branding materials, which includes facility level branding at SHC & PHC as well as standardized IEC materials to be displayed in the facility. Branding and design play a key role in not only making the facility user friendly but also in increasing the uptake of services. With this aim, the State Government of Chhattisgarh extended Ayushman Bharat branding to the interiors of the HWCs including all the areas of services from RMNCH+A, NCDs, emergency care, Geriatric care, Mental Health etc. and also to promote health by spreading awareness for yoga and wellness through comprehensive IEC management

The Innovation

The objective of developing the internal branding package is to empower the

beneficiaries and service providers with strategic use of communication materials and to create a conducive environment in the Health and Wellness Centres. The package also includes a set of IEC materials to provide information on the additional services that are being provided at HWCs and beyond.

In purview of the local context and keeping the guidelines of Ayushman Bharat at core, Chhattisgarh team developed a package incorporating learning & finding from the field visits & previous experiences.

The Internal Branding Package Components Are:

- Facility internal branding materials for Sub-centre and PHC
- New IEC material on the new additional services of HWCs and adaptation of existing RMNCH+A IEC materials with the Ayushman Bharat branding.
- Facility branding guideline, which details out the above mentioned components, area and room-wise, within the facility in terms of design sample, dimensions, cost, material used for developing, location for placement, target audience and uses.

Scalability

After proper scrutiny by the State Government of Northeastern States Assam, Tripura, Sikkim, Manipur, Mizoram, Meghalaya & Nagaland successfully adopted the package, they translated the package in their own vernacular languages.

Cost Effectiveness

The Internal Branding Package was developed initially for three Model HWCs, each one from three districts (Durg, Raipur and Mahasamund) of Chhattisgarh. The total cost incurred per HWC was only Rs. 9500/-.

Independent Evaluation

Although, independent evaluation was not done by any agency, but seven more State Governments namely Assam, Tripura, Sikkim, Manipur, Mizoram, Meghalaya and Nagaland adopted the Internal Branding Package after careful scrutiny, which proves the credibility of the package.

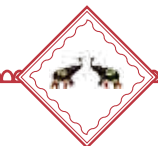
Contact

spmcmgrhm@gmail.com



MAHARASHTRA

ARCHITECTURAL WAY OUT- Uniformity in Process Flow of Health and Wellness Centre



Background

The Prime Minister of India has launched Ayushman Bharat to address the critical issue of access to health care. Provision of comprehensive primary care is an important part of Ayushman Bharat. The strategy is to re-define the role of Sub-centres and their staffing pattern and strengthen the sub centres into Health and Wellness Centres (HWCs). HWCs will provide preventive, promotive, rehabilitative and curative care for a package of services related to RMNCH+A, Communicable diseases, Non-communicable diseases, Ophthalmology, ENT, Dental, Mental, Geriatric care, treatment for acute simple medical conditions and emergency and trauma services. HWCs will deliver this comprehensive set of services through a team-based approach by adding Community Health Officers. Human resource available at each HWC will be 1 CHO, 1 ANM, 1 MPW & 5 ASHAs.

HWCs will not only expand the service package, but will also create a perception in the community that the facility close to them offers a platform for preventive and promotive action related to various health issues. Apart from

service provision, key interventions envisaged under HWCs include population enumeration, creation of family folders and individual health cards, to be part of an IT platform and to assure continuity of care, the provision of point-of-care diagnostics, serve as a collection point for samples as part of a diagnostic hub, provide regular refills of drugs for chronic diseases, and access to tele-health.

Rationale

Maharashtra state is committed to transform all 10687 Sub-centers (SCs) into Health and Wellness Centres, out of which 280 have already been operationalized (Infrastructural correction is yet to be done) in 2017-18. The state will also operationalize total 1393 HWCs in 2018-19. This transformation of SCs will be done in a phase-wise manner and is expected to achieve 10687 SCs in all till 2022. This transformation is supported by Government of India under NHM. As per the guidelines of HWCs, a fund of Rs. 7 Lakh is being provided for the infrastructural upgradation of each SC to health and wellness centre. As it is routinely seen, public health facilities are constructed by engineers in

consensus with district officials, with a little say from the hospital managers/planners. Studies have shown that evidence-based planning and design of a health care facility help attract and retain staff, improve patient safety, generate high levels of patient satisfaction and confidence in the quality of care and is tied to better health outcomes.

It has been seen that although outside premises such as the availability of space gardening, boundary wall varies from place to place, most of the SCs in the state are divided into 4 common types of internal layouts. Accordingly, the state has decided to upgrade existing 10 SCs from Jamner block (Jalgaon district) to HWCs with envisaging appropriate architectural flow and uniformity of all HWCs in the state. All engineers and empanelled architects of infrastructure development wing across the state will be orientated to this concept and they will be asked to replicate the same in their respective district.

Contact

shsrc.gom@gmail.com



EMERGING INITIATIVES

R MNCH + A

NIDDCP BEST PRACTICES

NATIONAL IODINE DEFICIENCY DISORDER CONTROL PROGRAMME

Iodine is a micro-nutrient which is essential for normal growth and development of human as well as the animals. The daily requirement of iodine is generally 100 – 150 micrograms. Iodine deficiency disorder impact "refers to all of the ill effects of iodine deficiency in a population, which can be prevented by ensuring that the population has an adequate intake of iodine". Iodine Deficiency Disorders occurs when the availability of iodine is lower than the required amount and the thyroid gland is not able to synthesize sufficient amount of thyroid hormone.

National Iodine Deficiency Disorder Control Programme is implemented to reduce iodine deficiency disorders among the population and improving awareness about consume only iodized salt. Iodine Deficiency disorders are a worldwide major public health problem. As per information available, more than 1.5 billion people all over the world are at risk of IDD.

"Prevention is better than cure" – The simplest method to prevent the broad spectrum of IDD is to consume iodized salt daily.

It is a commitment of the Government of Assam to ensure that all its citizens have access to iodized salt.



For sustainable development of the Iodine Deficiency Disorders in Assam following good practices are carried on...

Strong co-ordination of intersectoral department for improvement of IDD



Regular monitoring of salt at railway unloading point by joint monitoring team of the Food Safety Officer (H&FW), Inspector of FC&CA, Officers of Legal Metrology and Railway officers. As per resolution of NIDDCP, Co-ordination committee meeting it has been made mandatory rule by Ministry of Food & Civil Supply and Consumer Affairs to collect sample at salt unloading point (Railway station). They have done testing with spot salt testing kits at spot and send informal sample to State IDD lab and formal sample to state public health laboratory.

Regularly reviewed the programme by state co-ordination committee, where Principal Secretary of the Health and F.W is the chairperson of the committee, Regular reviewed by Govt. of India, Mo HFW Dept.



Development guidelines for Awareness on use of salt at consumer level, retailer level and wholesaler level and shared the guidelines with the responsible officer/departments. It helps us to monitor the programme at wholesaler level to consumer level.

Awareness programme conducted such as street play, house to house visit, meeting with the community leaders and front line workers etc. The programmes are conducted state level to grass root level such as villages, tea garden and char areas etc. The key messages of IDD included in the training module of S.S.A, Assam. It increase the awareness among population to consume only iodized salt.



Goutre prevalence ranges from 1.46% to 6.33% (as per survey data). Survey completed in 27 nos. of districts and re-survey completed in 25 nos. of districts. For the 2018-19 Goutre survey will be done collaboratively with the community medicine department of Guwahati Medical College and Hospitals. Planned to link Goutre patient with RBSK. As the treatment part is not included under NIDDCP.



Developed tally sheet by state IDD Cell and used the tally sheet for easy assessment of iodine content of salt at field level when testing is done by Spot salt testing kits (specially for ASHA, AWC, MPW's, Teachers). We have shared the tally sheet with other states also in last regional level review meeting in the year 2017-18. The tally sheet is use in the entire state of Assam for field salt testing.

Presently a co-ordination programme is going on with the department of endocrinology Guwahati Medical College and Hospitals for research purpose. They are sending urine samples from the thyroid patients for urinary iodine estimation to State IDD Lab, Assam.



Providing adequately iodized salt to pregnant mothers for proper mental and physical development of the foetus support to "Right to Child" for optimal growth and development. Considering all facts, State IDD Cell, Assam continuing its efforts with various activities to combat the risk of IDD.



