सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

We Care...

Good, Replicable and Innovative Practices

2019

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Government of India
Nirman Bhawan, New Delhi

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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 sixth publication in this series and captures 110 best practices and innovations, including health programmes, medical devices and technologies. They span programmatic areas ranging from health systems, maternal and newborn 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 Heath Mission. The publication includes the presentations made at the sixth national summit held at Mahatma Mandir, Gandhi Nagar, Gujarat where both 37 oral and 73 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 1500 proposals have been received through this portal. In the last one year, more than 300 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 Ayog 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.

DPH
தமிழ்நாடு அரசு
நடமாடும் மருத்துவ

RMNCAH+N

MCH SERVICES

Problem Statement

- Sepsis in pregnancy remains third leading cause of maternal death accounting for 10 to 15% of maternal deaths. As per MDSR State data of Chhattisgarh, Sepsis accounts for around 11% of maternal deaths.
- No testing of environmental surfaces in the labour rooms, OTs and PNC Wards.

Programme Description

- 01 day training of staffs posted in the units was conducted at AIIMS Raipur, High touch sample areas were defined beforehand and communicated to the districts, Collection of samples pre cleaning and post cleaning with an interval of 30 minutes was done from 23 labor rooms, OTs and PNC Wards by swabbing. Testing was done at AIIMS Raipur and the results transmitted to the units for corrective action.

Programme Outcomes

Total 03 round of surveillance will be carried out. First round was completed. Samples were collected from 23 labor rooms of 22 districts of Chhattisgarh state. Total 544 samples were collected from April 2019 to August 2019. Out of this, 54.57% (322) Samples were found positive with common organisms like Staphylococcus aureus, Methicillin Sensitive Coagulase Negative Staphylococcus and Klebsiella pneumonia.

Contact Details

Email: office.mdnrhm@gmail.com

Phone: +91-9479053511

USING MULTIPRONGED STRATEGY

For Improving Facility Based Management of Low Birth Weight (LBW) babies

Problem Statement

Haryana state is focusing on improving the child health services to reduce the Infant Mortality. Infant Mortality Rate (IMR) has dropped from 61 in Haryana (SRS 2005) to 44 as per SRS 2011 and further to 30 as per SRS 2017. The greatest risk of childhood death occurs during the neonatal period, which extends from birth through the first month of life. The NMR has reduced from 33 in 2010 to 21 in 2017. Further significant gains in NMR reduction will be possible on addressing the LBW and their management. Haryana established the network of SNCUs in the district hospitals starting in 2010.

Programme Description

The multipronged strategy for addressing Low Birth Weight babies includes:

1. ***Identification of hidden low birth weight babies*** – The state supported the districts to replace all conventional manual weighing scales with digital weighing scales in all Newborn care corners.
2. ***Improving access to care of small and sick newborns by increasing the number of SNCUs*** – Haryana has 23 SNCUs, 22 of them located in district hospitals and remaining 1 in SDH. The state has planned to upgrade 5 NBSUs to SNCUs.
3. ***Kangaroo Mother Care Units in all SNCUs*** – All SNCUs have a functional KMC unit with trained staff.
4. ***Family Participatory Care*** – The state along with VRIDDHI/USAID organized 4 Regional trainings. SNCUs were provided with printed posters and recording and reporting registers to facilitate the implementation.

Programme Outcomes

In government institutions the reporting of LBW increased from 10% to 18% in 2018-19. In Aspirational district Mewat, the institutional delivery increased from 64% to 69% in 2018-19, reported low birth weight babies increased from 3% to 14% in the same period.

The total SNCU admissions increased by 5% from 23206 in 2017-18 to 24402 in 2018-19. The percentage of LBW admissions increased between the two years from 11627 LBW admissions in 2017-18 to 12314 LBW admissions in 2018-19. This included increase in admission of babies with birth weight <1800 gms from 13.2% to 14.8%.

The percentage of admitted babies receiving KMC was increased from 16% in 2017-18 to 18% in 2018-19. This was further strengthened by the implementation of Family Participatory Care (FPC) which facilitates involvement of parents for routine care, developmental supportive care, KMC and optimal feeding and care of newborn at home with identification of danger signs. NHM Haryana has conducted total of 4 state level ToTs from March – August 2019. In these trainings total of 104 participants were trained which includes 16 paediatricians, 14 MOs, 71 staff nurses, and 4 others. These participants were from 23 SNCUs and 6 NBSUs from 21/22 districts of Haryana. All three NBSUs and single SNCU of aspirational district Mewat trained in the FPC. Facilities have started reporting and till August 2019 total of 1892 FPC sessions were held in different SNCUs and about parents of 3000 admitted newborns have attended these sessions including 1225 low birth weight babies. Nearly 60% of parents of admitted newborns attended at least one session of FPC in the last three months from the reporting facilities.

Financial Implications

None of the interventions had any significant cost requiring special funding.

Scalability

Haryana has implemented these interventions at scale across all districts. The model depicts the feasibility of improving detection of LBW and improving preparedness of the health system to cater to LBW babies.

Contact Details

Email: md-hr-nrhm@nic.in

Phone: +91-1722573922

CONVERTING FIRST 1000 DAYS APPROACH INTO IMPLEMENTABLE MODEL

Developing Gujarat as a Cognitive Capital of India

Problem Description

Government of India had come out with a book on journey of first 1000 days and its importance and benefits, but the challenge was first to understand this concept, create an awareness among the people who matter and then translate it into something tangible on the ground with a clear road map.

Activities done under “First 1000 days Initiative”.

- Development of Resource materials.
- Capacity building module for ASHA.
- Guidelines on First 1000 day compliant facilities.
- Messages for mother regarding first 1000 days.
- Certification course on Journey of first 1000 days.

Community awareness activities:

- Audio and Video messages in Gujarati, Hindi and English.
- SATCOM, Live Programme on Doordarshan and Use of Saptadhara.

Certification of PDU Hospital Rajkot as First 1000 days complaint facilities.

Establishment of Midwifery Led Labour room to provide care with dignity.

Government medical colleges and other facilities by deploying Nurse Practitioners Midwifes.

Training on Alternate Birthing Positions.

Research and Implementation on Physiological Cord Clamping.

Strengthening Kangaroo Mother Care practices through political advocacy.

Promotion of use of Drumsticks and Iron Vessels for cooking, Kitchen garden.

Programme Outcomes

- Positive birthing experience for mother and baby in clutter free environment.
- Humanized care with privacy, dignity and respect.
- Optimal family participation in care of newborn.
- Benefits of newer evidences such as alternate birthing positions and physiological cord clamping.
- Support in cognitive development of children to reach their full potential.

Involvement of Stakeholders

UNICEF provided continues technical support beginning from development of implementation framework to implementation at field level. Other partners are Samhita and Shrimad Rajchandra Hospital, Dharampur.

Way Foreword

- Convert all Health Facilities to “First 1000 days Compliant facility.
- Development of Centre of Excellence under first 1000 day.
- Establish Midwife Led Care Unit at all delivery points.
- Communication campaign for first 1000 days.
- Development of monitoring framework with indicators.
- Use of digital technology (My Techo) to spread awareness.
- Collaboration with private practitioners.

Contact Details

Additional Director,
Public Health, Gujarat
Email: schoolhealthgujarat@gmail.com

IMPROVING FAMILY PLANNING COMMODITY LOGISTIC MANAGEMENT through FPLMIS

Problem Statement

An efficient and uninterrupted supply chain for FP commodities forms the back bone of FP Programme and is imperative for its successful implementation.

The digitalization of supply chain has revolutionised the health system. The earlier paper based manual system had many shortcomings such as poor inventory management, top down push for commodities, no source for real time information on demand of supplies, difficulty in compiling and analysing data at state or district level. These issues led to overstocking/shortage and stock outs of commodities at different facilities.

Programme Description

In order to streamline FP commodities management across the country GoI launched FPLMIS. It is a web based, mobile app and SMS based application for assisting in collection, processing, indenting and monitoring utilization of family planning logistics. This system is envisaged to be used by health functionaries at all level starting from ASHA to the state level Programme managers. Gujarat state rolled out FPLMIS in 2017-18.

Gujarat as a front runner in implementation of Programme has adopted various approaches including the following:

1. A cascade model of training. Master trainers trained at national level provided training at State level. Total six regional training batches were organized and Additional District Health

ASHA FPLMIS Trainig during ASHA Sammelan in FPLMIS

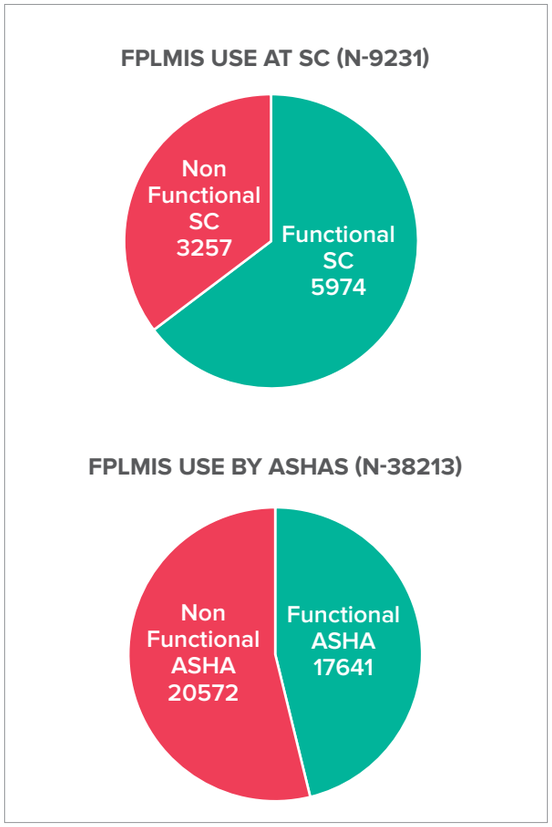
officers (Nodal FP officer), District Programme Co-ordinators (NHM) and pharmacists were the primary target audience for these training. Further trainings were organized by regional and district administration. So far, more than 33,000 Healthcare functionaries including ASHAs have been trained on use of FPLMIS.

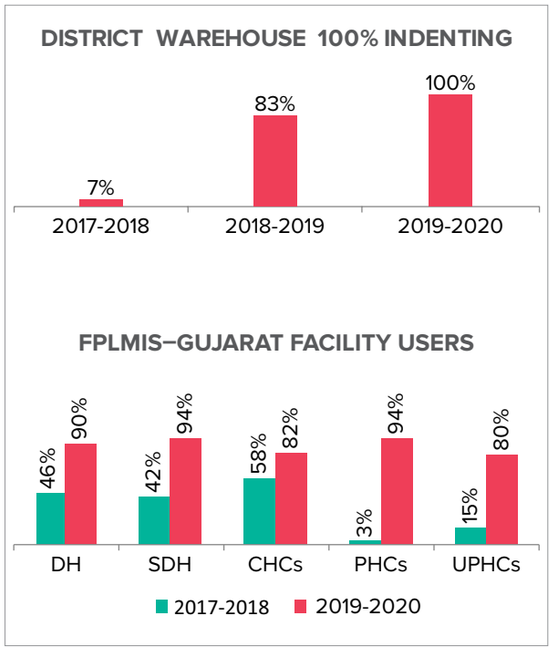
2. Training presentations were translated in to vernacular language to increase understandings of ASHAs on FPLMIS. SMS codes for indenting have also been translated and pasted on to ASHA diaries across the state as ready reckoner.

3. To provide constant monitoring & supportive supervision, SATCOMs and video conferences are organized at regular interval to provide guidance and resolve queries.

Programme Outcomes

State level monitoring and supportive supervision is being continued to see utilization of FPLMIS. As of October 2019, more than 90% facilities (2000/2216) are using FPLMIS for indenting in Gujarat. 64% of sub centres (5974/9231) and 46% of ASHAs (17641/38213) are also using it regularly for indenting. Indenting from district ware houses has also increased





from merely 7% in 2017-18 to 100% in 2019-20.

Challenges & Lessons Learned

Acceptance of new digitalized system over the age old paper based system was a challenge. However, peer support from the younger and computer literate FHWs/ ASHAs have now motivated all health care workers to use the system. Mass indenting by all FHWs & ASHAs during ASHA sammelen were tried out to percolate peer learning and was found to be very useful.

Way Forward

FPLMIS has helped tremendously in streamlining logistic management of FP commodities. Now the focus is on ensuring compliance to this supply related aspect as well as on demand generation activities at community level.

Contact Details

Additional Director Family Welfare

Email: adir-hlt@gujarat.gov.in

RBSK SWASTHYA KIRANA

Programme Description

- Rashtriya Bal Swasthya Karyakram (RBSK) commenced from the year 2013-14 in Karnataka,
- The activities are undertaken by the RBSK Mobile Health Teams comprising of 2 Medical Officers, 1 Staff Nurse and 1 Ophthalmic Assistant/ Pharmacist. Every Talukahas 2 RBSK Mobile Health Teams to conduct the Anganwadi and School health screening activities. Monitoring of the Mobile Health Team activities and to gather real time screening information of each child on a single platform, Department of Health in convergence with Department of Education came out with the Health Module in the **"Student Achievement Tracking System (SATS)"** which is the software of Department of Education. The Health Module named **"RBSK SWASTHYA KIRANA"** came into existence.
- **"RBSK SWASTHYA KIRANA"** software **– "Health Module"** implementation helps in capturing the Comprehensive newborn Screening of all newborns at the Delivery Points of Public Health

Institutes and follow-up of all babies requiring intervention at the DEICs.

- SMS to School Head Master and College Principals are sent 03 days prior regarding the RBSK Mobile Health Teams visit.
- Health screening of children between 0-6 years and 6-18 years at Anganawadis, Schools and Colleges respectively, Medical and Surgical requirements of the child and those requiring further referral to Government Hospitals and referral hospitals are automatically generated along with the beneficiary details.
- SMS is also sent to the Medical Officer of the referral hospital and parents are also intimated regarding the same via SMS.
- Child health screening details, referral and follow-up information is also available.
- Health records of the newborn and all children screened at the Anganwadi, School and Colleges get automatically carried for the successive years.
- **"RBSK SWASTHYA KIRANA"** has also **"Inventory Module"** which includes information on Iron and Folic Acid tablets (IFA-Pink and IFA-Blue) distributed under Weekly Iron and Folic Acid Supplementation (WIFS) program. Tab. Albendazole used for Deworming children between the age group of 01-19 years are also captured in the software during National Deworming Day (NDD).
- State Government owned Programme **"SHUCHI"** which promotes Menstrual Hygiene among adolescents girls (10-19 years) provides Free Sanitary Napkin Pads. Complete information on its procurement, supply, distribution and current usage are gathered in the software. The software helps in implementation and monitoring, the real time data.
- Successful implementation and detailed information of the Programme is made easier with this **"RBSK SWASTHYA KIRANA"** software platform.

Contact Details

Email: ddrbsk-hfws@karnataka.gov.in

Phone: +91-9449843295

LEVERAGING TECHNOLOGY FOR ADDRESSING the Third Delay in Maternal Health

Problem Statement

- Third delay contributes significantly to maternal and neonatal outcomes.
- Health system readiness had to be upgraded using modern technology that facilitates 'on the job' support to providers.

Programme Description

Alliance for Saving Mother and Newborn (ASMAN) is an initiative of development sector partners- BMGF, MSD for Mothers, Reliance Foundation, Tata Trusts and the USAID.

Major Highlights:

- Real time data entry with notifications enabled for high risk cases.
- On-the-job clinical decision support through integrated clinical rules.
- E-partograph.
- Interactive dashboards, reports and registers.
- 24*7 specialist support through Remote Support Centre.
- Games and E-learning content.

Programme Outcome

- ASMAN application implemented in 42 identified delivery points from April 2018 to March 2019.

- More than 100 thousand cases were recorded and 40 thousand high risk cases were detected through the application.
- Supported LaQshya by auto collating clinical indicators for monitoring.

Scalability

- Sustainable design by utilizing existing health system resources.
- Open ended application facilitates flexibility in the design to incorporate or modify any aspect of the application.
- Enables quality improvement through LaQshya.