"Prevent brain damage by using iodized salt"

Contact

spm.nhmassam@gmail.com



SCALING UP COMMUNITY INTERVENTIONS TO PROMOTE FP SERVICES IN MPV DISTRICTS



Problem Statement

Community awareness and need for outreach lies at root of improved access to family planning services. The lack of women's ability to negotiate use of contraception is well documented for a state like Bihar, therefore, any efforts to reverse the same requires involvement of other major stakeholders in decision making including mother in law and husbands. Therefore, need to deliver context specific family planning message to different types of the clients, appropriate to their context and circumstances requires a varied and cohesive multi pronged communication intervention. The role of intensive and sustained community outreach efforts become indispensable in an otherwise supply driven Programme environment and is such the logical answer to the problem as it directly interacts with the community and potential clients.

Programme Description

Promotional methods as envisaged in MPV opened the possibility to organize meaningful outreach and communication interventions to boost demand for Family Planning services. State has made significant headway in implementation of proposed community interventions since roll out of MPV in November 2016.

The State painstakingly worked with districts, major stakeholders and partners and issued detailed operational guidelines. Districts developed the extensive microplan with including name of the ASHA, name of the AWWs and details of Aarogya Diwas/VHSND including dates of the meeting. A NIRDESHIKA (Guidelines) for SAAS BAHU SAMELLAN was developed lend the activity necessary and meaningful structure and to standardize the process of engagement with participants. It delineates the role of the ASHA/ANM/AWWs involved in organizing the activity and contains games and activity details to be conducted for active engagement. State is also working with partners to develop a reference film on SAAS BAHU SAMELLAN for reference and understanding of the FLWs.

NAYI PEHAL KIT received the primacy that it deserved for its role in introducing newlyweds to the concept of family planning and promoting spousal dialogue around same. The Kit additionally carried IEC leaflets containing information on Family Planning besides the recommended utility items including contraceptives.

DSAARTHI- Awareness on wheel, a smartly designed mobile publicity van equipped with

interactive communication (Audio-Visual) devices, IEC material and FP commodities applied across all 38 districts to create awareness and mobilize community during MPV fortnights.

Programme Outcome

Bihar, up to 1st quarter of FY 2018-19, 49282 SAAS BAHU SAMELLAN has been conducted so far reaching 515962 participants. 118972 NAYI PAHELI KITS have been procured and distributed among newlyweds. Saarthi – Awareness on wheel covered all Panchayats during Population Stabilization Fortnights/ MPV Special drives.

Financial Implication

The operational cost are funded under NHM PIP (37 out of 38 districts are the HFDs, comes under MPV).

Scalability

All promotional methods/community interventions received well in community, reflecting a welcome need for such interventions and demonstrate its relevance and higher chances of scalability.

Contact

ddfpbihar@gmail.com

SAVING LOW BIRTH WEIGHT NEWBORN AND REDUCING NEONATAL MORTALITY

Problem Statement

Global estimate of preterm births reports that 14.9 million babies (11%) were born preterm out of 135 million live births worldwide in 2010. India contributes to 27% of the total global neonatal deaths in every year. Major causes of Neonatal deaths in India are Preterm Birth (35%), Birth Asphyxia (20%), Pneumonia (16%) and Sepsis (15%), etc.

Programme Description

These low birth weight babies can be survived through very cost effective and home based



measures like (i) Frequent breast feeding in neonatal period, (ii) Extra thermal care through skin-to-skin contact or Kangaroo Mother Care (KMC) and (iii) Prevention of infection by extra skin & cord care in babies and hand hygiene of care provider.

Programme Outcome

An independent evaluation and assessment of the weak new born identification and tracking were undertaken by Bihar Technical Support Unit in 4 rounds. (4th round in sept-oct 2017)

- Increase in accurate identification of low birth weight (LBW) babies from 2% (1st Round) to 5.1% (4th Round).
- Increase in immediate post-partum FLW visits to identified preterm & LBW babies:
- Increase in appropriate counselling for identified Preterm-LBW both at facility and at home.
- Preterm-LBW tracking intervention has led to increase in extra new born care practices in identified Weak New Born
- Weak New Born tracking intervention had led to reduced mortality of identified Preterm & LBW babies.

Implementing Partners

Care India Bihar and NHM, Bihar

Financial Implication

No separate expenses were incurred in the training of staff nurse and ASHAs; they were trained during their routine meetings. Total cost of this project is budgeted at Rs 42,00,000/- per annum including telephone calls charges and printing of registers for 694 facilities. The costs involved for this intervention had also been proposed in PIP of FY: 2018-19.

Scalability

This intervention has been rolled out across the state. Other states can also adopt the method as the strategies involved are in accordance with the routine activities of community intervention.

Contact

prmoharana@careindia.org



EFFORTS TO ENHANCE MALE PARTICIPATION IN FAMILY PLANNING

Problem Statement

Increasing male participation is critical to the success of the national family planning Programme. Unfortunately, male sterilization continues to lag behind due to multiple reasons such as a patriarchal structure and various myths and misconceptions. There is also very little awareness about the vasectomy procedure and unfortunately a significant share of the family planning burden still falls on women.

Programme Description

The State took immediate measures and initiatives towards this particularly after the 2014-15 tragic incidence of sterilization deaths in Bilaspur district. To overcome barriers and involve men in the process of family planning, we took the opportunity to conduct dedicated focal group discussions. It was regularized as an awareness chaupal named “Mor Mitan Mor Sangwari” where persons who have already adopted male sterilization are invited and the Sarpanch showcases him as an ambassador of male sterilization for the society. The role model addresses the chaupal where he discusses about male sterilization and his life post the procedure. To improve facility based services, planned calendars for mobilizing Surgeons on

fixed days services were established. Line listing of beneficiaries was done and organized along with adherence to quality standards. Necessary follow ups with the field staff was also ensured by involving health staff and mitanins. Well performing field and health staff were also recognized and suitably awarded.

Programme Outcome

Under strong and supportive leadership and through a dedicated health staff team, the State performance in male sterilization increased substantially by more than three-fold from 1983 in 2014-15 to 7183 in 2017-18.

Financial implication

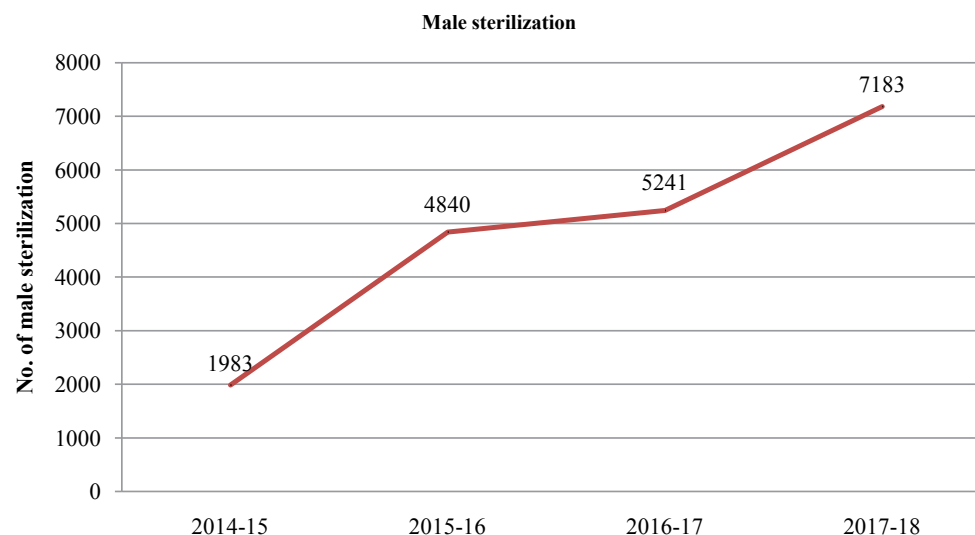
The operational cost for all Programme components is funded through NHM.

Scalability

This Programme is scalable across all states. A systematic plan along with strong implementation can ensure the increase in male participation in family planning.