Implementing Partners

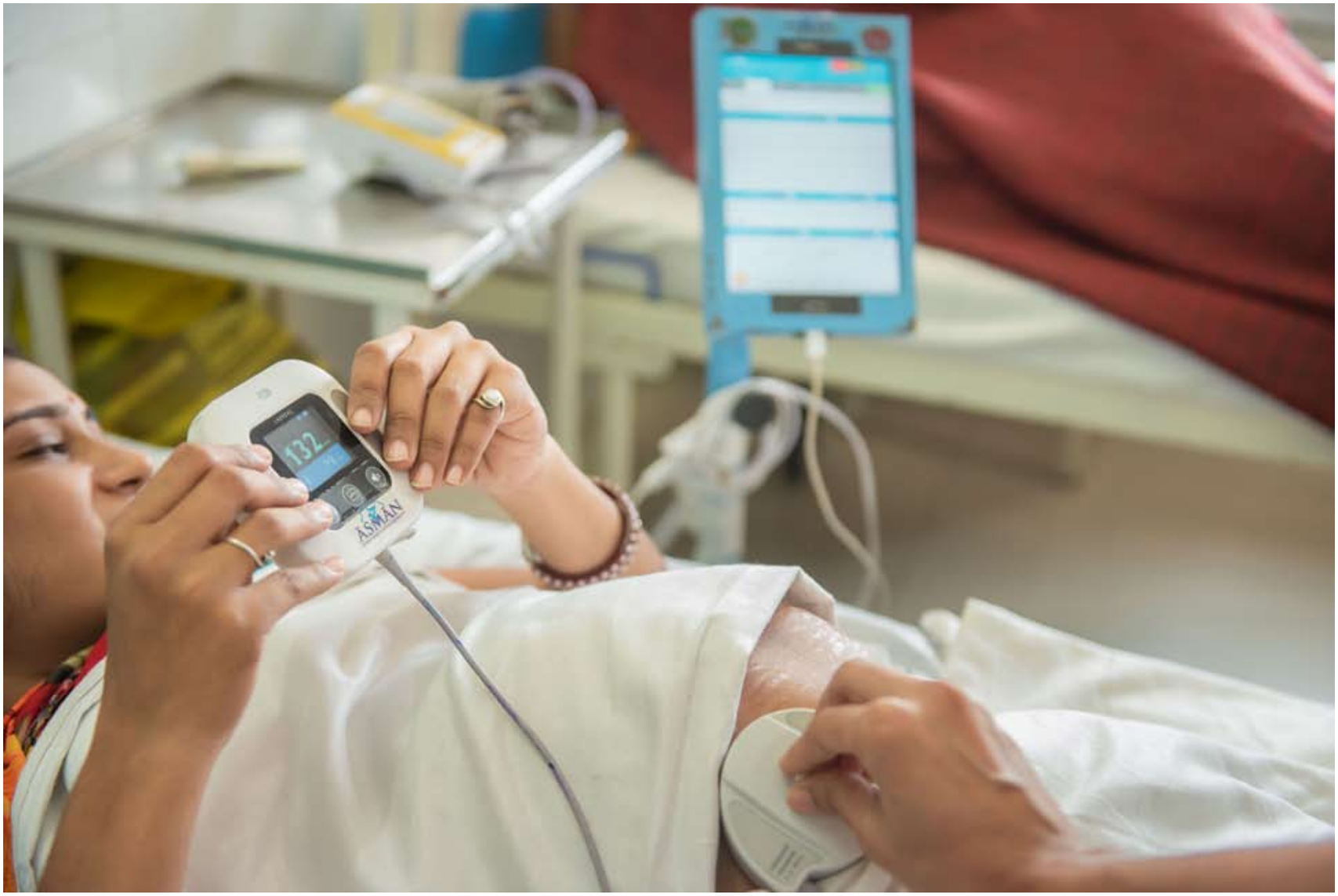
Govt. of Madhya Pradesh through ASMAN.

Financial implications

- Replaces all data entry and managerial tools
- Cuts printing costs and saves space
- Provides value additions in clinical aspect by decreasing providers work load for managerial work, knowledge enhancement, clinical decision support and remote specialist support.

Contact Details

Deputy Director-Maternal Health, NHM, Bhopal



RASHTRIYA KISHORE SWASTHYA KARYAKRAM: Convergence

Problem Statement

RKSK (**Rashtriya Kishore Swasthya Karyakram) was** launched in 2014 in Meghalaya, 122 adolescent friendly clinics "The Friends corner" have been established till date. However these centres designated specially for adolescents in health facilities are under utilise mostly in CHCs and PHCs. Keeping in view the key objectives of **Rashtriya Kishore Swasthya Karyakram, i.e.** to help adolescents realise their potentials and support them to make informed choices in their lives, the state decided on a month long Advocacy Campaign to mark the completion of 5 years of RKSK in Meghalaya which was held from 14th January to 14th February 2019.

Programme Description

The Advocacy campaign was officially launched at the State and District level on the 14th January 2019, The campaign themed "The future is here, ACT now" witnessed the participation of various stake holders from Government and Non Government Organisations. The District Administration headed by the District Collector, Social Welfare Department, Sports Departments, local Youth Clubs, RBSK teams, National Mental Health Program, National Oral Health Program, NPCDS together with the RKSK team are the driving force of this campaign.

Engaging with adolescents through Infotainment activities in the form of Sports and games like football, stone games, marathons, cycle rallies, are great crowd pullers. Side by side health screenings was conducted by Health teams. Gender friendly activities like dancing & singing competition, quiz & debate competition were also held. On the concluding day the 14th February 2019, State & District level Programme like musical evenings, Beauty Contest & talent show, Road shows and Rallies were carried out bearing the RKSK and Adolescent Health slogans. Prizes and awards were given to each participant during the campaign.

The campaign period coincided with the National Voters Day & Republic Day on on 25th & 26th January, respectively. RKSK gain popularity through these platform as well. RKSK Tableau was displayed during the Republic day parade. The subject on RKSK was mentioned by the Chief Minister Shri Conrad. Sangma in his speech, in West Garo Hills.

Programme Outcomes

- RKSK Programme (Peer educators, Adolescents Friendly Clinics, WIFS)

have gained popularity amongst the masses, especially the adolescents. These events were highlighted in all regional and local media both print & electronic, and social media.

- Under this platform not only the adolescents but other Health Programs like NOHP, NMHP, RBSK, NPCDS have benefitted.
- Behaviour Change Communication is inevitable during this month long campaign.

Scalability

1. The Block Level Campaign was held in 1st quarter of 2019-20 with a theme "Effects of tobacco use and drug misuse among adolescents".
2. The Tiffin box competition was held in the form of mega AHD (adolescent health days) during the Poshan Abhiyan (2nd Quarter) with a theme "Eat Well Feel Good". The Objective is Anaemia prevention and promoting local healthy diet.

Both these activities were held in convergence with National Mental Health Program, National Oral Health Program, Police Department, Education Department, social welfare department and various faith based organisations.

Implementation partners

JHPIEGO in 3 three district implementing AB-HWCS, namely Ri Bhoi District, West Jaintia Hills and West Garo Hills.

Financial implications

Rs 1.5 lakhs at State level, Rs 1 lakhs at District & Block level, Rs 2500 per Village in PE Implementing villages.

Contact Details

State Nodal; officer RKSK
Email: lyngdohflourish@yahoo.com
Phone: +91-8787801130

PROJECT SAFAL SHURUAAT

Problem Statement

To increase the demand for immunization and hand washing with soap at key occasions, in select districts of Uttar Pradesh. This joint initiative augments the two national priorities of the Government of India- Routine Immunization and Swachh Bharat Abhiyaan.

Along with a focus on these two priority behaviors, the umbrella of successful parenting also helps parents to adopt other related behaviors - age-appropriate nutrition, early child care and development, as well as improved parenting skills.

Programme Description

The project focuses on engaging with the following:

Primary Audience:

- Parents of children under 2 years.

Secondary Audience:

- Influencers in the family, gate keepers and elder siblings at home (School students).
- Influencers in the community: PRI members, schoolteachers, health practitioners, retired servicemen and other key opinion leaders.
- Health system: Frontline health workers and staff of primary health care system; other relevant staff form the health department at different levels from block, district to state level.

The project is built to empower the collective efficacy of the couple, the families and the community. The project addresses barriers at different levels of the socio-ecological system, to facilitate progress for the parents.

Key elements of programme design (Communication intervention sites):

District Launch – To create awareness among key government stakeholders, to build systematic ownership and emphasize the need for collective action.

Village Launch – To introduce the project at the village level, pave an entry of the Safalta Coach (a male and female duo- the field staff) and garner support from key opinion leaders, elected representatives and FLWs.

Home Visits – One to many household level contact sessions addresses barriers to behavior change at different levels of the socio-ecological system, using learning through demonstration, tools, technology and recognition, to help build knowledge, self-efficacy and eventually change practices.

Anganwadi Center Activity – Contact sessions with young mothers and the family

gate-keeper – the mother in-law, at the Anganwadi center, delivered by the Safalta Coach along with the front-line health worker, expanding a traditional health service delivery post at the village level, to discuss and trigger health behaviors.

School Contact Programme – School contact sessions, exposing young children to key behaviors, through a range of fun and interactive activities.

Male Engagement Activity – A contact session specially focused on fathers of 0-2-year-old children, to sensitize and mobilize them to embrace and support early childhood development.

Journey so far

The project has been piloted in 2 districts of Uttar Pradesh (Allahabad and Hardoi). In Phase 1, the project reached to households with 0-2 year old children, across 807 villages in 2 districts of Uttar Pradesh in 2018-19. Through the different elements of the programme, the project established a direct reach of 4,54,118 people that included parents of 0-2 year old children, students, key opinion leaders, government officials, health functionaries and other community members. In Phase 2, the project is being further expanded to additional twelve districts, in 2019-20, to gain an estimated direct reach of 3 million people.

Impact

During the pilot a robust Concurrent Monitoring (CM) system was set in place, to track the key indicators on hand washing and immunization in synergy with the interventions. This also provided mid-course corrections. Some key findings obtained from the CM are as below:

Hand washing with Soap:

- The incidence of HWWS after defecation increased 5 times (from 13% to 70%)
- The incidence of HWWS after disposing child faeces more than doubled (from 11.2% to 26.7%).
- The incidence of HWWS before cooking by mothers increased 5 folds (from 4.3% to 21.2%).
- The incidence of HWWS before eating increased 8 folds (from 2.6% to 20.8%).
- The incidence of HWWS before breastfeeding a child increased 6 times (2.7% to 17.8%).
- A 20% increase in knowledge around 'HWWS prevents diseases' was observed.

Immunization

- An incremental rise was observed in people possessing the Mother and Child Protection (MCP) card (85.2% to 96%).
- Knowledge about the number of times a child needs to get immunized (7 times in 5 years) increased 5 times (14% to 72.1%).
- A significant rise was observed in proportion of people aware about diarrhea (from 21% to 35%) and pneumonia (from 21.1% to 41.1%) being vaccine preventable diseases.
- A significant increase was observed in the compliance of critical vaccines:
  - 55.2% increase in compliance of Rota (from 1.2% to 56.4%).
  - 27.4% increase in compliance of Measles-Rubella (from 45.9% to 73.3%).
  - 14,4% increase in compliance of Pentavalent (from 66.1% to 80.5%).

Implementation partners

Project Safal Shuruaat (successful beginning), co-sponsored by **Gavi, the Vaccine Alliance** and **Hindustan Unilever** and implemented by **Group M**.

Contact Details

Email: mdupnrhm@gmail.com

Phone: +91-7897829999

সতৰ্কতা আৰু সুৰক্ষা
মেলেৰিয়া, ডেংগু, জাপানীজ
এনকেফেলাইটিছ, ফাইলেৰিয়া আদি
ৰোগ সমূহৰ পৰা ৰক্ষা পোৱাৰ মূলমন্ত্ৰ
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প্ৰতিষেধক প্ৰদান কেন্দ্ৰ
এটি টিকাৰে দুটা ৰোগ প্ৰতিহত কৰিম

ABHWC

GUJARAT- "TECHO+" (TECHNOLOGY ENABLED COMMUNITY HEALTH OPERATIONS) to Support Continuum of Care

Problem Statement

Limited availability and use of IT solutions to capture service delivery across levels of care i.e., from community to secondary level facilities act as hurdles in enabling continuum of care. This also leads to gap in recording and reporting of services provided by the public health system, with consequences such as fragmented services and Out of Pocket Expenditure (OOPE).

Programme Description

TeCHO+ is a mobile and web based application functioning as a job-aid at various levels from community to the state level administrators for improving coverage and quality of health services

Figure 1: *Components of the TeCHO+ mobile and web-based application*

TeCHO+
(Technology enabled Community Health Operations)

Mobile phone as job aid to health workers to increase coverage health care

- Longitudinal, health record and digital tracking of all individuals
- Scheduling and activity planning in form of reminder
- Use of multimedia to transmit targeted health information and improve counselling for behaviour change communication
- Manage electronic health record
- Notify stock levels and stock out of health commodities
- Receive training content in form of multimedia files
- Decision support in form of digital checklist and In-built algorithms to screen and risk stratify a case with complications
- Referral coordination to facilitate referral to functional facility and emergency transport

Web interface to provide timely information and tools to PHC/CHC/District hospital to facilitate supportive supervision and referral linkages

- Human resource management in form of list of health workforce cadres and monitor performance monitoring of ASHAs
- Digital tracking of selected high-risk cases
- Registration of birth and death events
- Data synthesis and aggregation to provide monthly reports
- Manage inventory and distribution of health commodities
- Calculation and timely payment of incentive to ASHAs
- Mass broadcast of motivational messages and training content to ASHAs using announcement feature
- GVK EMRI call center contact beneficiaries for reminder of drop out services and verification of service already provided

i.e, Android based application of ASHAs, MPW, CHOs; Web based portal for service providers at PHC/ block/ district level and for administrators at PHC/block/ district/ state level. After a successful pilot and evaluation of ImTCHO in 3 tribal districts since 2013, the TeCHO+ Project was launched by the Hon. Prime Minister on 8th October, 2017 for scale up in entire state.

At present, the android based application is being used by 10,793 Female Health Workers, 850 CHOs and 2487ASHAs from selected districts of Narmada and Bharuch. The web portal is being used by 2219 users at health facilities and administrators.

Programme Outcomes

Use of TeCHO + has enabled real time data entry of the beneficiaries and service delivery, making the tracking of users and monitoring of service delivery possible.

Performance of TeCHO+ (As of 21/09/2019)	
Population enumeration	6.42 crore (98.2 %)
Pregnant women (Concurrent)	6.01 lacs (73.6 %)
Children (0-5 year)	54.96 lacs (95%)
New Pregnant Women Registration (against est.)	94.13
Early Registration	60.00 %
Delivery Registration (against est.)	84.70%
Child Registration (against est.)	88.28%
BCG vaccine coverage (against est.)	84.79%
Penta -3 Coverage (against est.)	76.95%
Fully Immunized Children (against est.)	82.70%
NCD ??	

Scalability

The TeCHO+ has been rolled out in entire state to cover entire state population i.e, 6.55 crore). The IT platform, which initially focused on RCH related services has been expanded to include nutrition, non-communicable diseases, cerebral palsy and ophthalmology to synergize with the efforts of delivering comprehensive primary health care services. TeCHO+ will also be expanded to capture services related to RBSK, Mental Health and epidemic surveillance in phased manner. Thus, this can potentially serve as model for scaling up to other states.

Implementation Partners

NHM, Gujarat, Argusoft, SEWA rural and GVK EMRI

Contact Details

Email: dassrathpatel55@gmail.com

Benefits: (replace with a flow chart)

Field level health workers:

1. Support in Inter Personal Communication through use of inbuilt mobile video
2. Useful for timely identification and/ referral management of beneficiaries.
3. Reminder for due service through work plans
4. Ease of maintaining records of all beneficiaries
5. Notification for high risk cases for improved follow up

Medical Officer:

1. Automatically generate monthly reports based on entry done on mobile.
2. Timely information of high-risk mothers and children for follow-up
3. Facilitates supportive supervision and monitoring
4. Updated information of birth and deaths of respected area.
5. Supports estimation of ASHA's incentive

AARDRAM MISSION IMPLEMENTATION

Problem Statement

Provide easily assessable, universal and free quality services at primary healthcare facilities for ensuring health and wellness and institutionalizing referral protocols.

Programme Description

'Aardram Mission', is a state government effort to make government hospitals people- friendly by improving basic infrastructure and quality of services by upgrading Primary Health Centres (PHCs) as Family Health Centres (FHC). FHCs are equipped with laboratory, pharmacy, well attended OP counters, fitness centre and yoga training facility. Field staff at FHCs are trained on NCDs and CD related health issues and management. Team building trainings consisting of people's representatives and all health staff (including doctors and field staff) are also being conducted for facilitation in providing quality services in govt. health institutions. As a part of wellness, State has planned for "Sampoorna Yoga Keralam," which envisages the propagation of yoga. It is proposed to disseminate yoga training to the public by empowering ASHA, school volunteers and community volunteers through continuous yoga trainings. Muhamma Grama Panchayat is declared as Sampoorna Yoga Gramam (23575 people trained out of 30000 population) in Muhamma, Alappuzha District.

State has upgraded 170 PHCs to FHCs in 2017-18 and another 500 PHCs in 2018-19. In current year, target is to cover all the remaining PHCs. Under Sampoorna Yoga Keralam, aim is to empower Yoga Volunteers to train public, school children, etc. through six sessions/ month, extending within one-two years to cover the entire ward, school and public (covering all 941 panchayats).

Programme Outcomes

Ownership of health institutions among Panchayati Raj Institutions and general public is clear, with institutions augmenting more funds for health institutions over and above the budget allotted through budgetary support.

Funds under Members of Parliament Local Area Development Scheme (MPLADS), Members of Legislative Assembly Local Area Development Scheme (MLALADS), Panchayat funds, CSR funds etc. are being tapped for the upgradation of health institutions.

Scalability

The intervention includes defined components, to strengthen public health institutions and has utilised funds from existing funds and from other government departments, thus demonstrating multi-sectoral convergence. This mode can be adopted for scale, with contextual modifications, depending upon avenues for resource mobilization.

Implementation Partners

This is an effort of the state government. The Department has collaborated with Panchayati Raj Institutions for infrastructure, for Sampoorna Yoga Keralam- National AYUSH Mission-Kerala, Department of Indian Systems of Medicine-Kerala, LSGI, School Education Department, Social Welfare Dept., Yoga Professionals (Medical officers of AYUSH Yoga Medical Officers and qualified yoga instructors) etc. are partners.