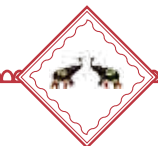
Contact

spofpdhscg@gmail.com





DISTRICT EARLY INTERVENTION CENTER (CHHOTI SI ASHA)



Problem Statement

Early childhood is the most important phase for overall development factors like disability and malnutrition pose particularly difficult challenges. However, to make this problem solved at an early age, U.T of Dadra and Nagar Haveli has their District Early Intervention Center to minimize developmental risks and enhances child development.

Programme Description

It identifies disability and malnutrition at the initial stages and provides suitable aids and a holistic treatment. This is to ensure that children reach their maximum potential for development in their early years.

- To understand the concept of early identification & intervention of development delays.
- Identification of early signs of delays in Under 5 children in the district by conducting screening test based on developmental milestones for early identification of development impediments in newborn and U5 children

- To have a comprehensive specialized multi-disciplinary evaluation of child for social development, visual development, speech and hearing development, mental development, normal development growth etc. under a single roof
- To provide comprehensive specialized multi-disciplinary intervention to remove or reduce developmental impediments.
- To facilitate acceptance of onset of development delay by a family in their infant.
- Making society aware about the concept of EIC; increasing acceptability of disability in society and to involve it in society-based and home-based identification.

Services Available

New born Screening, Immunization, Physical therapy & sensory integration, Occupation Therapy, Special education, Psychology/ counseling, Dental Services, Speech Therapy, Vision treatment, Audiometry et

Scalability

District Early Intervention Centre is the first of its kind model in the State demonstrating early identification, intervention for all children registered. It demonstrates the efficacy of intersect oral such as Health, ICDS & Social Welfare, inter-departmental and inter-institutional convergence model optimizing resources.

Cost Effectiveness

Extremely beneficial to the tribal population of Dadra & Nagar Haveli which has led to saving of many lives through various types of surgeries thus reducing the out of pocket expenditure. The transportation costs which used to be around 2000-3000 for trip to Mumbai, Surat has reduced to NIL and surgeries amounting to 2.5 -3 lakh has reduced to NIL. T

Contact

nrhmdnh@gmail.com





MOTHER IN NEONATAL INTENSIVE CARE UNIT (M-NICU) - Quality Improvement Innovation



Problem Statement

Family participatory neonatal care as a strategy has been recently initiated by the Government of India to provide developmentally supportive care to neonates, but its reach is still limited to few centres and family's role as care givers, is still intermittent and sporadic. To achieve effective family participatory care, mother needs to be 24x7 next to the baby in NICU.

Programme Description

A pilot initiative of a 12 bedded Mother in Neonatal Intensive Care Unit (M-NICU) at Safdarjung Hospital, New Delhi was initiated in December, 2017. This unit has all facilities for a level II neonatal care and provides a defined minimal care package for mothers. It has sufficient space for maternal beds, kitchen, toilet and bathing facilities for mothers.

Programme Outcome

A total of 200 mother baby dyads have received intensive neonatal care in M-NICU over a period of 9 months (Dec2017-August 2018). Observations in M-NICU indicate that mothers can be easily trained to follow asepsis routines, monitor the neonates and are better prepared

for post-discharge care of neonates. Short experience of 9 months, shows lower mortality and sepsis rates, higher breastfeeding rates and better parental satisfaction in M-NICU as compared to NICU.

Financial Implication

This innovation has been done with same existing staff, equipment and facilities. The only effort has been the re-organization of infra-structure and services, so that neonatal and maternal care can be provided at same place, so that they need not be separated.

Scalability

A major impact of project is, that Govt. of India has circulated the guidelines to expand the concept of M-NICU and reorganize all Special newborn units in the country to accommodate both baby and mother together. This will provide quality and developmentally supportive newborn care while ensuring zero separation of baby and mother from birth to the discharge.

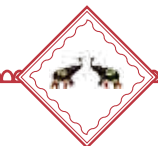
Contact

chellaniharish@gmail.com





TEST AND TREAT ANEMIA



Problem Statement

NFHS-IV highlights anemia as a severe public health problem (>40% prevalence) in all vulnerable age groups and warrants immediate attention. Ministry of Health and Family welfare is committed to Anemia Free India and has intensified efforts to reduce anemia prevalence by 3 percent/year till 2022.

Programme Description

Anemia T3 camps, was a month long celebration initiated during Poshan Maah (September) under the aegis of POSHAN Abhiyaan. The objective of the camps was to initiate a dialogue on anemia by mass screening via Test-Treat-Talk approach, under Anemia Mukta Bharat strategy. National Centers of Excellence and Advanced Research on Anemia (NCEAR-A) and Diets (NCEAR-D) at AIIMS and Lady Irwin College, New Delhi respectively along with 6 Regional AIIMS in coordination with respective State Health Mission conducted facility and outreach camps in their field practice areas. Beneficiaries identified with mild and moderate anemia were given Iron Folic acid tablets and dietary counselling by doctors and nutritionist and dieticians respectively. Severe anemia cases

were referred to the nearest government facility for treatment.

Programme Outcome

A total of 34,147 people participated in the camps organized at various sites across the country. Of the total people screened, 43% (14,673) were found to be suffering from anemia (28.2% mild, 13% moderate and 1.8% severe anemia). The camps were very successful in terms of promoting Test and Treat Strategy, a new intervention under Anemia Mukta Bharat using digital hemoglobinometer as Point of Care (PoC) tool for screening and management of anemic cases. It also provided an excellent opportunity for counselling and increasing awareness on importance of Nutritious and Fortified food items to combat anemia. .

Implementing Partners

MoHFW, MoWCD, AIIMS, Lady Irwin College and Development Partners.

Financial Implication

Screening cost for approximately 6000 people per site was around Rs 2 lakh (supported by UNICEF and NHM)

Scalability

Can be scaled up country wide through leveraging existing platforms.

Contact

skant76@gmail.com





LSAS AND EMOC CARE

Problem Statement

Gujarat has a huge shortage of specialists (Obstetricians, Anesthesiologist) at FRU level. Being first referral center, First Referral Unit (FRU) envisaged to provide round-the-clock services, availability of skilled workforce is an essential component in FRUs. Since majority of the maternal and newborn deaths occur at the time or around childbirth, improving the quality of care for childbirth related services including availability of skilled manpower is essential.

Project Description

To ensure operationalization of FRUs through multi-skilling and redeployment of Medical officers.

- GOI/ FOGSI, HFW department and SIHFW as the nodal training center identified 3 medical colleges for EmOC and 2 medical colleges for LSAS training. .
- On Day Zero of the training, workshop/ Meeting of MC & DH faculties with SIHFW is being conducted to have a common understanding and be on same page.

- GOG has taken the resolution on 14th December 2016 for compulsory training of MOs placed at CHC FRUs on LSAS / EmOC.
- Name sent by district is screened by SIHFW nodal. And if any MO shows unwillingness, the candidate is dropped.
- Regular monitoring is conducted by SIHFW Team, Medical Collage FOGSI, State Officials.
- Refresher training for 15 days were conducted for 5 MOs and 5 General Surgeons on EmOC.
- The attention and encouragement from the highest authority in the state motivates the trained MOs to perform better. PS Health congratulates them on saving lives on phone, in VCs and through SMS.

Programme Outcome

Since inception, 22 batches of EmOC training and 16 batches of LSAS training have been conducted where 114 MOs and 128 MOs are trained with EmOC and LSAS respectively. Of the total, 60% of the LSAS trained MOs and 98% of EmOC trained MOs are placed at the FRUs and performing C-sections. The trained MOs

were paired or placed along with obstetricians at facilities with high delivery load to further refine their skills.

Implementing Partner

SIHFW with Support of NHM Gujarat

Financial Implication

All expenses incurred through NHM PIP budget.

Scalability

The system has already been Rollout for all districts and it can be replicated across all States of India.

Contact

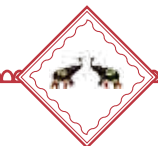
spmu.health.gujarat@gmail.com





HIMACHAL PRADESH

INSTITUTIONALIZING REPRODUCTIVE AGE MORTALITY STUDY TO ESTIMATE MATERNAL MORTALITY RATIO



Background

As per the World Health Organization, one of the prime international goals is reduction in maternal mortality. Therefore, it becomes imperative that reduction in Maternal Mortality is monitored closely. Monitoring of maternal mortality helps decide allocation of funds to maternal health Programmes. It also helps in tracking the effectiveness of such Programmes in reduction of maternal mortality.