Financial Implications

During 2017-18, funds of around Rs. 20 lakhs for each institution was provided from state government with NHM being the implementation agency. During 2018-19, NHM funds of Rs. 20 lakhs for selected 300 institutions were received. Further, during the same year, Government of Kerala provided Rs. 20 lakhs each for another 200 institutions. During the current year, the funds for remaining health institutions are augmented through NHM. For Sampoorna Yoga Keralam, budget of Rs. 32.40 lakhs is envisaged which will be met from NAM funds as well as NHM – H&WC funds.

Contact Details

State Nodal Officer, Aardram- 9447124413

State Nodal Officer (HWC)- 9946105471

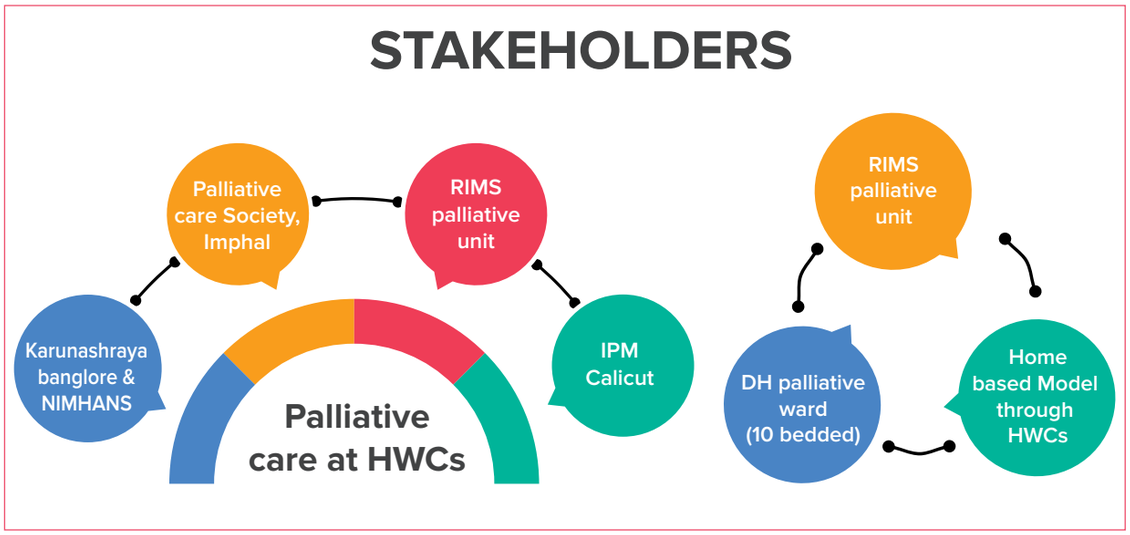
HOME BASED PALLIATIVE CARE
Through Multi-Stakeholder Participation

Problem Statement

Palliative care is required for patients in terminal stages of cancer, neurological and cardio-respiratory diseases. According to India, Health of Nations, State report 2017, in Manipur, the leading causes of mortality are cardiovascular diseases (28.7%) and cancer (12%) and therefore there is high unmet need for palliative care services in the state.

Programme Description

National Programme for Palliative Care was approved for Manipur in 2017-18. In addition, about 58 HWCs are currently operational in the state. In order to introduce palliative care at the primary healthcare level, a multi-stakeholder collaboration and cooperation approach was adopted in the state. In November 2018, a consultative meeting was held between State Palliative Cell (of NHM), Radiotherapy department of Regional Institute of Medical Sciences (RIMS) Imphal, Institute of Palliative Medicine, Calicut and Karunashraya Bangalore. Training of state trainers on palliative care was done at Karunashraya Bangalore (Hospice and Home care) and NIMHANS (Hospital Based Care). Subsequently Foundation Course in Palliative Medicine, Nursing and Care was conducted for MOs (90), Nurses (83), CHO (30), ASHA (243) and NCD (43) staffs between Jan - Feb 2019.



In the second year, palliative services were started in seven District Hospitals by launch of Palliative OPD and wards. In 2019-20, the state introduced home-based service model for palliative care services at 27 Health and Wellness Centres. The Palliative Care Society, Imphal (PCSI) supported organization of awareness camps, mobilization activities and training of service providers (MPW-Female/ANM and ASHAs) in palliative care.

As part of the home-based initiative, ASHAs play a key role in identification and mobilization of families who require palliative care to CHOs. After assessment by CHOs, the patient is referred to Medical Officer for medical examination. Medical Officer sees the patient by conducting home visit (at least once in three months).

Follow up is done by CHO along with ANM and ASHA through weekly home visits. The details of symptoms, pain assessment and other nursing care are recorded and reported. Necessary medicines are provided under free drugs & diagnostics initiative Necessary drugs under Free drug initiative and diagnosis are given. Those patients requiring morphine tablet or Fentanyl patches are examined by the oncologist/ trained physician in District Hospital and are delivered by CHO. There is also linkage with the palliative OPD opened at Department of Radiotherapy, RIMS and those patients attending RIMS are also informed to the concerned CHO of the village where the patient come from linkage has been created with the palliative OPD at Dept of Radiotherapy, RIMS i.e., information about patients attending RIMS is shared with the concerned CHO.

Programme Outcomes

At present, 58 HWCs are providing palliative care services in 9 districts to 188 patients.

Scalability

As this initiative relies on multisecroral partnerships and capacity building of existing resources, it can be scaled up with gradual operationalization of Health and Wellness Centres. The scale would require, skill building Primary health care team and strengthening continuum of care from village level starting with identification to assessment and follow - up of patients.

Implementation Partners

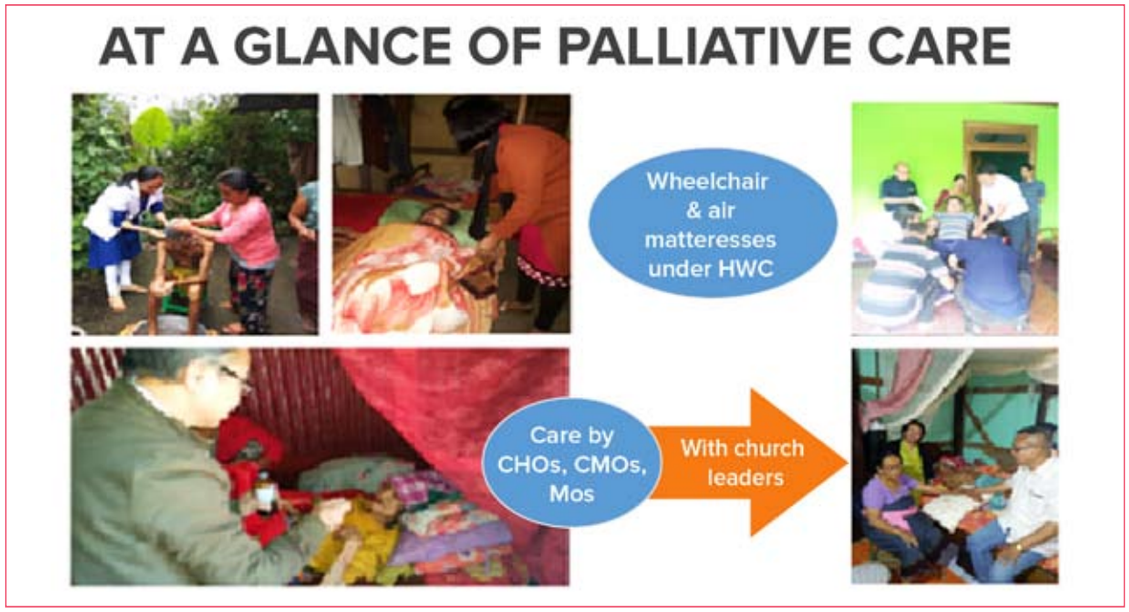
NHM (Manipur), (RIMS, Imphal), Institute of Palliative Medicine (IPC, Calicut) and Karunashraya (Bangalore), NIMHANS and WHO.

Financial Implications

Workshops/TOT on palliative care and Training of human resources- (Rs. 17.11 lakhs), expenditure on drugs and consumables (Rs. 10.50 lakhs) and IEC and other logistics (Rs. 28.80 lakhs).

Contact Details

Email: smd.manipur@gmail.com



CERVICAL CANCER SCREENING:
Double Benefit

Problem Statement

The report on cancer burden in North Eastern states of India by NCDIR (Under ICMR) 2017 highlights that the common causes of cancer among women in Manipur are Breast, Lung and Cervix, with cervical cancer constituting about 9.2% of the total cases.

Programme Description

The Health and Wellness Centres are expected to provide expanded range of services at HWCs which include services related to Non-Communicable diseases, Mental health, ENT, Opthalmology, Oral health, Geriatric and palliative health care etc, in addition to the existing services (RCH and communicable diseases). As part of this effort, universal screening of common NCDs and cancers (Hypertension, Diabetes, Oral cancer, Breast cancer and Cervical cancer) has also been rolled out as the first step.

As per guidelines, screening of all individuals over 30 years of age for Diabetes, Hypertension, Oral and Breast Cancer are undertaken at SHC level while screening for Cancer cervix through Visual Inspection of Acetic Acid has been

planned at PHCs. In order to improve the coverage of cervical cancer screening and provide skill-based training to Community Health officers in VIA, the training was conducted at identified SHC- HWCs of Thoubal and Imphal West District by trained Gynecologists or trained Medical Officer. Training of CHOs at HWC-SHC level and MOs at HWC-PHC level was conducted once in three to four months.Women were mobilized to the HWCs for screening on a fixed day where the trainers conducted VIA screening and provided hands ontraining to CHOs of the SHC- HWCs. In addition, MOs of the linked PHC were also trained during this sessionto provide mentoring support to CHOs for VIA screening.

Programme Outcomes

The initiative contributed in building skills of CHOsand strengthening screening of cervical cancer at SHC- HWC level. Subsequent to the training at HWCs of five Imphal West and eight Thoubal, the CHOs have started conducting VIA screening on fortnight basis. The VIA positive patients are referred to District hospital NCD clinic for further management.

Total Trained in Month of April & May, 2018	64 + 33
Total VIA done during Training at 9 HWCs	181
Total VIA done by CHOs at 9 HWCs after Training so far	1654

Scalability

Since the hands-on training of CHOs and screening on cervical cancer at SHC-HWCs through CHOs relies on use of existing trained manpower, it is scalable in other districts. However, it would require active collaboration from different sections of the Health Department.

Implementation Partners

NHM (Manipur)

Financial Implications

This financial implication of this Programme in the state and districts was for conducting awareness Programme at the HWC level and Training of HR for VIA at HWC costing Rs. 20,000/- per session of 10-15 health staffs.

Contact Details

SNO-NCD and HWCs

Email: smd.manipur@gmail.com

Phone: +91-9856738691

MARCHING AHEAD IN ACHIEVING UNIVERSAL HEALTH COVERAGE: A Milestone under Sustainable Development Goals (SDGs)

Problem Statement

Odisha faced several challenges such as high out of pocket expenditure despite high utilization of public sector, inadequate public healthcare infrastructure, HR shortage, limited use of advance medical technology, lack of assured medicines and diagnostic services and lack of continuum of care across levels of care

Programme Description

During last one decade, Odisha has introduced several reforms for strengthening delivery of health services through outcome- based, participatory planning process and additional resource allocation from State budget.

Based on the guiding principles- “Sustha Odisha, Sukhi Odisha” and “Healthcare for All – Each Life matters”, over 40 free and assured health care schemes were introduced under National Health Mission and with steady increase of health financing under State Budget. The share of health budget as % of GSDP has been increased from 0.89% in 2005-06 to 1.48% in 2018-19.

Some of the key initiatives at state level include -mobile health units under KBK; Sishu Abong Matru Mrutyuhara Purna Nirakarana Abhijana (SAMMPurNA), Free Cancer Care Programme - Day Care Chemotherapy Center at DH, Corpus Fund for Human Resource in KBK+ areas; Incentive for HR in difficult areas, reimbursement of transportation cost @ Rs. 1000/- to all pregnant women for institutional delivery in notified villages; Durgama Anchalare Malaria Nirakaran- DAMaN; ASHA Kalyan Yojana; establishment of new Medical and Nursing Colleges; Universal Eye Healthcare Programme ; Cash incentives @ Rs. 500/- per month to all Blood Disorder for continuing treatment; Free Specialists Services at Urban PHCs/CHCs under Ama Clinic; Strengthening Ancillary Services in Public Facilities; Drop back assistance of Rs. 500/- to pregnant women and sick infants; Digital Dispensaries through telemedicine in difficult areas; Free Blood Services to all at Government Blood Banks; and Free Healthcare Services

for all at all public health facilities up to Medical under the Biju Swasthya Kalyan Yojana (BSKY) with cashless assistance of Rs. 5 Lakhs per family per year and additional Rs. 10 lakhs for the women members of the beneficiaries' families

Programme Outcomes

There is a marked trend of improved utilization of health care services. For instance:

- Over 3.3 Crores patients received free medicines since 2015.
- Annually over 1.50 crores patients received **Free Diagnostic** Services
- Over 60,000 dialysis sessions conducted since 1st January 2018
- Over 2,95, 587 free surgeries conducted since 15th August 2018.
- Over 62,000 patients received free cancer consultation services and 22715 patients received chemotherapy and 5659 patients received radiotherapy sessions conducted since Aug, 2018
- Primary health care services provided in 6251 difficult areas through 177 Mobile Health Units
- Annually over 10 lakhs pregnant women and sick newborn benefitted under SAMMpurNA
- Increased MBBS seats from 450 to 1150 through 4 new Medical Colleges,
- Creation of 2508 posts of doctors, 400 posts of Dental surgeons and 5719 posts of paramedics.
- Around 70 lakhs families (3.5 crores people) covered under BSKY.

Financial Implication

Annually more than Rs.1712.76 Crores are being spent under State Budget schemes excluding NHM budget.

Implementation Partners

NHM and Health and Family Welfare Department All line departments, Development Partners, Private Providers and premier health institutes outside the State with financial support of NHM,

Scalability

Sustained and multi-pronged strategies adopted over the years backed with steady increase in investments in health care has created a strong foundation in the state to achieve Universal health coverage. Implementation of these strategies can provide evidence and guidance for other states to develop plans for achieving UHC.

Contact Details

State Programme Manager
Email: spmnhmodisha@gmail.com

ELKOMETER

NON-COMMUNICABLE DISEASES

THE KERALA COPD PREVENTION AND CONTROL PROGRAM: "SWAAS" (Step Wise Approach to Airway Diseases)

Problem Statement

COPD is one of the leading causes of mortality and morbidity worldwide. As per the Global Burden of Diseases estimates for India, COPD is the second leading cause of mortality in India..Assuming that the National estimates for Asthma and COPD reflect the situation in Kerala too, the numbers of COPD and Asthma among adult cases in Kerala are estimated to be 530,000 and 480,000 respectively.

Programme Description

The objectives of the Kerala COPD prevention and control program:

1. Identification of COPD in the early stages
2. Develop a structured Programme for COPD diagnosis and treatment, from primary care level leading up to the tertiary care level
3. Develop a system for generating information on disease burden of COPD
4. An indigenously developed pulmonary rehabilitation Programme incorporating department of AYUSH

Components of SWAAS programme

- Screening & Diagnosis using Spirometry
- Staging of Disease
- Guideline based Treatment for Asthma and COPD
- Provision of Inhaler medications
- Pulmonary Rehabilitation Programme
  - Smoking cessation clinics
  - Exercise clinics
  - Depression Screening
  - Dietary Advices
- Referral & Follow up Services
- Drugs & Equipments
- The equipments including Spirometers, oxygen concentrators and drugs including inhaler medications will be procured through Non-Communicable Disease control Program.

Programme Outcomes

SWAAS clinics started in 159 Hospitals

(120 FHCs + 39 Sub Districts /District Hospitals)

Financial Implications

The expenses incurred for intravenous bronchodilators, corticosteroids, antibiotics other consumables will be reduced. Since existing human resources are trained and utilized additional HR is not required for running the programme.

ACHIEVEMENTS OF SWAAS CLINICS TILL June 2019	
Number of patients undergone symptomatic screening (Attended SWAAS clinic)	47,601
Number of patients screened with Spirometry	15,881
Number of COPD diagnosed	10,726
Number of Asthma diagnosed	7081
Number of patients received smoking cessation services	5821
Number of patients who Quit smoking	674
Number of patients received pulmonary rehabilitation services	3247
Number of alternate diagnosis made (TB/Cancer ,ILD , Bronchiectasis, Cardiac Diseases etc)	545

Scalability

The risk reduction strategies and the community level interventions in air pollution control, work place interventions, biomass fuel exposure reduction, good burning habits etc will definitely help in overall disease burden in future

Contact Details

Email: drmsmanu@yahoo.co.in,
statencddivision@gmail.com
Phone: +91-9846478793

State Nodal Officer NCD
Phone: +91-9447001934

IHCI (INDIA HYPERTENSION CONTROL INITIATIVE)

Door to Door Screening as a Mechanism to Expand Registeration

Problem Statement

Despite progress of the IHCI towards 20% of estimated hypertension (HTN) burden, new registrations have seen a steady decline over past 2-3 months. The PBS HTN yield is 20-25% of the estimated HTN burden.

Programme Description

Objective- To accelerate enrollment of rural and urban population for Hypertension treatment through door to door screening of individuals in Wardha and Bhandara Districts of Maharashtra.

A pilot was conducted in Wardha district in March 2019 for catchment area of two identified Sub Centres, which covered a population of approximately 10,000 across six villages. A total of 4,100 individuals of age group of 30 years and above were screened for Hypertension and Diabetes by Multi-Purpose Workers (Female) and ASHAs. In a time span of twenty days, 970 individuals suspected for Hypertension and Diabetes were line listed by six teams, and mobilized for confirmatory diagnosis which was planned in a camp approach. At the village level, five camps were organized where identified individuals were screened for confirmatory diagnosis and treatment was initiated for diagnosed NCD cases. Approximately 750 suspected individuals were reported to attend these NCD camps, and within two identified Sub Centres, 430 Hypertension and 120 Diabetes cases were enrolled in IHMI in April and May 2019.

Based on the findings from the pilot, a strategy for scaling up the initiative at the division level was planned to ensure universal screening for individuals of age group 30 years and above in the division by March 2020. The screening will be initially undertaken in rural areas followed by the urban areas. A target based on the prevalence has been already specified and accordingly demand of medicines has been calculated and entered into e-Aushadhi portal.

Trainings for service providers in the Wardha and Bhandara district has been completed, and 49 CHOs from Bhandara and 54 CHOs from Wardha have been trained so far in IHMI and Diabetes protocols and Simple Application.

One hundred additional facilities have been created to initiate, monitor and escalate treatment as per IHMI and Diabetes protocols. Door to door screening has been initiated in the both districts and will be further escalated upon completion of re-orientation of Medical Officers on IHMI.

Programme Outcomes

Approximately 750 suspected individuals underwent screening for confirmatory diagnosis and 430 Hypertension and 120 Diabetes cases were diagnosed and enrolled in IHMI in April and May 2019. A detailed report for all screened individuals was prepared, where 78 patients were identified to receive lifestyle modification. Forty-eight patients refused to undergo treatment and were not registered under IHMI.

In addition, 35% prevalence of Retinal Haemorrhage (n=35) and 17% elevated Creatinine levels (n=560) was recorded in these camps. All the remaining Hypertension cases recorded based on prevalence estimates are to be enrolled by December 2019. (need more data on treatment adherence)

Scalability

Undertaking door to door or population-based screening has enabled higher case detection, including complicated cases.This intervention builds on an existing programme and uses existing staff to undertake an intensive effort to improve case detection, making it a potentially scalable model.

Implementation Partners

Government of Maharashtra in collaboration with the IHMI/ICMR

Contact Details

Email: shsrc.gom@gmail.com

Phone: +91-9822171517

OLYMPUS
CX31

COMMUNICABLE DISEASES

NATIONAL VIRAL HEPATITIS CONTROL PROGRAM

Problem Statement

Eliminating Hepatitis-C from the state of Haryana through:

- Identifying the hot spots.
- Generating awareness among people.
- Conducting screening in hot spots.
- Ensuring linkage of positive identified patients with the health services.
- Ensuring availability of Drugs and testing facilities.
- By ensuring follow up with the patients.

Programme Description

Respected Sir/Ma'am

May I draw your kind attention to the problem stated above, The NVHCP Programme was imbibed by the State of Haryana in July 2018, prior to that Hepatitis control Programme named **Jeevan Rekha** existed in the state since 2013. Haryana is the pioneer state to provide free Hepatitis-C diagnosis and treatment to all Haryana domicile patients.

Programme Strategy

- Identifying the Hot spots:
  - Previous research done by the state in 2012 highlighted high disease prevalence in Ratia district of Fatehabad.
  - Data of patients collected from all the dictricts showed Fatehabad, kaithal, Jind, Panipat, Sonipat, Karnal, Sirsa and Hisar districts contributing most of patients.
- Generating awareness among people:
  - Special awareness drives were run in hot spots to educate the people about causes of spread of Hepatitis.
  - Special focus was given in the awareness of Saloon professionals/ Barbers.
  - Posters/pamphlets were distributed.
- Conducting screening in Hot Spots:
  - Screening drives were conducted in the hot spots.
  - Over 90000 person screened.
  - Prevalence study is made on the basis of data.
- Ensuring linkage of positive identified patients with the health services:
  - Counseling was provided to all positive identified persons and their apprehensions and doubts were cleared.

- Data as per specified format recorded.
- Data confidentiality was also ensured.

- Ensuring availability of Drugs and testing facilities:
  - Empanelment of lab services through decentralized model adopted for handling large patient inflow for diagnostics.
  - Online drugs portal helped the State in keeping in check the drugs inventory.
- To ensure follow up with the patients:
  - Tele-callers facility were established at the State Headquarter.
  - Follow up with the patients throughout the treatment was ensured.

Programme Outcome

- The screening drives outcomes in screening near about 4,000 positive patients out of approx. 90,000 persons.
- It helped the State in Progressing towards goal of eliminating Hepatitis-C from the State.

Scalability

- Model is highly flexible to be scaled in ICTC centres, De-addiction centres, Prisons and also among high risk population at the level of entire State/ country.
- It is subjected to manpower & financial constraints.
- The state of Haryana already scaled this model to all the prisons in the State.
- All 19 prisons given status of treatment centres and testing as well as treatment of all positive identified prisoners being done in Prison itself.

Implementation Partner

Screening drives were conducted in collaboration with Shri Gopal Jimaharaj Sansthan (NGO).

Financial Implications

Whole screening Programme as well as HR services was funded by Shri *Gopal Jimaharaj Sansthan* (NGO).

Contact Details

Email: nvhcpharyana@gmail.com

Phone: +91-9467059923

MUKHYA MANTRI KSHAY NIVARAN YOJANA: State's Initiative to End TB

Problem Statement

Tuberculosis is number one infectious killer disease globally and also in India. Hon'ble Chief Minister Himachal Pradesh launched Mukhya Mantri Kshay Rog Nivaran Yojna (MMKRNY) on 24th March 2018 with an aim to meet the targets of ending Tuberculosis ahead of timelines set by Government of India. To accerlate the process of ending TB, there was an additional budgetary requirement over and above RNTCP.

Programme description

MMKRNY focusses on preventive, investigative and curative measures. TB elimination committees notified at state and district level. Panchayati Raj Department and Ayurveda Department were formally engaged. Sensitization programs conducted for PRI members, forum for TB free Gram Panchayats constituted; intensive active TB case finding campaign conducted. Orientation training programs conducted for MOs and pharmacists in Department of Ayurveda. Diagnostic services expanded; five CBNAAT machines procured. CMEs for private practitioners and chemists organised. TB Mukt Himachal APP developed.

Programme Outcomes

Total 5527 PRIs from 3301 gram panchayats across the State were sensitized under MMKRNY. This scheme generated mass awareness among different stakeholders to go TB free. Near 500 new TB cases detected in the 1st round of TB Mukt Himachal Abhiyan and put on treatment. State registered highest Annualized TB case notification rate in India in 2018. Total 396 Private practitioners and 930 chemists has been sensitized. 61% increase in TB case notification from private sector reported in 2018. Total 692 Ayurveda Medical Officers and 1027 Ayurveda Pharmacists has been trained under the scheme. Contribution of Ayurveda department in case finding and patient management is increasing. Expanded CBNAAT facilities resulted 72% Universal DST.

Scalability

This scheme can be scaled up in all states as a State's initiative

Implementation partners

Nil

Financial implications

Rs. 2 Crore/annum

Contact Details

Dy. MD (NHM-HP) Shimla (HP)
Email: ddnrhmhp@gmail.com

Phone: +91-9418013888

A QUEST TO ELIMINATE LYMPHATIC FILARIASIS:

Through Introduction of Triple Drug Therapy

Programme Statement

Lymphatic Filariasis (LF) a mosquito borne infectious disease is a public health problem in India and second largest cause of disability worldwide. There are 256 districts which are endemic for LF in 16 States and 5 UTs in India. For elimination of Lymphatic Filariasis, the national programme was launched in 2004 and it is based on twin-pillar strategies of Annual Mass Drug Administration (MDA) and Morbidity Management & Disability Prevention (MMDP). Since 2007, Annual Mass Drug Administration has been conducted using 2(two) drugs i.e. Albendazole and DEC.

IEC at Village level

Programme Description

To accelerate the elimination, GoI introduced Triple Drug Therapy wherein two existing MDA drugs were supplemented by a new drug 'Ivermectin'. Triple Drug Therapy has an advantage of reducing microfilaria rate <1% in 2-3 rounds against 5-6 rounds required with two drugs.

In this regard, Simdega District of Jharkhand has been a pioneer in effectively carrying out the drug administration campaign. With 90.78% compliance rate, Simdega has emerged as a role model for remaining states and districts to learn. The district under the leadership of the Deputy Commissioner (DC) took it as a challenge to do everything possible to successfully execute IDA in the district. During the MDA, apart from the health department other departments i.e. education, rural livelihood, Women & Child Development, PRI Members, Local leaders, religious leaders etc. were involved in planning & implementation.

An innovation campaign **"Bhag Filaria Bhag"** was launched in the district for ELF. Three days awareness campaign was launched in all schools of the district. This infused a lot of interest among students and substantially built their understanding and awareness about the disease. Local media, newspapers, TV channels etc. were engaged to spread awareness about the programme. Multiple filarial booths were set up in the local schools and Anganwadi Centers to cover the big population in a hassle-free manner. Anganwadi Workers and Sahiyas (ASHAs – Accredited Social Health Activists) were identified and trained as drug administrators well in advance. Attendance of community people at the booths for consumption of drug was notable. Finger marking for the beneficiaries was introduced first time in the programme. For left out population, house to house visit plan was mapped. A micro plan was developed along with tracking registers around that to cover all the houses in the district.

Programme Outcome

With the innovative approach, under able leadership of district administration and with the support from development partners, Simdega district become an exemplar district with 90.78% reported coverage and 83.7% compliance (as per assessment conducted by ICMR-VCRC).

Contact Details

Email: smo.smcs2@gmail.com

Supervised triple drug therapy

STEPS:
A Novel Step for Engaging Private Sector to end TB

Problem Statement

Approximately half of the TB patients in India seek care from private sector. Concerted efforts by the National TB Programme are going on to get all these cases notified. In addition, leaks in TB care cascade were identified in the country.

Programme Description

System for TB Elimination in Private Sector (STEPS) in Kerala is envisioned as collective efforts by public and private sector for the benefit of the society. It has three major interventions:

- System for TB Elimination in Private Sector (STEPS) Centres is a single-window in a private health facility serving as a nodal centre to systematically track every TB patient diagnosed by in-house clinical departments, units and clinicians, notify them to RNTCP, follow them up during the entire treatment and report treatment outcomes to RNTCP from the facility itself in the most patient centric way so that each patient receives highest standards of TB care from the health facility of his/her choice. STEPS centres were established in 318 private hospitals.
- To support STEPS, consortium of private hospitals is being formed with state and all districts.
- To sensitize and support specialist practitioners for TB notification, a coalition of professional medical associations is being organised at state and all districts.

Programme Outcomes

Health facilities that established STEPS have reported 100% notification verified through their MRD and pharmacy data. The overall notification from private hospitals [Enrolled/diagnosed] improved from 3829 in [Jan- Sep 2018] to 5040 [Jan-Sep 2019]- a 31% increase in notification from private sector. STEPS also led to an evident compartment shift from private anti TB regimen to RNTCP regimen leading to 2000 additional cases put on RNTCP regimen, which is 70% of all notified cases from private sector. This also led to improvement is microbiological confirmation of cases [From 32% to 41%], Universal DST [from 16% to 41%], providing Direct Benefit Transfer to patients reaching private sector [from 51% to 67%] and HIV screening status [from 42% to 71%] among patients reaching private sector.

Scalability

It is based on social responsibility of the private sector blended well with profitable customer care services and self-realisation of Government about its actual role to serve entire citizens. It is a win-win-win scenario for Public, Private and Society, so itself easily replicable.

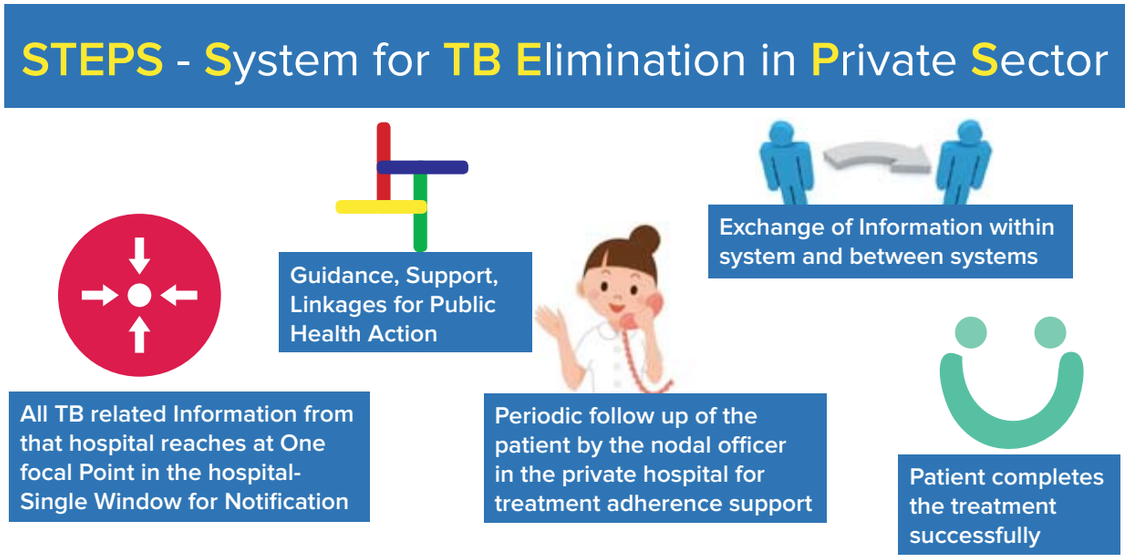
Implementation Partners

Indian Medical Association, Project JEET, Private hospital Consortiums & Coalition of Professional Medical Associations for TB Free Kerala.

Financial Implications

It is a zero-cost model. No additional financial implications to the program.

Figure 1: Thematic representation of a STEPS centre within a private hospital



Contact Details

State TB Officer, Kerala

Email: stoke@rntcp.org

Figure 2: All private hospitals adopted STEPS in Wayanad district with IMA State President and State Coalition leaders

REDUCTION IN MALARIA BURDEN UNDER INTENSIFIED MALARIA ELIMINATION PROJECT: 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, Chhattisgarh 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.

Global Fund to fight AIDS, Tuberculosis & Malaria (GFATM) is supporting for malaria control and elimination in India since 2005. Under Global Fund (GF) support, the malaria elimination in the supported states has accelerated towards the desired goal. Currently, Intensified Malaria Elimination Project (January 2018 – March 2021) is implemented in 7 NE states (Arunachal Pradesh, Assam, Meghalaya, Mizoram, Manipur, Nagaland & Tripura) and Madhya Pradesh.

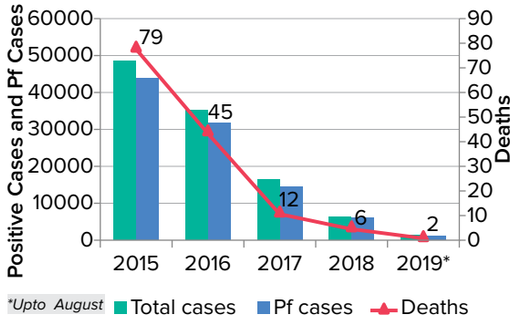
Problem Description

The main strategies of the Global Fund support are Early Diagnosis &Complete Treatment (EDCT); Integrated Vector management including promotion of LLINs; intensive IEC; and capacity building & training of the health workers & community volunteers; mobility support, surveillance, human resource support.

Programme Outcome

In 2015, Meghalaya is one of the high burden states which contributes 4.16% of total cases, 5.16% of Pf cases and 20.58% of deaths to the country. The state had achieved a tremendous reduction in malaria cases, Pf cases and deaths as shown in Fig 1. There has been 87% reduction in total cases, 86% reduction in Pf cases and 92% reduction in deaths in 2018 in comparison to 2015. There has been 73% reduction in cases, 75% reduction in Pf cases and 100% reduction in deaths as in August, 2019 compared to the previous year.

Figure 1: EPIDEMIOLOGICAL SITUATION OF MEGHALAYA 2015-2019



In Meghalaya, the major contributing districts are East Garo hills, West Garo hills and South Garo Hills. In these three districts as a whole, there has been 86% reduction in cases, 86% reduction in Pf cases and 93% reduction in deaths in 2018 from 2015. In aforementioned districts, till August, 2019 in comparison to 2018, there is overall 75% reduction in cases, 76% reduction in Pf cases and 33% reduction in deaths. Some pragmatic steps taken were : a targeted technical approach using a package of effective tools, data-driven decision-making, involvement of communities, decentralized implementation and control of finances, skilled technical and managerial capacity at sub national levels, hands-on technical and programmatic support from partner agencies, and sufficient and flexible financing. All these factors were essential in achieving success along with acceptance of LLINs by community.

Contact Details

Email: meghspovbd@yahoo.in

Vehicles provided for Monitoring and Supervision

Capacity building of ASHAs on Malaria

LLINs usage by Community members

DIRECTED INITIATIVES FOR SUSTAINABLE HEALTH ACTION-(DISHA-TB)

A Community Based Approach for TB Elimination and other Interventions

Background (Problem Statement)

National TB Control Programme (NTCP) is being implemented since 1962. However, the treatment success rate is low and death & default rate remains high. Spread of MDR TB is threatening to further worsen the situation. India contributes 27% of the global burden of TB cases.

RNTCP (Programme Description)

Multi sectoral strategy is being adopted in Telangana to fulfill the commitment of eliminating TB by 2025. The key to strategy is immediate diagnosis and aggressive follow up of the treatment and awareness about the disease.