Objective

To estimate the Maternal Mortality Ratio of Himachal Pradesh.

Methods

We looked at the existing methods used in estimating MMR.

- Health Facility surveys
- Population census
- Household surveys

Our state invited proposals to estimate MMR based on household survey. The fertility is very low with the Total Fertility Rate (TFR) being 1.6,

much below the replacement levels. The low TFR would not help in substantially reducing the sample size for estimating the MMR. Keeping in view the low fertility of the state it was decided that this method would not be suitable for our state and repeated surveys would be cumbersome and therefore it was decided not to use this method for estimating MMR in the state.

▪ Reproductive Age Mortality Studies (RAMOS)

This method involves capturing all the deaths of women of the reproductive age group. Subsequently these deaths are categorized as maternal or non-maternal. This mechanism was put in place in June 2016. All the concerned health functionaries were sensitized about the mechanism and its importance. The reports of the deaths started coming in from June 2016 itself.

For the purpose of calculating MMR, we decided to take the numbers of live births from the Health Management Information System portal which captures data online right from the sub-centre level which would be used as denominator.

Results

For the period June, 2016 to March, 2018, ASHAs reported 997 deaths of women in the age group of 15-49 years on the call centre. This translated to an average of 45 deaths per month in the mentioned period.

The details of all the deaths were shared with the respective BMOs, keeping both the district and state headquarters in the loop. Out of the 411 deaths of women reported for the period June 2016 to March, 2017, 410 (99.76%) were categorized by the BMO. For the period April 2017 to March, 2018, out of the 585 deaths, 579 (99.97%) were categorized by the BMO as either maternal or non-maternal.

Contact

spomhhp@gmail.com





MADHYA PRADESH INITIATIVE TO STRENGTHEN CONTRACEPTIVE SERVICES AT PUBLIC HEALTH FACILITIES THROUGH ON-SITE TRAINING



Problem Statement

Quality and affordable family planning is one of the important pillar in the India's flagship Programme RMNCH+A. Female sterilization has been the method of choice over past several decades, however, there is a renewed effort by GoMP to strengthen availability of spacing methods by improving access to affordable quality services across all public health facilities. As per NFHS 4, around 50% of total unmet need of family planning is for spacing.

Programme Description

Comprehensive Contraceptive Care (CCC) Programme in identified 355 high delivery case load facilities. This innovative Programme, Comprehensive Contraceptive Care (CCC) aims at improving family planning services through On-Site Training and post training support with focus on skill building for IUCD services. Under the Programme a team of trainers visits the facility to conduct the training for the eligible providers. Focus of the training is on improving provider knowledge, behaviour and skills on spacing methods, techniques of insertion for IUCD, infection prevention, waste management, FP counselling, record keeping, etc. On-Site

Training model helps increase the provider base significantly as once the team of trainers reaches a facility, they are able to train all the eligible providers in that facility in accordance with the GoI training norms.

Programme is being implemented in all the high focus districts of MP and it caters to the training and skill development requirement of the service provider serving rural and semi urban women and men in reproductive age group. It also focuses on building FP counselling skills of ASHAs who are the key contact in the community.

Programme Outcome

Since the inception of the Programme, 2500 plus service providers have been trained in IUCD and other family planning methods. More than 1.5 lakh women received quality IUCD (PPIUCD, PAIUCD & Interval IUCD) service. Programme has resulted to improvement in the quality of service and awareness among service providers, ASHAs and community. Training and post training support at facility has brought about a positive impact in the skill and behaviour of the providers. Improving counselling skills was the key component. One

of the most significant improvement has been observed in record maintenance, and reporting of contraceptive services GoMP has initiated unique mechanism of Household client follow-up of sampled clients. As per the initial results more than 70% clients reported continuation of IUCD as method of contraception and are satisfied with the service.

Implementing Partner

Government of MP with technical support of Ipas Development Foundation (IDF) is implementing a Comprehensive Contraceptive Care (CCC) Programme

Contact

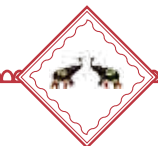
jdnhmmp@gmail.com





MADHYA PRADESH

QUALITY IMPROVEMENT IN SPECIAL NEWBORN CARE UNITS (SNCU)



Problem Statement

Madhya Pradesh is a state having Special Newborn Care Units across the districts for more than 10 years. Currently, SNCUs have gained stability in terms of

HR, procurement, and financial support through National Health Mission. However, there are concerns about quality of care indicated by high rates of antibiotic and oxygen use, hospital acquired infections and low rates of early feeding.

Programme Description

An orientation Programme to build local capacity, empower, initiate and sustain efforts in improving quality of care in 6 SNCUs under NHM, MP

In August 2017, orientation of Six SNCU teams in a two day workshop has been conducted. Six teams comprising doctors and nurses from 6 SNCUs were trained in quality improvement methods at Bhopal. Workshop included description of methods as well as their practical implications. The teams identified, prioritized and analysed the problems and designed their quality improvement projects based on PDSA

(Plan Do study Act) cycle approach. Six quality improvement projects were developed at the end of workshop.

Programme outcome/evaluation: the overall use of antibiotics in SNCU decline from 50% in the baseline period (April to July 2017) to 19.7% in the last quadrant of the study. PDSA 1: Improved process of drying-wrapping and measuring baby temperature before transfer.

PDSA 2

Provision of a “pink-slip” to the family for rapid identification of baby at SNCU entry point. Hypothermia decreased progressively from 76% (19/25) in first week to 29% (9/31) in second, 19% (4/21) in third and 10.5% (2/19) in the fourth week).

Over 8 weeks, proportion of eligible neonates who received first feed within 24hrs increased from 40% to 100% by end of the study. A detailed cost benefit analyses and quality improvement analyses has been described in the study using PDSA cycle and other methods.

Financial Implication

For initiating these 6 projects in SNCU Quality improvement workshop was conducted at

Bhopal Madhya Pradesh with a budgeted amount of 6,28,000Rs.

Scalability

A collaborative cross-learning environment with online coaching by facilitators was successful in improving the quality of care at SNCUs. It is possible to train and empower nurses and doctors of SNCUs in techniques of quality improvement in order to improve patient outcomes.

Contact

ddchnhm@mp.gov.in





INITIATIVE TO INCREASE ACCESSIBILITY AND AVAILABILITY OF MEDICAL METHODS OF ABORTION IN HARD TO REACH PUBLIC HEALTH FACILITIES



Problem Statement

Government of MP took initiative to strengthen Medical Methods of Abortion (MMA) in 2012. This initiative required mapping all Comprehensive Abortion Care (CAC) trained providers to analyze their post training performance and place of posting. It was observed that approx. 15% of doctors and primarily male doctors who were posted at PHC & CHC not offering CAC services even after follow-up and supportive supervision. Post training follow up with CAC trained providers' highlighted two key reasons for non-performance: women's reluctance to seek surgical/ invasive services from a male doctor and challenges in conducting surgical procedures due to non-availability of infrastructure or supplies at PHC and CHC level facilities. In light of these findings, it was decided to orient the low and non-performing doctors who are primarily posted at PHC & CHC level on Medical Methods of Abortion to initiate service delivery at their facilities.

Programme Description

With an objective to identify low/non-performing CAC trained providers, mainly

male providers who posted at PHC & CHC level facilities, facilitate one-day refresher training on MMA to make the low/non-performers functional and increase accessibility of MMA services at hard to reach facilities (mainly PHCs & CHCs), State government of Madhya Pradesh in partnership with Ipas Development Foundation (IDF) launched the scheme in 51 districts of the state in 2012.

This initiative includes training of doctors, strengthen of the facilities, periodic follow-up with trained providers to track their service provision and provide the required supportive supervision as well as documentation. Maternal Health, NHM, MP took the lead to further strengthen the interventions by leveraging MMA as the technology of choice to strengthen CAC services at Level-III & Level II delivery points. IDF supported the state in identifying the majority of CAC trained providers who are posted at PHC & CHC and who are low and non-performers for this intervention.

Programme Outcome

As a result of this intervention, 386 doctors have been trained on MMA and there

is significant increase in confidence and willingness to offer CAC services to women from their place of posting.

- 312 primary level health facilities PHC & CHC are strengthened to provide MMA services.
- Post orientation 249238 women have got CAC services where 27% women have started availing MMA services at public health facilities.

Implementing Partner

IPAS Development Foundation (IDF)

Contact

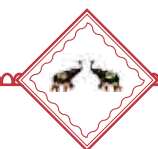
maternalhealthrch@gmail.com





DASTAK ABHIYAAN-

An innovative preventive strategy for addressing critical morbidities & mortality in U5 children



Problem Statement

For Madhya Pradesh, as per NFHS 4 (2015-16) under-five mortality rate in children is 65 per 1000 live births, a major proportion of which is attributable to underlying malnutrition. It is also noteworthy that 68.9% children are anemic while 9.2% children are SAM in the State. Though the institutional delivery is 80.8%, only 34.5% children received the benefits of early initiation of breastfeeding and only 58.2% children had exclusively breastfed in first six months of life. It is globally accepted that protocol based SAM management, optimal IYCF practices, addressing children with severe anemia, preventing childhood diarrhea & pneumonia can make a significant dent in U5MR.

Hence, the emphasis of the State was to shift focus from facility centric care to preventive and promotive aspects of health care targeting the major determinants of child mortality in the State.

Programme Description

Dastak Abhiyaan encompasses all essential principles of Public Health such as health promotion, specific protection, early diagnosis

and prompt treatment, rehabilitation and disability limitation. The basket of services takes into consideration all major determinants of U5 morbidity & mortality. It leverages existing systems of Health & ICDS without incurrance of any additional cost, thus extending the benefits of health service delivery and outreach services upto the door step of the community. Key objectives of the Programme were:

- Provide health and nutritional services to children below the age of 5 years through door to door visits.
- Line listing of all partially immunized and unimmunized children for full immunization under Mission Indradhanush.
- Screening of all children aged 6 months to 5 years for severe anaemia ($\leq 6\text{gm}$).
- Active case finding for Severe Acute Malnutrition (SAM) and referral of medically complicated critical cases to Nutritional Rehabilitation Centres (NRCs).
- Raising community awareness towards prevention of childhood diarrhoea.
- Mass awareness generation and extension of IYCF practices under MAA Programme

- Identification and treatment of all sick under 5 years children especially childhood pneumonia and follow up of SNCU discharges.
- Salt testing under NIDDCP (13 districts of Madhya Pradesh).

Implementing Partner

NHM Madhya Pradesh

Contact

drpragyatiwari.health@gmail.com





STRENGTHENING CRITICAL CARE FOR SAVING MOTHERS WITH INTER DEPARTMENTAL COORDINATION



Problem Statement

In last four years approx. 24 thousand admissions have been made in these ICUs across five medical colleges, 67.5 % are referred cases from periphery and remaining 32.5 % are either inpatients or direct admissions. 67.5 % referred cases indicate the unavailability of intensive care unit setups in the periphery. Medical colleges are the only available apex institute for tertiary medical care in most of the regions of State and their catchment area covers all the districts of the division in which they are established and some time it caters to population of other division.

Programme Description

With the objective to provide intensive critical care to the mothers in their antenatal and postnatal period, 12 bedded obstetric ICUs has been established in Obstetrics and Gynaecology department of 05 Govt Medical colleges with interdepartmental coordination between Department of Medical Education and Department of Public Health and Family Welfare and have been made functional since 2013.

Programme Outcome

With only 60 beds for exclusive obstetric critical care in 05 medical colleges across Madhya Pradesh, 4601 cases of Eclampsia/ Pre-eclampsia, 1895 cases of APH, 767 cases of PPH, 301 cases of ruptured uterus, 3498 cases of incomplete abortion with severe anaemia/sepsis, 4955 cases of septicaemia, 7621 cases of severe anaemia, 984 cases of obstructed labour and 6059 cases with other medical complications like Jaundice, heart diseases have been treated. These are all probable maternal deaths (cases of near miss of maternal death) which have been saved with continuous efforts of Medical and paramedical staff of exclusive and dedicated setups of obstetric ICUs.

Implementing Partner

NHM Madhya Pradesh

Scalability

After successful implementation and its huge impact in saving the life, State is now scaling it up and started establishment of exclusive obstetric intensive critical care units in MCH

wing of all 51 District Hospitals in phased manner. In 2017 – 18, 08 district hospital has been identified and in current financial year 13 district hospitals are identified for establishment of obstetric ICU and HDU (Hybrid Model).

Contact

maternalhealthrch@gmail.com



MADHYA PRADESH

HIRANYAGARBHA MATRU-MUSKAAN ABHIYAN - “A Novel Initiative for tracking High Risk Pregnant Women Through Inter-Sectoral Coordination”

Problem Statement

High-risk conditions such as severe anaemia, pregnancy-induced hypertension (PIH), HIV/AIDS and gestational diabetes mellitus (GDM) are associated with increased maternal and newborn complications as well as maternal deaths. Inter-sectoral coordination is required to ensure optimum nutrition and availability of transport for the management of high risk and follow-up visits at the health facility.

Programme Description

The Programme has been implemented in three districts of Narmadapuram division.

These are the key features of this Programme:

Early registration of all pregnant women and HRP women at routine activities (VHND, MSS and PMSMA).

Management of HRP women at appropriate facilities (at PHC, CHC, and FRU)

Inter-sectoral coordination with Dept. of WCD, dept. of forest and dept. of rural management

Monitoring is being done at block, district and state level through RCH portal/ANMOL.

Monthly review by Divisional Commissioner on every 2nd Wednesday.

Programme Outcome

The Programme was initiated in September 2017 and successful implementation started from January 2018 with coordination from Dept. of WCD, Forest and Rural Development.

From January 2018 to April 2018, total 1,35,093 pregnant women were registered and 7,484 (6%) high-risk pregnant women were identified. Out of 7484, 6055 (81%) identified HRPW were visited by PHC, MO and CDPO (WCD)

Implementing Partner

NHM, Madhya Pradesh



Financial Implication

The Programme is utilizing existing resources for home visits of HRP women to ensure follow-up and appropriate nutrition counselling

This initiative is leveraging resources from other departments like Dept. of WCD for nutritional supplementation, Dept. of Forest for transportation and Dept. of Rural Development for bringing social accountability, awareness and for better ante-care of the high-risk pregnant women.

Joint home visits to the house of HRP women in coordination with these departments also reducing fuel cost for visits and it is ensuring comprehensive follow-up and management of HRP women.

Scalability

This intervention will help the states to track and report the HRP women. Proper reporting of HRP women will help states in keeping their record and their management.

Contact

maternalhealthrch@gmail.com





INITIATIVE TO IMPLEMENT FAMILY PLANNING LOGISTIC MANAGEMENT INFORMATION SYSTEM (FP-LMIS)



Problem Statement

In a public health system, access to contraceptive methods may appear to be a routine task, but oftentimes the need to institutionalize a well-functioning supply chain management system is overlooked. Indian public health system follows a centralized contraceptive procurement system managed by the Ministry of Health and Family Welfare (MoHFW) at the national level. To improve the access to Family Planning commodities, it is important to have a well-functioning logistics and supply chain management system at all levels viz state, district, block, facility & ASHA.

Programme Description

The Introduction of FP-LMIS is a path breaking effort by Government of India to strengthen the supply and monitoring of the FP Commodities right from National till ASHA Level. It is a progressive step towards digital India moto of Honourable Prime Minister of country. This unique application enables users with instantly access to stock information, indent or issue any FP commodity. Since this information system can be operated from anywhere using web or mobile app or through

SMS it has reduced dependency physical records and papers

Government of Madhya Pradesh is committed to shared vision of digital India and has rollout FP-LMIS all 51 at all the levels. Dedicated team has been appointed to train users and to monitor the implementation.

In August 2018, GoMP in consultation with GoI has entrusted Ipas Development Foundation (IDF) to support rollout of FP-LMIS in district Vidisha to make it a FP-LMIS model district. Vidisha is a high priority district with TFR of 4 (AHS 2012-2013) and unmet need of family planning at 17.9 (NFHS 4) which is higher than the state average. There are 1 DH; 2 SDH; 7 CHCs; 22 PHCs; and 203 Subcentres in Vidisha. IDF team is providing support to facility in-charges and storekeepers to manage FP commodities and is facilitating trainings of ASHAs and ANMs.