The community based approach followed in Telangana State is using the services of TB cured patients called “TB Champions” as Community Resource Person (CRP), to sensitize their community on TB. These TB champions were trained using a community training module.

The target oriented monitoring and evaluation was taken up regularly on the following:

1. Regular and aggressive review from state to sub center, with clear cut targets and achievements.
2. Ensuring prompt diagnosis of suspected cases and UDST coverage.
3. All PHCs started functioning as DMCs.
4. Refresher training for staff as per their job chart.
5. Policy of carrot and stick was adopted.
6. All school children were addressed on identifying symptoms of TB.

Phase-I plan under community based management is as under

Districts covered	No of participants attended training	No of training days	No of teams allocated per district	Number of villages assigned per team	Number of villages target to cover	No of villages covered
10	250	50	5	20	1000	410

Overview of State Level Training - Community Based Approach

In the phase 1 of community based approach	Each core team comprises of 5 members	Target
▪ 50 teams were identified across 10 districts ▪ Trained at the State level in a standardized phased manner ▪ A total of 4000 Training Man Hours was used to train the teams	▪ 2 - TB champions (cured TB patients) from local community ▪ 2 - ASHA and ▪ 1 Health Supervisor	▪ A total of 1000 villages to be covered ▪ 50 teams (@20 villages/team/ district)

Timetable of 5 days state level training for CRP team members

Day 1	Day 2	Day 3	Day 4	Day 5
▪ Brief on RNTCP ▪ What is a Community? ▪ Understanding common disease ▪ TB, causes, symptoms ▪ High risk groups for TB	▪ Diagnosis of TB, Sputum collection ▪ Duration of TB treatment & adverse effects	▪ Nutrition requirement for TB patients ▪ Success stories by TB Champions ▪ Role Play ▪ Group work	▪ Incentives to TB patients (DBT) ▪ Patient support under other schemes ▪ Field visit (in community)	▪ Community Support ▪ Role & responsibilities for each team members ▪ Action plan for village visit

Agenda for Field Teams during village wise visit

3 Days wise work plan in the Field		
Day 1	**Day 2**	**Day 3**
▪ Village Survey by the team ▪ Introduction of Training Team to the villagers ▪ School visit and sensitization of the school children and teachers ▪ Visit to old age group, Orphanage or any high risk setting in the village if any. ▪ Discussion on the line list of TB patients in the respective villages, defaulters, deaths, success case studies ▪ Gram Sabha Meeting ▪ DISHA-TB activity ▪ Singing, Skit ▪ Success stories	▪ Gathering at community center/ Anganwadi Center ▪ Discussion with the patients and family members and their sensitization ▪ Sensitization of different Leaders in the village and planning for awareness activities with IEC. ▪ TB Clubs meeting in the presence of all Community leaders, staff and TB champions. ▪ Discussion on activities to be conducted in the village. ▪ Field visit by ASHAS/ANMS along with Supervision to collect samples from presumptive cases ▪ Screening of all symptomatic in the nearest DMC.	▪ Documentation of activities conducted in last 2 days ▪ Home visit done by the team members to the patients on treatment, defaulted for counselling ▪ Recording and Reporting completion ▪ Group work and Action Plan for Way Forward

Scalability

- Phase-I (Short Term)-10 districts
- Phase-II (Mid-Term)-10 districts
- Phase-III (Long Term)- PAN Telangana

Financial Implications

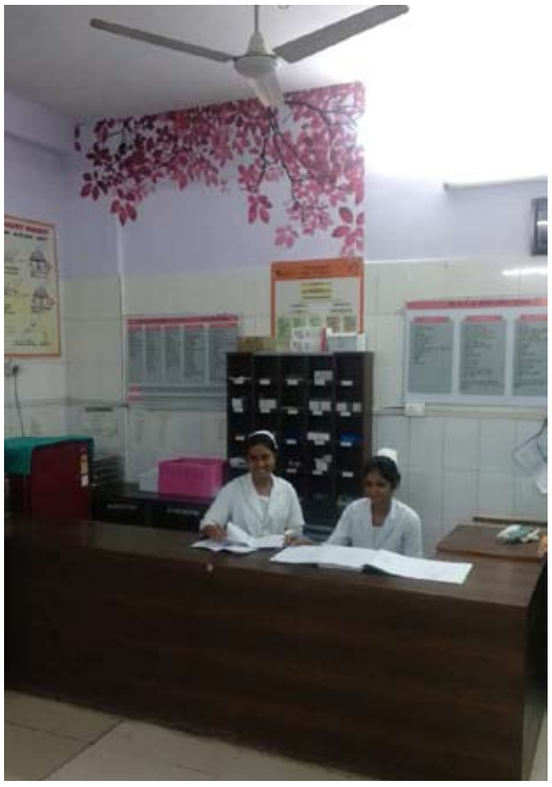
- Incentive and Honorarium = 200 teams * 5 members* 25 days* 300rs/Day = 75 lakhs* 4 months = 3crore.
- Training = 15 days at district level (200 teams*5 members *15 days @Rs500/ day = 75 lakhs

Contact Details

CHFW/MD-NHM
Phone: +91-9491033000

HEALTH SYSTEMS STRENGTHENING

PERSON CENTRED CARE THROUGH SHARED LEADERSHIP



Problem Statement

Banka district hospital is the CEmONC centre for a population of more than 2 million across a geographic area of 3020 sq. km. Among many challenges, there was low rate of 1.02% C-sections, which was not assuredly available (most cases were referred to higher facilities at night despite 3 pairs of surgeons and anaesthetists). The office orders clearly was not helping the local team take up the responsibility.

Programme Description

The hospital leadership and frontline workers participated in Continuous Quality Improvement (CQI) Collaborative of Bihar State Health Society since February 2018 which primarily focussed on human psyche and humane aspects of change. The leadership and coaching workshops conducted ensured buy-in of commitment and accountability from civil surgeons, medical superintendents, district Programme managers and hospital managers while orienting them about role of a coach. The frontline staff and leadership was sensitized on system thinking and collaboration. The focus was on building a culture of trust and transparency . Labour room nurses were encouraged by hospital leadership to report complications, LAMA, referrals, near misses without fear so that further corrections and amendments could be made. As a demonstration of doing the deputy superintendent himself started doing C-sections after his EmOC training. Consistent engagement and regular interaction between the entire team has kept things improving. Intrinsic motivation was built in the staff by storytelling of real experiences, felicitation of champions and engaging with all team members over tea on a weekly basis which nurtured informal relationship and strengthened team work. Strengthening existing data systems and transparency regarding results and progress was also emphasized.

Programme Outcome

C-section rate improved from the baseline median of 1% and achieved the monthly target of 5% from January 2019 to May 2019. Patients satisfaction surveys scored an average 84 out of 100 marks in the month of July 19.

It was concluded that high impact leadership behaviours by hospital leadership and staff with support from District Health Society and Civil Surgeon, were important key enablers for improvement in services.

Scalability

Positive results from this Programme indicate a potential of combining appropriate leadership capacity building in science of continuous improvement

Implementation Partners

Care, India and Institute for Healthcare Improvement

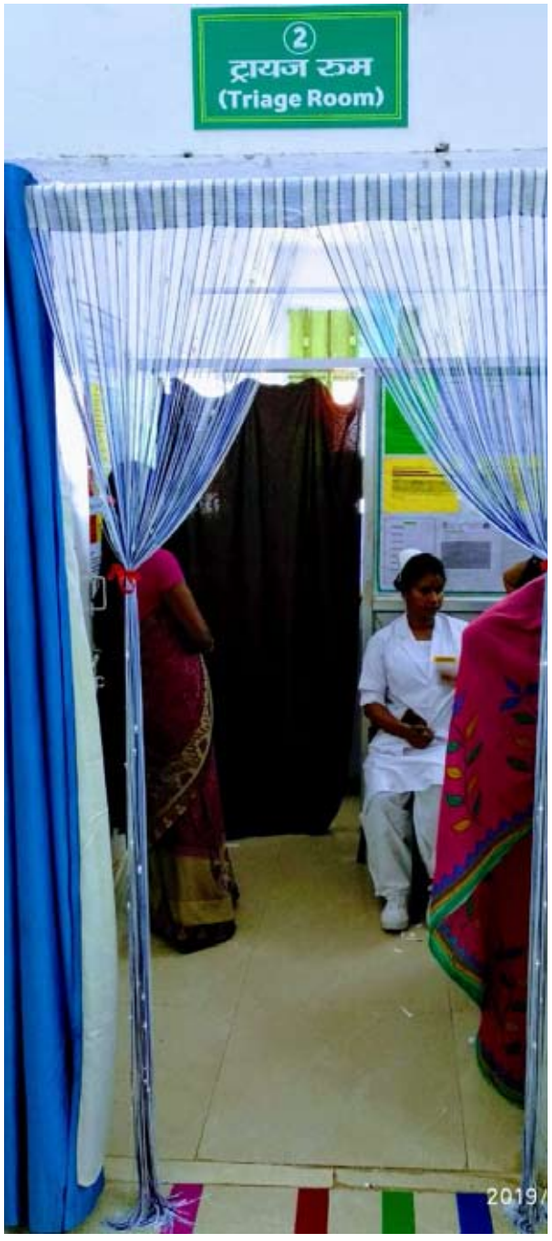
Financial Implications

Within the resources made available to the district by State and NHM

Contact Details

Email: mailtoprabhat@gmail.com

Phone: +91-9473191868



COMMUNITY MONITORING OF HEALTH SERVICES THROUGH SOCIAL AUDIT UNIT

Problem Statement

Despite efforts to strengthen VHSNCs to lead community level monitoring of health services, success has been limited, due to, limitations of VHSNCs capacities to undertake structured processes on a periodic basis.

Programme Description

Social Audit unit (SAU) of Rural Development Department was engaged by stateas independent agency to support in identifying issues and concerns of community, health facilities, and health service providers and help in addressing issues. Process was undertaken in 5 districts (one district in each administrative division- Hazaribagh, Deoghar, West Singhbhum, Ranchi and Palamau) spread across all 5 regions in20 blocks and 80 Gram Panchayats.

151 social auditors from five regions were trained on the communitization processes, who subsequently conducted extensive mobilization and discussions with community and VHSNCs for 3 days, followed by village level exercises of community monitoring and 105 public hearings conducted at Gram Panchayat (80), Block (20) and District (5) levels. Actions were taken to resolve problems such as incentives of ASHAs, medicine supplies and out of pocket expenditures by patients. Structures were formed from Panchayat to state, for addressing issues at each level. To build transparency, state engaged local media to report on these issues. State has ensured commitment and rigor at all levels, active participation by senior officials including ministers, facilitated the process. This intervention was undertaken in FY 2018-19 and Rs. 8 Lakh was spent.

Programme Outcomes

Programme processes improved at various levels: a) payments of ASHA incentives were regularised (delays of 6 to 24 months existed prior to the exercise), b) Services in VHNDs expanded to include tests of hemoglobin and urine and counselling on family planning, c) Rest rooms for ASHAs were established in DH and FRUs, d) Utilization of RKS untied grants improved, e) Availability of Pregnancy test kit and Calcium & Iron tablets for ANMs was ensured.

Participation of PRI members on health programs in their constituencies, synergy between NHM and media, and health department's commitment for availability and quality of services improved.

Scalability

The state has built upon existing institutional mechanisms in the state and has continued the interventions in FY 2018-19. Plans to scale it up in entire state are underway.

Implementation Partners

Social Audit Unit (SAU) of RD Dept. Govt. of Jharkhand & Advisory Group on Community Action (AGCA) Secretariat.

Contact Details

Community Mobilization Cell,
NHM Jharkhand
Email: cmcelljhk@gmail.com

OPTIMUM UTILIZATION OF COUNSELLORS THROUGH Comprehensive Multi-Skilling Program

Problem Statement

Since the beginning of NHM, the positioning of counselors is as per vertical programs' need under various national programs of NHM, thus they are trained in respective specific programs. However as per the recent shift from vertical Programme perspective to health systems approach, it has been proposed to optimize Human resources productivity through multiskilling. In NHM, Maharashtra, several different Programme counselors are appointed at Hospitals such as RKSK, ICTC, Mental Health, Sickle cell, NCD etc. none utilized optimally.

Programme Description

Counseling is an important public health strategy for disease prevention, and compliance to treatment. Maharashtra developed this innovative multi skilling of counselor for their effective utilization. Project is implemented in 32 Health Facilities of 25 Districts of during Jan-2019 to July 2019 with objectives of ensuring optimal utilization of counselors for providing comprehensive counseling services to patients and their relatives at Health facilities to improve overall awareness about various health programs amongst the patients and family members.

Two days ToTs of District level Officers/ HFWTC faculty followed by District level trainings using the training material and flip chart by SHSRC with financials support from UNICEF. Programme was monitored and evaluated.

Programme outcome

2,48,157 patients and 2,10,432 relatives counseled during 19,937 days visit in wards. 13,309 group session and 7,971 field counseling sessions conducted by approximately 1200 Counselors.

Scalability

The Programme has a potential for up scaling to other states in the country.

Implementation Partner

Public Health Department, Maharashtra (SFWB and SHSRC)

Financial Implication

60 lakhs.

Contact Details

Email: shsrc.gom@gmail.com
Phone: +91-9822171517

unicef
समुपदेशकांसाठी चित्रपुस्तिका
माता व बाल आरोग्य
SHSRC
Maharashtra

PREVENTION & CONTROL OF HEMOGLOBINOPATHIES PROGRAM

Problem Statement

In Tamilnadu the estimated prevalence of Sickle cell anaemia is 0-31% and Thalassemia 1-3% The cost of treating a Thalassemic child for one year is estimated to be 2 lakhs. The morbidity is high. The awareness about the disease is less in the affected community and among health care personnel.

Programme Description

The Programme was implemented on November 2017. X and XII standard children in Government & Government aided schools and unmarried school dropouts > 14 years of age in tribal areas are screened for carrier state of Thalassemia and Sickle Cell Anemia in 30 blocks in 13 districts in a phased manner. Complete blood count, NESTROFT and Solubility tests are done at school by the tribal Mobile Medical team. High Performance Liquid Chromatography (HPLC) is done for positive persons at identified Tertiary Institutions to diagnose trait. Cascade screening of family members of positive persons is performed.

Non-directive genetic counseling is offered to the affected family.

Programme Outcomes

During November 2017 to March 2019, 10042 Children were screened, out of which 874 (8.7%) were trait. Out of 874 children, 305 (35%) had sickle cell trait, 553 (63%) had Thalassemia trait, 10 (1.2%) had sickle cell anemia and 6 (0.7%) were mixed. In the cascade screening among 932 contacts, 56.7% had trait.

Scalability

Antenatal screening among mothers and prenatal diagnosis.

Financial implications

Rs. 329 Lakhs utilized so far

Contact Details

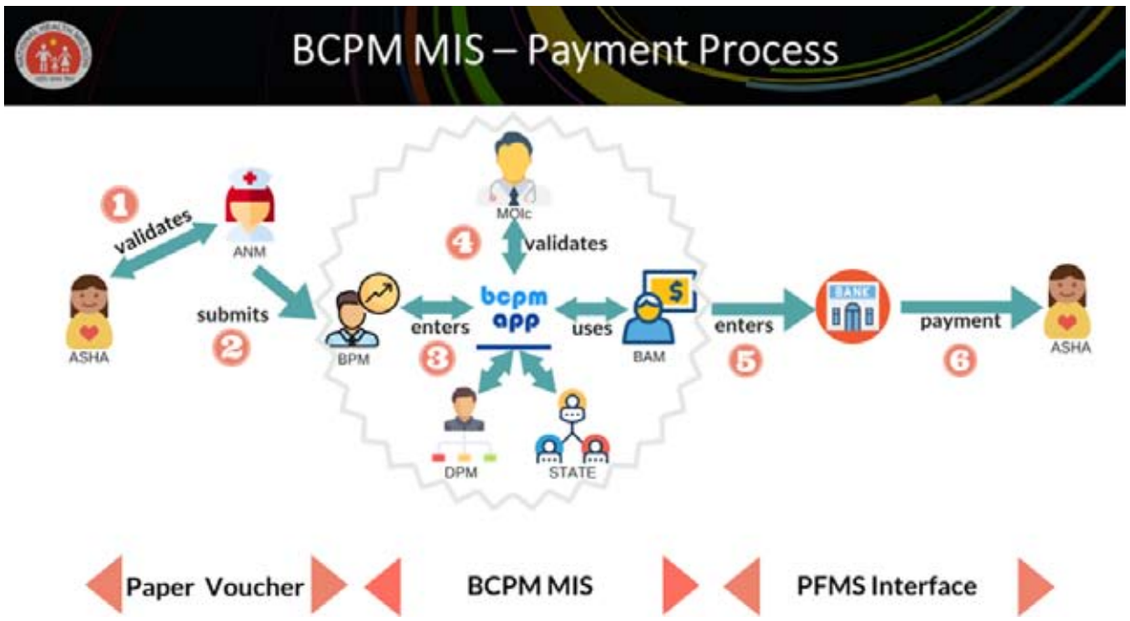
Mission Director,
National Health Mission

Deputy Director,
National Health Mission

DIGITAL ASHA PAYMENT

Problem Statement

ASHAs are honorary volunteers who play a vital role in improving last mile delivery of healthcare services and receive performance linked incentives. Uttar Pradesh has over 1.5 lakh ASHAs and despite improvement in payment process for incentives, delays in ASHA payments continue to be a challenge. In addition, the payment processes are impacted by reliance on paper-based systems for reporting and incentive calculations which affects transparency. Paper based data limits detailed analysis and provision of actionable insights. It also makes it difficult to review FMR-wise ASHA incentive disbursement and utilisation, limiting programs capacity to review and plan for corrective measures.