Programme Outcome

With rollout in all the Districts, 1028 users have been trained and 51 districts have started using FP-LMIS for indenting and issuing of commodities. Initial stock entry has been done for 506 the facilities. In Vidisha almost

55 users have been trained and have started using this system. Trainings are on-going in Vidisha and entire states.

Financial Implication

The Operational cost of application, which is developed by C-DAC is minimal as it is internet or SMS based. Training and monitoring cost have been sanctioned by NHM.

Scalability

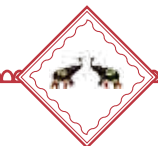
Initial learning form Vidisha indicates that system has huge scope of scalability, and will definitely aid in streamlining effective, efficient and uniform management of FP commodities.

Contact

drjlmishra12@gmail.com



ASSURED LAST MILE SUPPLY OF IFA COMMODITIES IN - A Scalable Pilot



Problem Statement

Anemia in MP remains high at 68.9% in children aged 6-59 months & 54.6% in pregnant women despite continued efforts. The reduction in anemia has only been ~3.3% in the past 10 years for pregnant women². It is a felt need of the State to improve access to Iron Folic Acid (IFA) tablets (Pink, Blue, Red, Ferrous Ascorbate) and Syrups Bottles to children 6-60 months, children 5-10 years, adolescents 10-19 years, pregnant and lactating women, non-pregnant women 20-49 years, while also ensuring supply to the platforms of allied departments such as schools & AWCs.

Programme Description

Strengthening up-stream processes and improving down-stream drug delivery by leveraging drug delivery by mechanism (use of AVD on non-vaccination days) was conceptualized. There are both supply and demand side opportunities present to improve this uptake. While, there are continued efforts in improving the uptake by the beneficiaries by working closely with the front line workers and the community, effective delivery to Anganwadi Centres (AWCs) and schools remains a challenge. Thus, warranting a need to:

- Streamline the forecasting norms followed across each node in the supply chain, inventory management principles, and define periodicity of procurement
- Leverage the distribution channel defined for vaccine delivery through AVDs, to ensure effective, on-time and assured delivery of IFA stock

Programme Outcome

The number of Districts Procuring adequate stock for IFA blue increased by 105% from before Intervention. Procurement increased for IFA in cycle 1 with 51% of the districts becoming supply secure, having adequate supply of 6 months and 14% districts having 75% of the required stock for becoming supply secure. IFA Stock-outs (stock level zero) at schools have reduced post pilot. Field visits were made to 561 schools before pilot and 71 schools after pilot to assess the stock status. DDBs record the stock in hand at the AWCs and schools while completing deliveries. With all AWCs and schools reporting this data, the true consumption levels of each AWC and school will be identified to conduct targeted deliveries and ensure that there are no stock-outs or overstocking

Scalability

The implementation of the strategy has established the operational and financial feasibility of the supply chain system. MP government leveraged existing resources and infrastructure for implementing the supply chain strategy, proving this to be a time, logistics and cost effective solution.

Cost Effectiveness

The upstream strategy can be implemented without incurrance of any additional cost by incorporating the usage of this forecasting tool into the existing training modules.

Contact

drpragyatiwari.health@gmail.com





LEVERAGING PMSMA FOR IDENTIFICATION & TRACKING OF HIGH RISK PREGNANCIES BY ENSURING COMPREHENSIVE ANC SERVICES



Problem Statement

Quality Ante-natal care is essential for the safe motherhood and healthy baby. High risk conditions such as Severe Anaemia, Hypertension, HIV/AIDS and GDM are associated with increased maternal and newborn complications as well as maternal deaths. Adequate identification and appropriate management of high risk pregnant women is essential for averting these preventable maternal deaths and ensuring safe delivery. Tracking of high risk pregnant women needed streamlining and efficient mechanism of follow-up for her high risk status. Comprehensive Ante-natal care services, optimum nutrition and availability of transport for the management and follow-up of high risk pregnant women is need of the hour for rapid decrease in maternal mortality ratio. A focused approach and technically efficient guidelines were needed to ensure identification, tracking and follow-up of high risk pregnant women.

Programme Description

Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) provides a platform for comprehensive ANC services which includes check up by medical officer, all prescribed Lab tests, counselling and

medicines to pregnant women who come on 9th of every month. Identification of high risk pregnant women has been strengthened due to PMSMA but tracking and follow-up of HRPW remained a challenge. After identification, HRPW is marked with red sticker/red MCP card and line listed.

To streamline tracking and follow up of HRPW, Dept. of Health and Family Welfare has leveraged PMSMA as a platform to identify HRPW and started an innovation that is home visits through a sector level team led by sector medical officer to homes of HRPW. Sector level team visits HRPW along with ICDS supervisor, follow the health status of HRPW, counsel her on required treatment, birth preparedness complication readiness (BCPR) plan and nutrition. Team also ensures social accountability of the family of HRPW to take special care of the HRPW until her safe delivery.

Along with focusing on tracking of HRPW, Madhya Pradesh has implemented some of the good practices of PMSMA like providing iron and protein rich refreshment (dry fruit laddoo) to pregnant women on PMSMA day, token system for crowd management and PMSMA registers to improve record keeping.

Programme Outcome

Pilot of Home visits have been implemented in three districts initially and it yielded very positive results. Identification and reporting of HRPW is now gradually increasing as we are ensuring their entries in the RCH portal.

Other good practices like token system also proved efficient in crowd management, provision of refreshment in adopting nutritious diet and PMSMA registers in improving record keeping.

Financial Implication

The most significant factor of this innovation is that it doesn't implicate much financial resources and still efficient. Home visits through sector level team to ensure follow up and management of HRPW incur only mobility charges for the team. Team member gets mobility allowance as per the norms and they include home visit of HRPW along with their visit plan.

Scalability

Seeing the result of three districts, Government of MP scaled it up to all 51 districts.

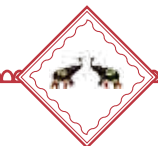
Contact

maternalhealthrch@gmail.com



MADHYA PRADESH

CONCURRENT MONITORING THROUGH RI MONITORS IN ROUTINE IMMUNIZATION



Problem Statement

Routine immunization is one of the key interventions to save children from vaccine preventable diseases. Inadequate or no immunization is often associated with serious forms of morbidity and mortality. By fully immunizing the children, we can reduce infant mortality rate (IMR) significantly. Our aim is to achieve full immunization in 100 percent children before the age of one year.

Programme Description

HMIS data is available to us on regular basis, however, it is the evaluated coveredata which tells us the real picture of completeness of immunization. AHS, DLHS and NFHS are the popular surveys which have given us the reliable data for action in recent years. long intervals and no sub-district level data limit the relevance of these surveys. It is necessary for state to know the status of immunization and the challenges therein on a concurrent basis so that immediate corrective actions may be taken. Madhya Pradesh state therefore decided to develop its own system of concurrent monitoring through graduate Multipurpose Health Workers, MPW (Male)

by sending them as monitors to districts other than their districts of posting. This will ensure a reliable data for action on a monthly basis.

164 Monitors were selected from a large number of more than 3700 MPWs through a vigorous process of selection. The monitors were trained to monitor immunization activity on various parameters using standard session and house to house monitoring formats. Monitoring was done on 4 immunization days every month. The data was recorded on an android based application developed by NCCVMRC and analysed. The monitors were paid a honorarium for this purpose. The findings uncovered challenges at sub district level in achieving acceptable level of immunization coverage. The monitors provided hands on training to the ANMs and provided feedback to block and district officials for taking corrective measures at a higher level. .

Programme Outcome

The findings of monitors were found to be unbiased and acceptable. Data from House to house monitoring (Aug-17 to Jul-18):

No. of sessions monitored: 14,838

No. of Children checked (0-35 months): 50765

Scalability

Concurrent monitoring gives a reliable data on quality and completeness of immunization services on a monthly basis to the Programme managers at district and sub-district level for taking appropriate corrective actions. Concurrent monitoring in routine immunization, by deploying RI Monitors from within the system, has been found to be a cost effective and replicable intervention for strengthening routine immunization coverage in state.