Programme Description

Aweb-mobile based integrated platform "Block Community Process Managers (BCPM) MIS" was created for standardised mapping of Geographies (District, Blocks, and Villages), Health Facilities (DH, CHC, PHC, SC), and Health Workers (ASHA, ASHA Sangini, ANM, MoIC, BCPM, BAM etc.). The application includes a module to digitize ASHA and Sangini incentive payment process to reduce delays and build transparent payment process. The payment process comprises of following steps:

- ANM approved paper based, monthly vouchers submitted by ASHAs by 20th of the month.
- BCPMs entered and submit the vouchers digitally by 25th of the month.
- MOIC approves the voucher on the portal by 28th of the month and.
- BAM makes payments by 5th of next month using pre-formatted PFMS integrated excel sheets.
- ASHAs receive a SMS with head wise breakup at all stages of payment.

Programme Outcomes

Since the launch in Oct, 2018, 90% of functional ASHAs are paid incentives by 5th of the followingmonth. Granular data access has helped improve functionality of ASHAs by 67%. Overall average monthly incentive per ASHA has increased by 35%. Programme dashboard, called Analytica has enabled strategic use of data for physical and financial review and monitoring at state, division, district, and block level, greatly strengthening the programme.

Scalability

The application is currently used across all 820 Blocks and is being planned for scale up for payment of urban ASHAs. The modular design of the application allows for changes as per GoI and GoUP formats.

The mapping used in the application is compatible with RCH and NCD applications.

Implementation Partners

National Health Mission, supported by UP TSU and Tattva Foundation.

Financial Implications

- NHM Contribution: BCPM Tablets, Internet, and Training costs.
- Partner Contribution: Software Development and Hosting, Helpline Support, Trainings.

Contact Details

NHM, Uttar Pradesh

Email: gmcpspmu@gmail.com

Phone: +91-9450113467

BUDDY-BUDDY MODEL OF EMOC-LSAS

Problem Statement

Though MMR and IMR in Uttar Pradesh has declined over the years, state still accounts for second highest MMR and thirst highest IMR in the country. Majority of these deaths could be averted by ensuring comprehensive obstetric care services through FRUs. However, out of 305 designated FRUs in UP, only 98 are functional. Also 64% of Specialists posts are vacant. As per NFHS data, the proportion of C-section reported in public facilities has declined from 11.1% to 4.7% in past 10 years.

Programme Description

The state is focusing on operationalization of 291 FRU[1] by 2020. To initiate, a detailed gap assessment was conducted to identify non-functional FRUs (without a pair of Anaesthetist & Gynaecologist or those not performing adequate[2] C-sections). A "Buddy-Buddy Counselling Session" was conducted wherein all LSAS and EmONC trained doctors in UP were brought together and were asked to choose their preferred FRUs. Priority was given to doctors to choose from the list based on seniority. During the first round of counselling, 47 buddy-doctors were identified, and transfer orders were released within 15 days. The LSAS and EmONC trained buddy-doctors were posted at DH for 6months under mentors hip of specialists (Anaesthetist-Gynaecologist). During this period, they assisted the specialists in C-section cases and were expected to conduct minimum 5 C-sections independently per month under supervision. At the end of 6months, the doctors were posted back to their respective FRUs. The performance of the buddy doctors was also linked to incentives:

- ***Incentives during Mentoring Period:*** Rs 1000 per buddy-doctor and specialists (mentors) for maximum of 5 C-section per month.
- ***Team Incentives post-mentoring period at Inactive FRUs:*** Rs 1200 per doctor, Rs 600 for MBBS Doctor supporting in Post-op, Rs 600 per staff nurse and Rs 400 per OT Technician for all C-sections performed in the FRU.
- ***Incentives for visiting FRUs by Specialist Mentors after Mentoring Period:*** Rs 2500 per specialist per visit.

1. Excluding 14 Medical Colleges.
2. 10 in case of district hospitals and 5 in case of CHC-FRUs.

- Required equipment was made available to provide suitable work environment to the doctors.

Programme Outcomes

The state plans to make 31 FRUs functional by December 2019. Another 100 FRUs are aimed at making functional through by 2020 which would potentially activate 130 out of 153 non-functional FRUs.

Scalability

The model is scalable and can be implemented in other states, specially those not having specialist cadre.

Implementation Partner

UP-TSU

Financial Implications

Provision of incentive in NHM PIP

Contact Details

Email: mdupnrhm@gmail.com

Phone: +91-8650000503

राष्ट्रीय शहरी स्वास्थ्य मिशन, हरियाणा
NATIONAL URBAN HEALTH MISSION
आपके पास केवल एक ही जीवन है,
इसे स्वस्थ रखें

NATIONAL URBAN HEALTH MISSION

"TAARE ZAMEEN PAR": A Night Vigil

Introduction

- The moto of Pulse Polio Campagin - "Ek Bhi Bachha Choota Toh Surksha Chakar Toota" is being implemented in letter and spirit.
- Chandigarh is a city of opportunity and with the increase in mobility, the migration is high.
- Booth activities as well as house to house visits are undertaken during the day time.
- It was observed by the Health Department that the health functionaries are not able to cater to the nomads/ rag pickers/ beggars who are not static and cannot be included in the micro plans.
- To enhance the coverage of immunization and to provide the immunization services at doorsteps of Nomads of UT, Chandigarh.

Implementation

- An out of box idea emerged, given the name as "TAARE ZAMEEN PAR"- A NIGHT VIGIL which is first of its kind of activity only implemented in UT, Chandigarh.

- To execute this activity, six teams were constituted, a team comprising of male Medical officer, male health functionaries and police personnel who are engaged in coordination with the Police department. They were equipped with vaccine carrier, marker and torches to implement the activity.
- Teams were sent to the areas where nomads along with their children settle at night and vaccination of their eligible children have been undertaken.
- The activity was carried out at night hours from 8 pm to 11 pm, which was perceived as a great challenge initially but was super headed by the Mission Director (NHM) and taken ahead by the Health department.
- Since the activity was to be carried out at night, security arrangements for

the night staff was also the area of the concern, which was dealt by making the plan in coordination with Police Department.

Financial Implications

- No additional finance/stock is required.
- WHO has given the following observations:

"Very enthusiastic and motivating environment in the field after a long time with good quality of training and supervision at all levels. Keep it up team Chandigarh."

- Well appreciated by Governor of Punjab and Administrator of Chandigarh and has received SKOCH-Order of Merit Award.

Benefit for the Programme

The innovation has widened the horizon of 'Reaching the Unreached' and by capturing the potential beneficiaries which if not covered could act as carriers. The commitment of the department and officials has given a good coverage by almost capturing more than **300 left outs/ uncovered** during each round of Pulse Polio Immunization round.

Contact Details

Email: nrhmchd@gmail.com

Phone: +91-9876027113

DEFINING, DOCUMENTING CATCHMENT AREAS OF URBAN HEALTH CENTRES ON WEB PORTAL

to Facilitate Population Allocation to Frontline Workers

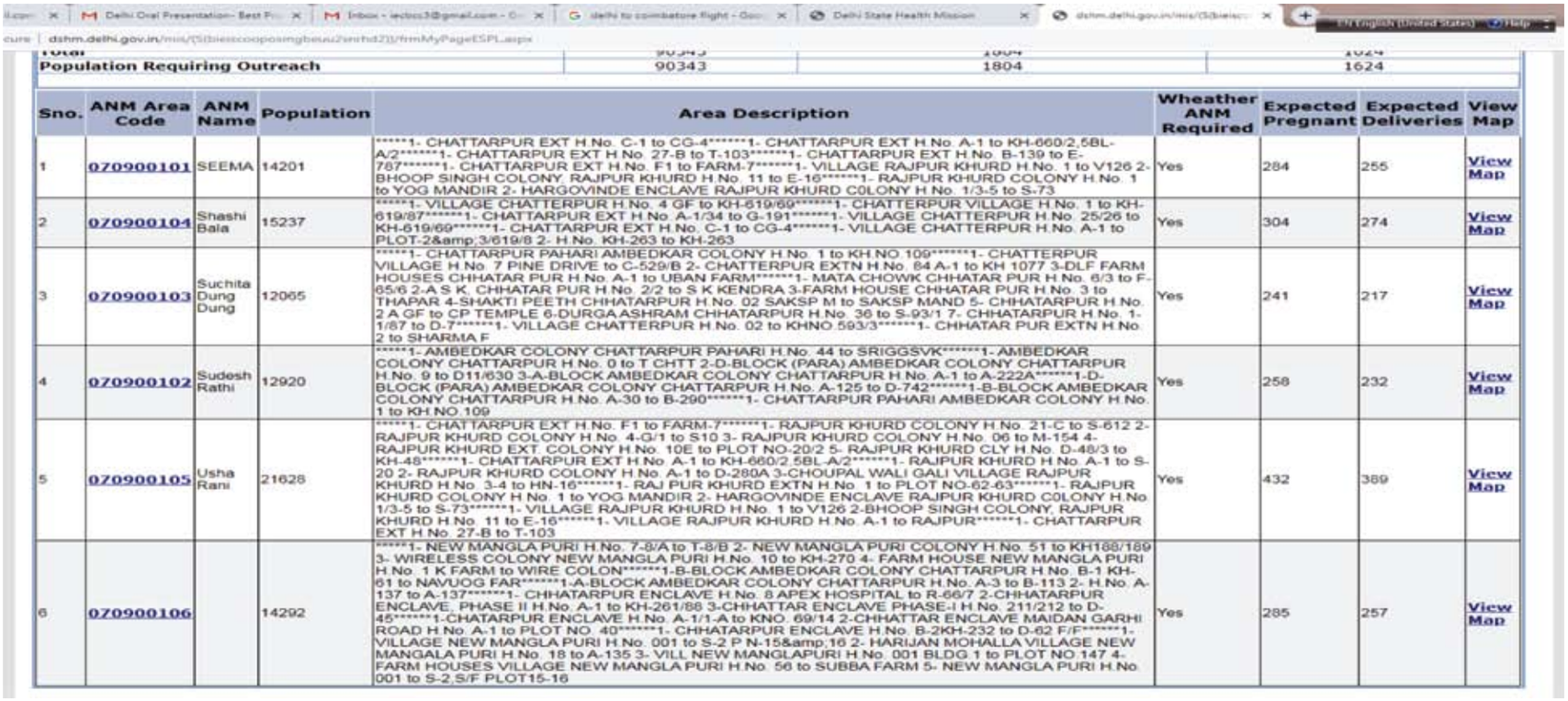
Problem Statement

In rural areas there are geographically and demographically well defined units-villages attached to a PHC / Subcenter (HWC) In Urban areas like Delhi, where lac after lac of population just stretches in continuity, it is important that each health center knows its catchment population for promotive and preventive health interventions and that each ANM and ASHA has a geographically and demographically defined population for which she is responsible. And the same must be available to the functionaries.

Programme Description

The Electoral database generated by Census was used to facilitate mapping of population with health facilities. Population level data is available for polling booths which have a population of 1500 to 2500 each. A group of confluent polling stations around the centre were used to provide the area description and the estimated population of the catchment area of the centre. Primary healthcare facilities of Government of National Capital Territory of Delhi (GNCTD) and Municipal Corporation of Delhi (MCDs) were mapped and infrastructure data compiled. Web-based software with electoral databases were provided to the UPHC teams/district nodal officers and training of MO I/Cs and their teams from GNCTD and MCD undertaken. Polling stations surrounding the health centres within 1.5 to 2 km identified with population totalling up to around 50,000 and attached to each

Picture- Sangam Vihar (resettlement colony) with a dense population of around four lakhs with multiple centres and health functionaries.



Population Requiring Outreach	90343	1804	1624

Sno.	ANM Area Code	ANM Name	Population	Area Description	Wheather ANM Required	Expected Pregnant	Expected Deliveries	View Map
1	070900101	SEEMA	14201	*****1- CHATTARPUR EXT H.No. C-1 to CG-4******1- CHATTARPUR EXT H.No. A-1 to KH-660/2,5BL-A/2******1- CHATTARPUR EXT H.No. 27-B to T-103******1- CHATTARPUR EXT H.No. B-139 to E-787******1- CHATTARPUR EXT H.No. F1 to FARM-7******1- VILLAGE RAJPUR KHURD H.No. 1 to V126 2-BHOOP SINGH COLONY, RAJPUR KHURD H.No. 11 to E-16******1- RAJPUR KHURD COLONY H.No. 1 to YOG MANDIR 2- HARGOVINDE ENCLAVE RAJPUR KHURD COLONY H.No. 1/3-5 to S-73	Yes	284	255	View Map
2	070900104	Shashi Bala	15237	*****1- VILLAGE CHATTERPUR H.No. 4 GF to KH-619/69******1- CHATTERPUR VILLAGE H.No. 1 to KH-619/87******1- CHATTARPUR EXT H.No. A-1/34 to G-191******1- VILLAGE CHATTERPUR H.No. 25/26 to KH-619/69******1- CHATTARPUR EXT H.No. C-1 to CG-4******1- VILLAGE CHATTERPUR H.No. A-1 to PLOT-2&3/619/8 2- H.No. KH-263 to KH-263	Yes	304	274	View Map
3	070900103	Suchita Dung Dung	12065	*****1- CHATTARPUR PAHARI AMBEDKAR COLONY H.No. 1 to KH.NO.109******1- CHATTERPUR VILLAGE H.No. 7 PINE DRIVE to C-529/B 2- CHATTERPUR EXTN H.No. 84 A-1 to KH 1077 3-DLF FARM HOUSES CHHATAR PUR H.No. A-1 to UBAN FARM******1- MATA CHOWK CHHATAR PUR H.No. 6/3 to F-65/6 2-A S K, CHHATAR PUR H.No. 2/2 to S K KENDRA 3-FARM HOUSE CHHATAR PUR H.No. 3 to THAPAR 4-SHAKTI PEETH CHHATARPUR H.No. 02 SAKSP M to SAKSP MAND 5- CHHATARPUR H.No. 2 A GF to CP TEMPLE 6-DURGA ASHRAM CHHATARPUR H.No. 36 to S-93/1 7- CHHATARPUR H.No. 1-1/87 to D-7******1- VILLAGE CHATTERPUR H.No. 02 to KHNO.593/3******1- CHHATAR PUR EXTN H.No. 2 to SHARMA F	Yes	241	217	View Map
4	070900102	Sudesh Rathi	12920	*****1- AMBEDKAR COLONY CHATTARPUR PAHARI H.No. 44 to SRIGGSVK******1- AMBEDKAR COLONY CHATTARPUR H.No. 0 to T CHTT 2-D-BLOCK (PARA) AMBEDKAR COLONY CHATTARPUR H.No. 9 to D11/630 3-A-BLOCK AMBEDKAR COLONY CHATTARPUR H.No. A-1 to A-222A******1-D-BLOCK (PARA) AMBEDKAR COLONY CHATTARPUR H.No. A-125 to D-742******1-B-BLOCK AMBEDKAR COLONY CHATTARPUR H.No. A-30 to B-290******1- CHATTARPUR PAHARI AMBEDKAR COLONY H.No. 1 to KH.NO.109	Yes	258	232	View Map
5	070900105	Usha Rani	21628	*****1- CHATTARPUR EXT H.No. F1 to FARM-7******1- RAJPUR KHURD COLONY H.No. 21-C to S-612 2-RAJPUR KHURD COLONY H.No. 4-G/1 to S10 3- RAJPUR KHURD COLONY H.No. 06 to M-154 4-RAJPUR KHURD EXT. COLONY H.No. 10E to PLOT NO-20/2 5- RAJPUR KHURD CLY H.No. D-48/3 to KH-48******1- CHATTARPUR EXT H.No. A-1 to KH-660/2,5BL-A/2******1- RAJPUR KHURD H.No. A-1 to S-20 2- RAJPUR KHURD COLONY H.No. A-1 to D-280A 3-CHOUPAL WALI GALI VILLAGE RAJPUR KHURD H.No. 3-4 to HN-16******1- RAJ PUR KHURD EXTN H.No. 1 to PLOT NO-62-63******1- RAJPUR KHURD COLONY H.No. 1 to YOG MANDIR 2- HARGOVINDE ENCLAVE RAJPUR KHURD COLONY H.No. 1/3-5 to S-73******1- VILLAGE RAJPUR KHURD H.No. 1 to V126 2-BHOOP SINGH COLONY, RAJPUR KHURD H.No. 11 to E-16******1- VILLAGE RAJPUR KHURD H.No. A-1 to RAJPUR******1- CHATTARPUR EXT H.No. 27-B to T-103	Yes	432	389	View Map
6	070900106		14292	*****1- NEW MANGLA PURI H.No. 7-8/A to T-8/B 2- NEW MANGLA PURI COLONY H.No. 51 to KH188/189 3- WIRELESS COLONY NEW MANGLA PURI H.No. 10 to KH-270 4- FARM HOUSE NEW MANGLA PURI H.No. 1 K FARM to WIRE COLON******1-B-BLOCK AMBEDKAR COLONY CHATTARPUR H.No. B-1 KH-61 to NAVUOG FAR******1-A-BLOCK AMBEDKAR COLONY CHATTARPUR H.No. A-3 to B-113 2- H.No. A-137 to A-137******1- CHHATARPUR ENCLAVE H.No. 8 APEX HOSPITAL to R-66/7 2-CHHATARPUR ENCLAVE, PHASE II H.No. A-1 to KH-261/88 3-CHHATTAR ENCLAVE PHASE-I H.No. 211/212 to D-45******1-CHATARPUR ENCLAVE H.No. A-1/1-A to KNO. 69/14 2-CHHATTAR ENCLAVE MAIDAN GARHI ROAD H.No. A-1 to PLOT NO. 40******1- CHHATARPUR ENCLAVE H.No. B-2KH-232 to D-62 F/F******1-VILLAGE NEW MANGLA PURI H.No. 001 to S-2 P N-15&16 2- HARIJAN MOHALLA VILLAGE NEW MANGALA PURI H.No. 18 to A-135 3- VILL NEW MANGLAPURI H.No. 001 BLDG.1 to PLOT NO.147 4-FARM HOUSES VILLAGE NEW MANGLA PURI H.No. 56 to SUBBA FARM 5- NEW MANGLA PURI H.No. 001 to S-2,S/F PLOT15-16	Yes	285	257	View Map

health facility. Overlaps were removed and unserved / underserved groups were documented by multi-agency district task groups. Each ANM, MO I/C, district nodal officer were provided with access to this information.

Programme Outcomes

The effort enabled

- Defining, codification and documentation of the areas for all GNCTD / MCD health centres.
- Defining, codification and documentation of 8000 – 12000 population pockets as ANM areas and around 2000 population pockets as ASHA areas.
- Generating the denominator for benchmarks for various activities and resolution of overlapping areas. Identification of unserved areas and their attachment to existing / new centres.
- Creating accountability for areas assigned and availability of data for targeted interventions.
- The data can be further used to build name / family folder-based empanelment of the attached population as the state progresses towards the provision of Comprehensive Primary Health Care.

Scalability

The process can be used in all urban areas and even rural areas as the main advantage of use of polling station / booth data is that no geographic pocket / habitation is left out. Mechanisms have been built in to add the population residing in that pocket which is not a part of the electoral data/or has recently migrated in the area.

Implementation Partners

This was an effort undertaken entirely by the state government.

Financial Implications

The software was developed in-house by team of programmers already deployed for developing multiple modules for the health department. Web- based application is hosted on the Delhi State Health Mission (DSHM) servers. Implementing functionaries were / are the existing health functionaries. Funds for trainings / meetings were sourced from routinely available fund for such activities.

Contact Details

State Programme Officer (DSHM)

Email: kmanika1960@yahoo.co.in;
dshmasha19@gmail.com

Phone: +91-9811484474

HI-TECH LABORATORY UNDER NUHM IN BENGALURU

A Concept of Hub and Spoke Model

Problem Statement

- Reduce out of pocket expenditure as per NSSO-2016 where in an estimated 10% of total household out of pocket expenditure accounts for diagnostics.
- The limited array of diagnostics available at UPHCs under NUHM leads to additional burden on tertiary care centres and patients.

Programme Description

- 6 Hi-Tech Laboratories have been established in Government Hospitals (UCHC) of ULBs under NUHM in Bruhat Bengaluru Mahanagara Palike (BBMP) On April 2018.
- Hi-Tech Laboratories are designed to operate as hubs under “Hub and Spike Model” design, the Special Outreach Camps and UPHCs serving as spokes.
- Laboratory, Radiology, Mammography and Ultrasonography services are provided free of cost for urban poor.
- 83 types of laboratory investigations at the hub and 19 types at the spokes (UPHCs).
- Basic lab services are provided in UPHCs and advanced diagnostics are referred/ transported to Hi-Tech Laboratory.
- Samples of active screening and referrals from Health Kiosk and SORC are being transported to Hi-Tech Laboratories.
- Hi-Tech Lab services are being utilised in mass screening camps of NCD, Active Case Finding campaigns for X-ray, LCDC etc in urban areas.
- Dedicated software for enrolment and reporting the results to the patient through message and to UPHC/UCHC.

- Five specialist doctors are supported by 30 paramedical staff in these laboratories through NUHM.
- An incentive of Rs. 200 is paid to the lab technician/ Group-D for the transport of samples from spokes to hub initially. State shall propose for courier system in FY 2020-21 PIP.

Programme Outcomes

- On an average of 100-120 patients seek services at the Hi-Tech laboratories. The rise in total tested samples has risen by 200 times in 2018-19 compared to previous year.

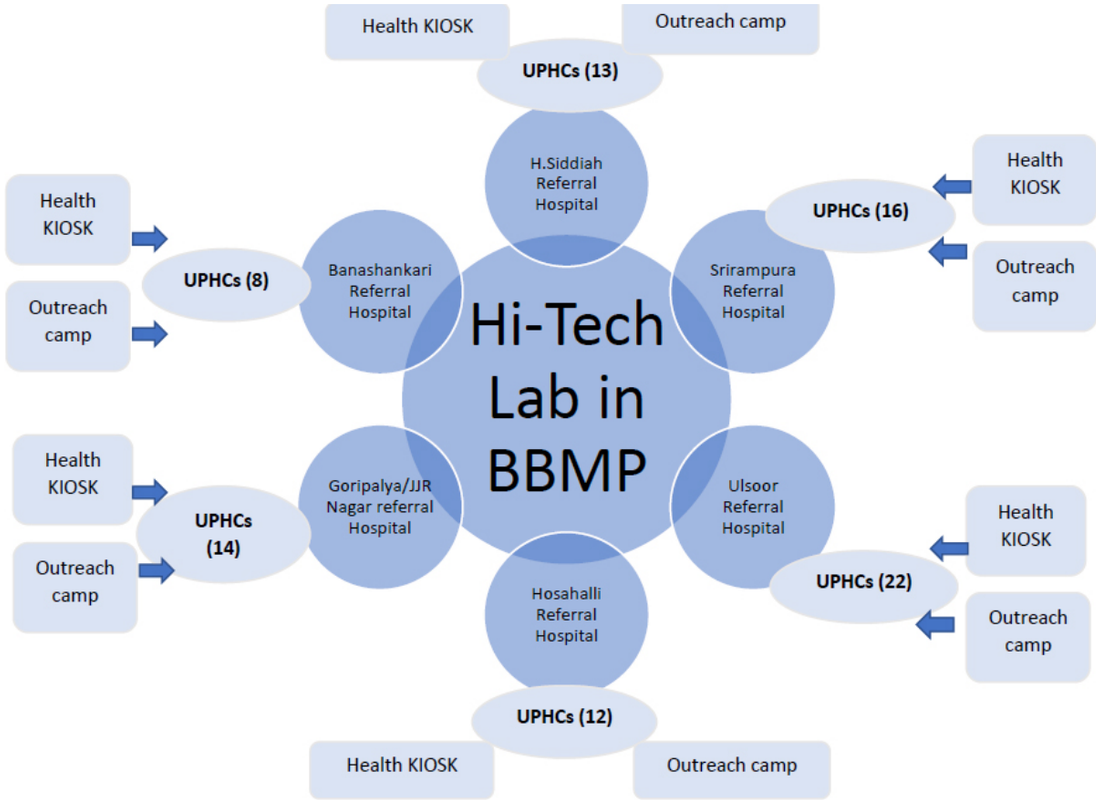
Financial Implications

- One-time investment of 4.3 crores.
- Annual Recurring cost of 17 lakhs (Excluding courier charges).

Contact Details

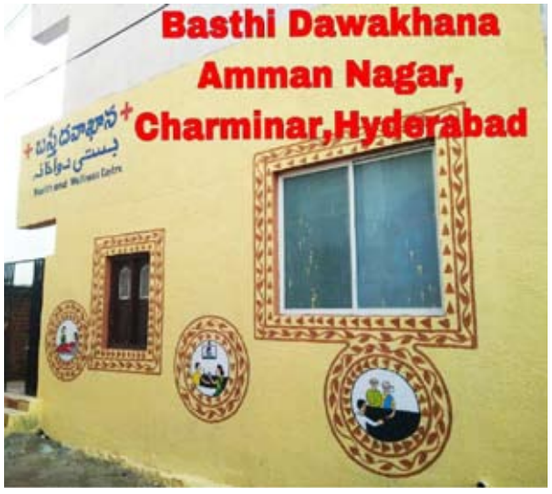
SNO, NUHM,
Phone: +91-9449843438

CPMO, BBMP,
Phone: +91-9480683473



Hub & Spike model of Hi-tech Lab

'BASTI DAWAKHANA': An Urban Health Initiative



Problem Statement

Poor health status of the urban poor and lack of access to urban primary health centres due to distance from slums, unsuitable OPD timings and less number of UPHCs, resulting in health care seeking at private facilities by urban poor.

Programme Description

"Basti Dawkhanas" meaning "health facility" for a small area caters to a population of 10,000. These are set in slums where the UPHC is located at a distance of over 3 kms. Staff includes a Medical Officer, a Staff Nurse and a Support Staff. Apart from outreach services, Basti Dawakhanas offer Consultation, Diagnostics and Medicines, all free to the end-user. All the medicines available at UPHC are available at Basti Dawakhana and procured through online indenting system. 53 diagnostic tests, including point of care tests and diagnostics through hub and spoke model, with hub at Telangana Diagnostic Services (in house) are available. An online digital module for recording OPD cases is used by MO. Telemedicine facility is available for consultation with specialists from Osmania, Gandhi General Hospitals and MNJ Cancer Hospital at 20 Basti Dawakhanas.

Programme Outcomes

115 Basti Dawkhanas are functional, with an average OPD of 100 per day per facility.

Scalability

The model has well defined components, a fixed financial requirement and has been able to demonstrate positive outcomes. The key components of the model are amenable to scaling up, particularly since it has been implemented within the ambit of the Government Health System, and through convergence with existing systems.

Implementation Partners

This is an initiative of Government of Telangana with active convergence between the Departments of Health,

Municipal Administration and Mission for Elimination of Poverty in Municipal Areas (MEPMA). Tata Trust is a partner for telemedicine services.

Financial Implications

Funding through NHM-The cost per Basti Dawakhana is as follows:

- Renovation – Rs. 7 lakhs.
- Equipment – Rs. 1.30 lakhs.
- Remuneration (per annum) – Rs. 7.8 lakhs.
- Medicines (per annum) – Rs. 5.6 lakhs.
- Diagnostics (per annum) – Rs. 2.00 lakhs.
- Untied funds (per annum) – Rs. 0.50 lakhs.

Contact Details

Programme Officer (NUHM)

Email: spmupeshi@gmail.com

E~HEALTH

E–UPCHAAR: Leveraging Information Technology for Implementing Hospital Management Information System (HMIS) in Public Health Facilities

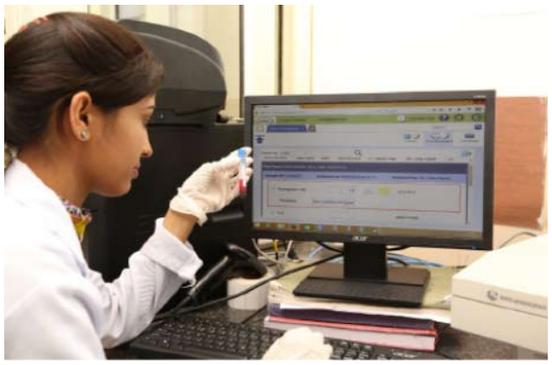
Problem Statement

Due to increase in demand of health care services it is hard to perform documentation manually in the hospitals. Hence, there is a need to use technology to develop Electronic Medical Records (EMRs), to improve treatment of an individual patient as well as utilize data for public health purposes, while ensuring consent, privacy and access to data.

Programme Description

'e-Upchaar' implemented by State Health Systems Resource Centre, Haryana across 56 healthcare facilities following objectives:

- Optimal utilization of infrastructure, equipment, facilities, HR, drugs & consumables.



Lab Technician utilizing the e-Upchaar application for result entry at DH Rohtak

Registration clerk capturing patient demographics in the application leading to generation of Unique Health ID (UHID) at DH Ambala City

- Transparency and availability of information related to services provided by the facilities.
- Reduction in patient waiting time through efficient queue management.
- Availability of EMR for every registered patient across all 56 facilities in the state.

Programme Outcomes

- Streamlining of patient flow (80 lakhs) through an efficient Token management system and generation of Unique Health ID. Registration time

(1 minute), follow up visits (15 sec), billing and cash (2 minutes) and same day availability of diagnostic report. Generation of EMR (70 lakhs) for continuum of care.

- Printed diagnostic reports and leading to savings e.g. due to non-printing of X-ray films in 22 facilities is 13 million (INR).
- Automation of manual processes- 102 lab machines and 62 radiology machines integrated with the application till date.
- Integration with 'Mera Aspataal' portal.

Scalability

The implementation is planned to be extended to all public healthcare facilities in the state after completing district hospitals and Govt. Medical Colleges.

Contact Details

Email: edhshrc@gmail.com

Doctors utilising the application for viewing the X-ray images through PACS integrated with the application at DH Panchkula

"MERA ASPATAAL"

Mera Aspataal (My Hospital) is a Ministry of Health and Family Welfare, Government of India (GoI) initiative to capture patient feedback on the services received from both public and empanelled private health facilities.

It works through multiple communication channels, including Short Message Service (SMS), Outbound Dialling (OBD), a mobile application, and a web portal.

The application allows feedback to be consolidated, analysed and disseminated on a frequently updated dashboard. Analysed data will be used to improve quality of services in healthcare facilities.

Implementation of "Mera Aspataal" programme was started in year of 2017 at Gujarat State:

- Total 1880 facilities has been on boarded till date. Remaining are in process.
- In first phase total 31 Hospitals on boarded. As state has Hospital Management software for online data uploading.Required data share through API (Web service) on daily basis.
- Other health facilities has been on boarded in phase manner.

Sr. No.	Facility Type	On boarded
1	Medical College Hospital	17
2	District Hospital	25
3	Sub District Hospital	30
4	CHC	264
5	PHC	1121
6	UHC/UPHC	260
7	Private Hospital	161
8	MHU	2
Total		**1880**

Implementation Challenges

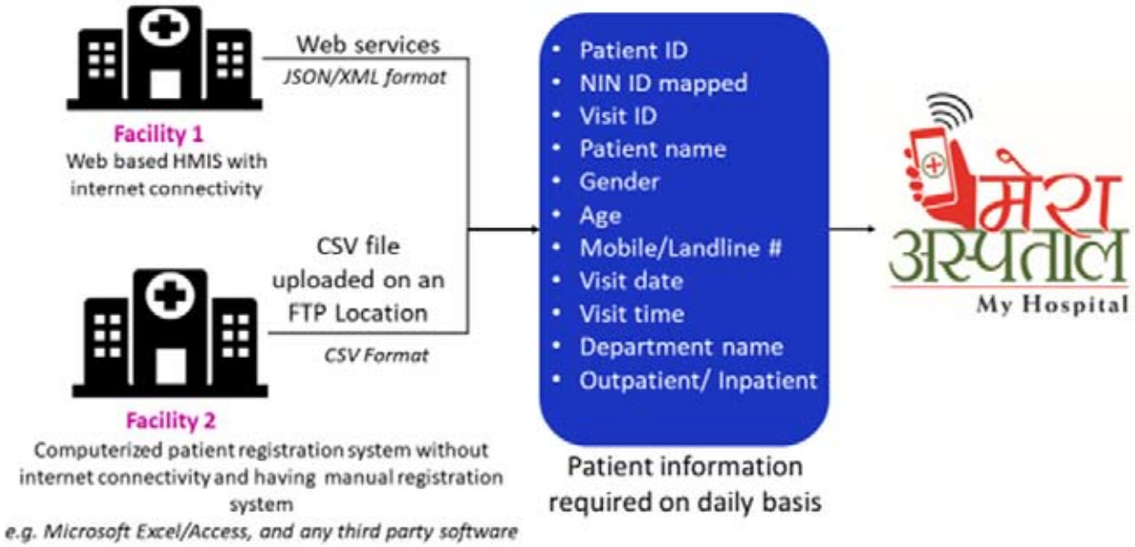
- Total 2230 Health Facilities (Including Aayusman Bharat PVT. Hospitals and MMU) need to on boarded in Mera Aspataal.
- Limited state level IT team to reach all facilities and trained all health facilities.
- We have no technical expertise at PHC/CHC level, not any Hospital

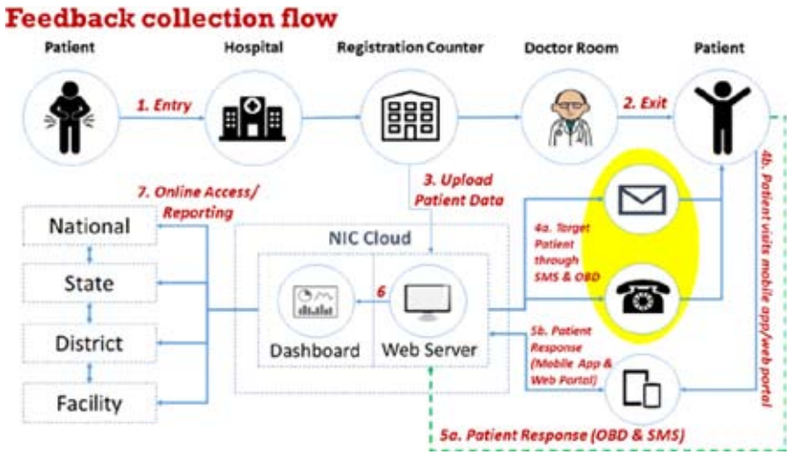
management software so faced difficulty in upload CSV for offline mode.