Contact

drtiwari.immunization@gmail.com





IRON SUCROSE SUPPLEMENTATION THERAPY AT PHC LEVEL



Problem Statement

Anemia in pregnancy is associated with high maternal morbidity and mortality. During ANC care it is found that there is high prevalence of anemia among pregnant women in various parts of Maharashtra and to reduce this prevalence of anemia, Government of India, have started a Programme in which, the Iron Sucrose Supplementation is given to Pregnant Women with low Hemoglobin level (Hb <7) at higher centers. In Maharashtra, still it was observed that there were many pregnant women who needed the supplementation, preferable close to their community. So, in Maharashtra, the scheme is being implemented, where the pregnant women receive Iron Sucrose Supplementation at PHC level under the guidance of trained gynecologist & obstetrician/Medical Officer.

Programme Description

All over India Iron sucrose supplementation is given to severely anemic pregnant women to rectify deficiency & to avoid further complications. This supplementation is given at Sub-district/District hospital level but not at PHC level. To cover all anemic women at

hospital level is difficult so this project was implemented in Maharashtra at PHC level. Pregnant women coming for ANC checkup are closely monitored and screened for Hb levels by SC ANMs, MO-PHC. Those pregnant women found with severe anemia (Hb < 7) at 24 to 26 weeks of pregnancy even after administration of IFA tablets and nutrition counseling are administered Iron Sucrose injection at PHC level after ruling out other causes like Sickle Cell Anemia, Thalassemia, malaria etc. All the necessary precautions are undertaken before administration of iron sucrose injection under direct supervision of Medical Officers and 100mg of injection iron sucrose in 100 ml. of Normal saline infusion is administered through I.V route for 30 min.

Programme Outcome

9558 pregnant women were detected as severely anemic (Hb < 7) from all districts in Maharashtra at PHC level out of which 9420 received treatment via this initiative. With this Programme the Hb levels among the mothers (who received the iron sucrose supplementation) increased, which in turn reduced the future morbidity and mortality among the Pregnant Mothers.

Implementing Partner

The Programme is implemented by Public health Department of Maharashtra

Financial Implication

The cost includes the cost of Inj. iron sucrose only which is given by NHM / PHD Maharashtra (Government Supply).

Scalability

Looking at the high number of severely anemic mothers in the country it was very important to give the Iron sucrose supplementation at PHC level along with the DH, SDH & RH level. Hence similar project can be implemented all over India especially in low performing states to tackle anemia problem in pregnant women.

Contact

shsrc.gom@gmail.com



MAHARASHTRA

DATTAK PALAK YOJANA (Adoption Scheme for Monitoring Progress of Malnourished Children)



Problem Statement

There is high prevalence of SAM and MAM children in Palghar District. Lack of co-ordination between various departments was a major issue. This created hindrance in regular follow-up by all concerned departments in order to improve outcomes in SAM and MAM management.

Programme Description

- The Dattak Palak Yojana covers the entire Palghar District as a part of the Palghar District Action Plan to combat malnutrition & to reduce child deaths.
- All block level officers of various departments (Health, ICDS, Education and Gram panchayat) are involved in Dattak Palak Yojana to improve status of SAM/MAM children in the district.
- Each officer such as BDO, THO (Taluka Health Officer), CDPO, Extension Officers, Health staff (MPW, ANM MOs), Gram Sevak is given responsibility of one SAM/MAM Child (Dattak) for regular follow-up of nutritional status along with their livelihood needs such as food ration, water, Health, etc. These officers track their Dattak child

with other departments so that his needs are met holistically.

Programme Outcome

Family – A joint visit by ANM, Anganwadi Worker and ASHA (AAA) is arranged, wherein following points are checked:

- Ration card and Aadhar Card availability of all family members
- If regular food rations are received by the family
- Migration status of family members.
- Coordination with other departments to improve and evaluate nutrition & health status of the malnourished child.
- Stenciling cards are provided to all the families with a SAM/MAM child

Malnourished Child-

- Immunization status & weight gain is checked during visit.
- As per the nutritional status (SAM/ MAM) of the child, referrals are given to nearest VCDC, CTC, NRC for further management.
- In case of missed service delivery, appropriate referrals are made.

Implementing Partners

PHD, ICDS, Education, Tribal, Water & Sanitation

Financial Implication

District level funds are utilized for implementation of this initiative

Scalability

The Dattak Palak Yojana is being incorporated in the District Health Action Plans of districts with High IMR.

Contact

shsrc.gom@gmail.com





AANCHAL MOTHER MILK BANK



Problem Statement

Breastmilk is a gold standard that covers all needs of a new born by providing optimal nutrition, protective anti-infective substances and benefits for long-term development of a child. However, the pre-term, low birth weight and sick babies admitted at health facilities, remain deprived of their mother's milk. These babies often have feeding problems and are

vulnerable to sickness and poor quality/ chance of survival and development. When breastfeeding is not possible, next best option is donated breastmilk from a healthy donor.

Programme Description

The Aanchalmilk bank provides services of a) collection, processing, storing and dispensing of donor human milk, to neonates in need, b) breastfeeding clinic to promote and support breastfeeding practices and c) counseling for lactation support.

mortality is being collected across all states and will be shared post completion of the first year of implementation of the Mother Milk Bank initiative. An independent evaluation of this recently launched initiative will provide further information on its effectiveness.

Implementation Partner

This is an initiative of the State Government under the MoHFW's guidelines on Comprehensive Lactation Management Centres.

Financial Implication

Not specifically provided but the model was deemed feasible and acceptable.

Scalability

A total 18 Mother Milk Bank are approved in the State and out of which 15 are operational. The milk banks can be gradually established in the Medical Colleges and District Hospitals of other states as well.

Contact

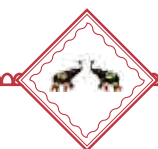
spm_raj.nrhm@yahoo.com





RAJASTHAN

CHIRAYU : Making Everylife Count



Problem Statement

Rajasthan was in bottom 4 in terms of NMR. Due to this 'Chirayu Programme' has been launched in 8 high focussed districts where NMR and IMR were high e.g. Udaipur, Jalore, Karauli, Barmer, Rajsamand, Dholpur, Sawaimadhopur & Sirohi. Rigorous planning and monitoring has been done. Additional Chief Secretary, Secretary, & Mission Director- NHM, AMD-NHM and Project Directors have adopted one district for mentorship.

Programme Description

The Programme consists of the following key components:

Rigorous planning: Additional Chief Secretary, Secretary, & Mission Director- NHM, AMD-NHM and Project Directors have adopted one district for mentorship. PCTS data-driven planning has resulted in identification of key improvement levers – e.g., practices in labor rooms, management of SNCUs, maximum FRUs operationalization (including caesarean-section performance) and effective community services (e.g., ante-natal care, home-based newborn care).

Innovations in human resource gap filling: For closing gaps in specialist vacancies (e.g., Gynecologist, Pediatrician), a bidding process

was used to attract the specialists. This approach has yielded promising results - 27 specialists have been offered the opportunity to join the Chirayu journey.

Data-driven reviews—with ranking and dashboards: To ensure sustained focus, reviews have been institutionalized, including an overall steering committee meeting, district performance reviews and facility-level reviews. Combined SNCU and LR reviews have also been institutionalized, where all the facility in-charges are connected via monthly Video Conference. These meetings are conducted after sharing information metrix from state and “district packs” are auto-generated and disseminated, to facilitate root cause analyses.

Clinical enablement: Across the state, doctors and nurses are being equipped with critical clinical skills through mentoring, on-site correction, hand holding and capacity building.

Focused Areas in Chirayu

- Ensure SNCU coverage & improve SNCU
- Labor Room practices improvement of High Delivery points
- Ensure FRU operationalization (improving C-section performance), and referral linkages

- Improve ANC coverage, HRP identification & delivery planning
- Fix Neo-natal death reporting
- Ensure Accountability & reviews

Programme Outcome

We have started witnessing clear signs of success. Leadership reviews have ensured that NMR focus has percolated to the field. As a result of the initiatives, key metrix are starting to improve, such as SNCU survival rate, important LR practices, rational use of antibiotics, facility and community follow-up of SNCU graduates. It has also resulted in improved line list reporting of neo-natal death and ANC registration over PCTS system.

Contact

md-nrhm-rj@nic.in





GESTATIONAL DIABETES



Problem Statement

As many studies have indicated GDM is emerging as a rising public health problem in pregnant women in India. Random surveys across many cities of India have shown that prevalence rates vary across different cities such as Kanpur in U.P - 13.4%, Haryana - 7.1%, Kashmir - 3.8%, South India - 21%.

Programme Description

A cohort study for Gestational Diabetes Prevention and Control Project was done for 2 years i.e from Sept 2013 to Sept 2015 at 198 ANC care public health facilities in Kanpur District of Uttar Pradesh. As per GOI guidelines for universal screening of Diabetes in Pregnant women, state GDM Project initiated in 18 Div Districts in 2017 onwards. A three day training for doctors and & Paramedical staff was done in all districts. A total of 6700 ANM in 18 Div Districts of Uttar Pradesh were provided with Glucometers and trained for 2 days at block level. After procurement and training of Medical officers and ANMs Programme was rolled out in all the 18 div districts by December 2017. Glucometers were also provided to all the CHCs, PHCs and District hospitals. This was

followed by a State launch for GDM on 3rd May 2018.

Programme Outcome

Till November 2018 a total of 647,456 pregnant women have been screened during 14-16 Weeks & 24-26th weeks of Gestation by using oral glucose tolerance test (OGTT) (DIPSI Diagnostic Criteria of \Rightarrow 140 mg/dl after giving 75 gms of glucose irrespective of fasting state. A two hour blood sugar value was tested with Glucometer).

In this one year study period it is seen that though our screening and reporting has improved with time, yet the overall Prevalence rate of GDM from all center is only 6.7% as compared to the Pilot study of Kanpur (2013-2015) where Prevalence rate was 13.6% for pregnant. The Post Partum Screening is only also only 8% which is low & Postpartum screening in the earlier study was 12%.

This data is likely to increase with more training and handholding of the field staff. Regular Monitoring and training of ANM and health care professional is also going on with more and more doctors realizing the importance of GDM.

Scalability

Blood sugar level is an important possible indicator of maternal and perinatal morbidity and mortality in GDM cases. DIPSI Test adopted by GOI, 2016 offers a great opportunity to diagnose GDM after 75 gm of Glucose, post 2 hour Blood Glucose value \Rightarrow 140 mg & manage GDM by MNT and Metformin or Insulin, and ultimately reduces Maternal and foetal complication and reduces Perinatal & Neonatal mortality & morbidity. It is still a challenge to take forward the testing and management of GDM to all the pregnant women and we have a long way to go.

Uttar Pradesh GDM Model provides a unique opportunity for ANM to do test for every ANC twice during Pregnancy and once after 6 weeks of delivery

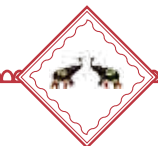
Contact

gmmhup@gmail.com



UTTAR PRADESH

FRU STRENGTHENING THROUGH REGIONAL RESOURCE TRAINING CENTER



Problem Statement

Uttar Pradesh ranks has second highest MMR only after Assam. The maternal mortality ratio (MMR) in the state has declined from 285 in 2012-13 to 201 per 100,000 live births for the period 2014-2016 for UP and Uttarakhand combined. The state also has the greatest burden of under-age-5 mortality in all of India (28% of all deaths; 364,000 deaths/year). The Infant mortality rate (IMR) of UP is fourth highest in the country, translating to about 250,000 infant deaths in a year. About 70% of the infant deaths in the state happen during the first 28 days of life and with an estimated neonatal mortality rate (NMR) of 34 per 1,000 live births; over 175,000 children die every year during the neonatal period. UP also has a greater share of maternal deaths.

Programme Description

To improve complication management at the tertiary level and to reduce mortality and morbidity related indicators (Case Fatality Rates due to maternal and new-born complications), UP-TSU with support from NHM engaged Medical Colleges as Regional Resource and Training Centres (RRTCs) for training and

mentoring of Medical Officers & Specialists in 50 FRUs including district women hospitals located in 25 HPDs. RRTCs supported the FRUs in continued medical education, on site mentoring, and regular supportive supervision.

Strategy for Operationalization of 50 First Referral Unit in 25 HPDs

- Improvement Dimensions based on availability and utilization of 9 Signal functions of CEmOC services
- Improving and strengthening complication management
- Focused on facility activation on CEmOC services
- Infrastructure Improvement
- Capacity Building: through RRTC Training and on-site mentoring activities
- Advocacy and Liaison:

Key RRTC support

I. Strengthening capacity of Specialists Doctors and MBBS-MOs serving in District Hospitals and CHC FRUs through training and on-site mentorship

II. Ensuring strict adherence to clinical protocols for management and stabilization of the complicated cases (referred-in) by training and mentoring of Specialists and Medical Officers from the identified FRUs.

III. To regularly provide feedback to the District Hospitals and CHC FRUs to improve and strengthen case management and referral mechanisms.

IV. Improve referral linkages between medical colleges and public health facilities,

V. To build a platform for stakeholders including government officials (CMO/ CMS/MOIC), TSU and Regional Resource Training Centre (RRTC) for communication exchange to improve complication tracking and management to save both mother and infant.

VI. To develop a system for systematic interaction and referral processes between FRUs and lower level facilities within their catchment areas.

VII. Promote and strengthen team work and coordination between facility doctors and their staff nurses, for better complication management at the facility.

Contact

mdupnrhm@gmail.com





SETTING UP OF MEDICAL GENETICS LAB PARTICULARLY CYTOGENETICS AT IPGMR THROUGH NHM



The genetic testing center at SSKM hospital, Kolkata is the only center at govt. hospital in entire eastern India. So far 1185 tests (Karyotyping from blood and few from other specimen) have been done which would have otherwise required around Rs 5000 to 6000/- per test in any accredited laboratory. It may cost around 7000-8000 if sampling is done from other tissues. So the amount of Rs 70, 00000 (70 lacs) has been saved on the genetic testing only since the initiation of genetic testing.

The cost of antenatal counselling, immediate postnatal management and follow up of infants in the neurodevelopment clinic and early intervention are also being done as a part of genetic testing and counselling services at SSKM hospital regularly, that is saving a considerable amount on these areas by this innovation.

The genetic testing and counselling center at SSKM hospital is under same roof as part of a department of Neonatology which runs the antenatal counselling clinic and genetic clinic by neonatologists and geneticist regularly to offer counselling and management of suspected genetic disorders and further genetic testing to prevent genetic disorder and birth defects in next pregnancy.

The department of neonatology along with genetic testing and counselling center is actively involved in training & teaching of DNB students of medical genetics for capacity building in this particular field which will further reduce the burden of genetic disorder in the society. The prevention genetic disorder and genetically determined birth defect will actually be highly cost effective affair as this will save the huge amount of financial resources for therapeutic, early intervention and lifelong rehabilitation services to support a child having developmental delay and congenital malformations due to genetic disorders.

Families of the 1185 children who actually had undergone genetic testing.

Population coming for genetic counselling from antenatal clinic, endocrinology, Pediatric medicine, Neuromedicine OPD, RBSK clinic, around 2500-3000 per year.

Approximately 4000 children per year (and their families) have directly been influenced by the test results and counselling services.

Contact

mdnrhm@wbhealth.gov.in









সাহপুৰীয়া কোচৰ চুক প্ৰাথমিক বিদ্যালয়
প্ৰতিষ্ঠা ৪.৯ এপ্ৰিল ১৯৫৪ খৃষ্টাব্দ
সাহপুৰীয়া গাঁও মোৰহাট - ৭৮৩০০১
ভাৰত - পশ্চিম বংগ

সাংস্কৃতিক শোভাযাত্ৰা
যোৰহাট জিলা ধূপাত নিৰস্তন কে
সাহপুৰীয়া গাঁওৰাই মনোমত
বিশ্ব ধূপাত বিৰোধী দিৱস
৩১ মে' ২০১১ জীৱাক
DISTRICT TOBACCO CONTROL CELL, JORHAT

বিজাত





NATIONAL HEALTH MISSION
Ministry of Health and Family Welfare
Government of India
Nirman Bhavan, New Delhi