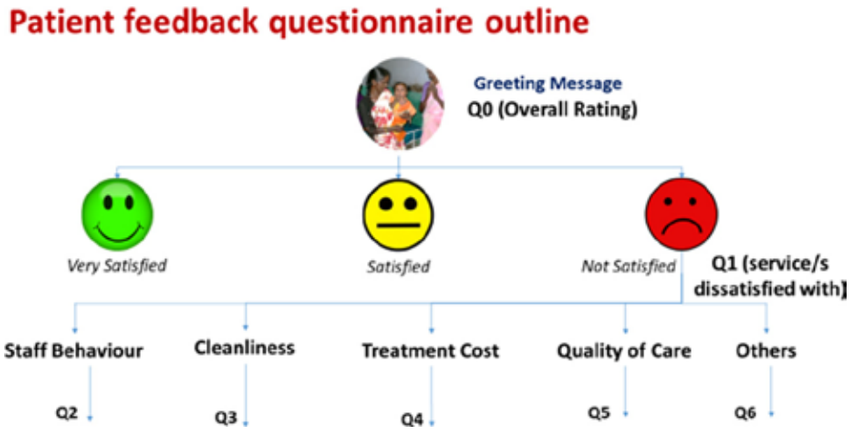
- Gathering required data from facility level for meraaspataal on boarding.
- Technical support for regular queries of meraaspataal up to PHC level.
- Creation of NIN id for Private Hospitals.

Overcome the Challenges

- Training (with help of State It cell Team and Saathi-Mera Aspataal Team) had given to District Programme Coordinator (DPC), Corporation Programme Coordinator (CPC), Regional Programme Coordinator (RPC), District Quality Assurance Medical Officer (DQAMO).
- All are appointed as a Nodal Officer and Master trainer for data entry and monitoring.
- Provision of Google Form for Enrolment of the health facilities.
- NIN Number had get generated which facilities did not have NIN number.
- Consulate Data Given to GoI Mera Aspaatal team for on boarding health facilities.
- In phase manner facilities get on boarded.
- District Data Manger-IDSP had trained and involved to overcome Technical Challenges and Strengthening data entry up to PHC level.
- RDD and CDHO has instructed from State level for conducting the district wise training and regular monitoring.
- Regular monitoring and Technical support given by state IT cell team.
- Weekly performance review by Principal Secretary and Commissioner of Health.







INTEGRATED HEALTH INFORMATION PLATFORM (IHIP)

DHO & Team addressing the District level Training On IHIP

Monitoring of IHIP in the field (health facility) by District team and hands-on training to respective Health Staffs

Problem Statement

Karnataka State is reporting disease surveillance data in aggregate mode under IDSP using existing IDSP Software Application (www.idsp.nic.in). There was no provision to report case based data in near real time modeand also additional disease conditions like KFD, Scrub Typhus etc. were not being captured. Further the existing application was not having advanced dynamic features.

Programme Description

Integrated Health Information Platform (IHIP) is the tool designed & developed with the support from WHO in order to have holistic picture of data reported under different National Health Programmes under "One-Health Approach". It is Web enabled electronic health information system for geo-spatial epidemiology. It is embedded with all applicable IT, Data & Surveillance standards for near real time reporting of village level, case based disease surveillance data.Thisplatformis also incorporated with advanced features like Mobile Application, GIS Utility, Dynamic reports, Disease dashboard, Text SMS & Email alerts, etc.

Programme Outcomes

IDSP Module of IHIP Platform has been launched in all 30 Districts in Karnataka on 26th November 2019 and presently all 30 Districts are reporting disease surveillance

State Level review meeting on Implementation of IHIP under IDSP in the Districts

data including Syndromic data by ANMs using IHIP Mobile Application after successfully undergoing trainings. In last one year, as per the data captured in IHIP 2,29,898 Syndromic cases, 23,68,479 Presumptive cases are reported and further 11,68,055 samples tested out of which 49,045 samples found Positive. Lab confirmed all positive case are reflected on GIS based map to identify individual geo-locations of cases for monitoring & response under IDSP. More than 2 lac Syndromic cases have been captured by ANM using Mobile Application.

Scalability

It is scalable to entire Country and roll out phase is going on.

Implementation partners (If any)

WHO Country Office, India is supporting trainings of IHIP by deploying technical resource persons.

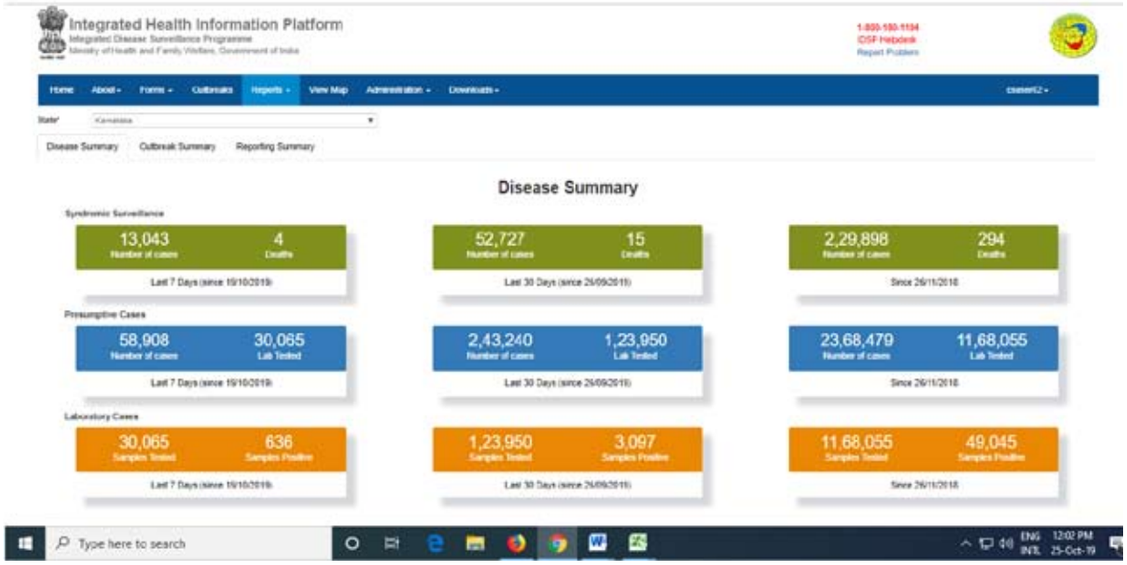
Financial implications

No financial support has been provided for the implementation of IHIP in the State for the year 2018. A total of 37,14,620/- rupeeshave been utilized from the NHM training line-item A.9 (SIHFW) after the approval from MD-NHM, for the cascade training and implementation of the IHIP in the State.

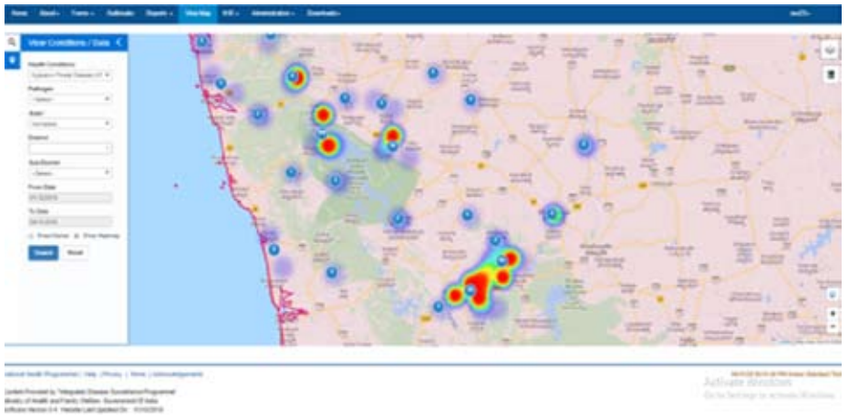
Contact Details

Director (NCDC) & NPO (IDSP)
Email: sujeet647@gmail.com
Phone: +91-8130255553

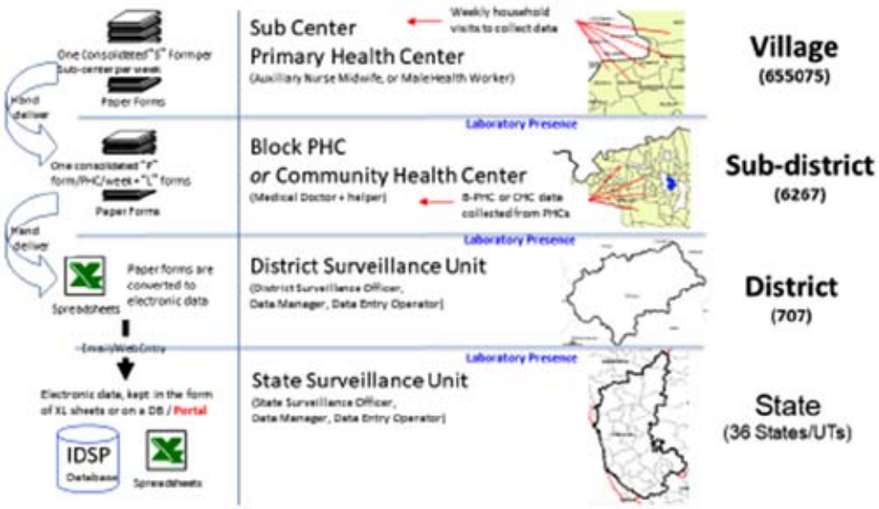
Joint Director (IDSP)
Email: himanshu.chauhan@nic.in
Phone: +91-9650561940



Heat-Map For KFD Disease reported in Karnataka State for the year 2019



IDSP's Data Collection Process at State-level



USE OF TECHNOLOGY FOR BETTER DATA VISUALIZATION AND DECISION MAKING MWMIS & ASMAN

Problem Statement

Rajasthan is only state in country, which has taken Dakshata to Pan-State. As of now, challenge is to address inadequate reporting, multiple registers and manual collection of data that resulted in hampered or no decision-making at all. Results of Dakshata is quite encouraging (20% reduction in SBR in Dakshata facilities compared to non-Dakshata) but to accelerate further changes it is pertinent that data collected at Labor Rooms should be used for better decision-making and developing individual accountability.

Programme Description

After developing standardized case sheet, digitalization of the same was done. Forty fields are made mandatory out of total 421 fields. Total 10 training batches conducted in which 224 data operators were trained. As on 31st Oct 2019, state is getting data from 200 facilities of 23 districts. ASMAN, which is real-time data entry software with in-built clinical decision-support system for nursing staff, is operational in 39 facilities of 4 districts.

Programme Outcome

1,12,779 case sheets have been entered in MWMIS. Completeness of critical indicators rose from 48% to 78%. Adherence to key clinical practices also improved such as mother's BP on Admission (25% to 87%) and temperature at discharge (86% to 94%) and fetal heart sound (89% to 96%). ASMAN has data for approximately 80000 deliveries.

Dashboard generated from MWMIS

Scalability

Standardized case sheet and availability of the data entry operator is a pre-requisite for scaling up the intervention. State is planning to scale-up ASMAN in additional districts.

Financial Implications

For MWMIS only incentivization- of operator is by NHM, Rajasthan. Tablets, internet connectivity and printer is required to make facility operational under ASMAN.

Contact Details

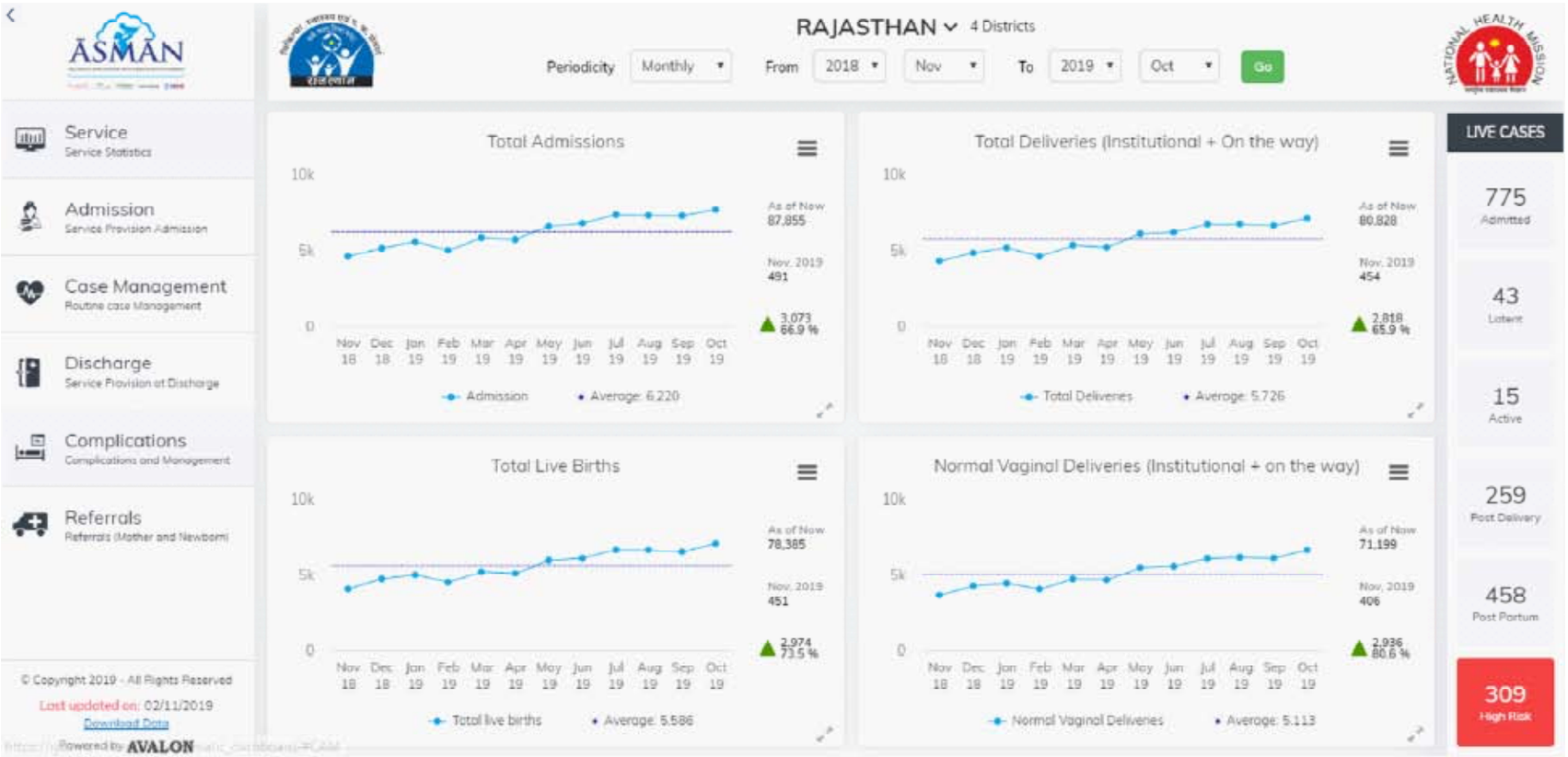
Project Director, Maternal Health, DMHS

Phone: +91-7733000888

SNO, Maternal Health, DMHS
Phone: +91-9680563287

Implementation Partners

JHPIEGO (funding support by CIFF, ASMAN)



Dashboard generated from MWMIS

MWMIS verification by GOI LaQshya Representative

Nurse Using ASMAN application

Nurse Using ASMAN application

UNIVERSAL HEALTH COVERAGE INFORMATION TECHNOLOGY (UHC IT) PLATFORM

Problem Statement

The State Health System is in need of intact forward and backward mechanism, within and between the health applications and, from community to tertiary care facility with user friendly IT Platform compatible for repeat process automation and advanced analytics like AI/ML and GIS.

Programme Description

All health applications are looking the disease conditions and events i.e. numerator. The state has conceptualized that the Comprehensive Universal Health Coverage IT platform with population as denominator is essential to establish a continuum of care from community to referral units. As a first step, Health IT standards was drafted, Family Folders module, outpatient module and drug inventory module were developed using the standards.

Master registry of Facilities, Family folders, Address, GIS maps and data dictionary are the cornerstone of the UHC IT Systems development. All applications aim to have the 8 modules namely data collection, data management, data analytics, visualization, reporting, documentation, public and communication module, which are essential for any health/related programme integration with UHC IT systems in phased manner.

Programme Outcomes

- Master Registry (Denominator): a common list for integrating all health and related applications:
  - Health facilities.
  - Geographical locations (address & admin units) with Service Area Mapping.
  - Family Folders with individual details
  - Fields and Options for selection like gender, lab test menu, diagnosis.
- IT Enabled Service Delivery:
  - Non communicable disease protocol is incorporated in the OP entry module. As and when the entry is made, interpretation is shown for decision support.
  - Drug indenting support: OP Line list entry made by the VHN/SN is consisting the drugs dispensed to the beneficiaries. The same is used for arriving the drug requirement of the UHC HSCs.
  - Clinical audit by the Medical Officers for supporting protocol adherence and the better data quality.

- Health staff can download the line list and generate the disease wise morbidity and follow up plan. Automated OP report is generated in the Portal. Health staff's contribution is to make the OP entry of walk-ins seen at the HWC.

- Population based outcomes:
  - HWC level MLHP can able to understand, among the population (~5,000) how many are diabetic, hypertension.

Scalability

- The UHC IT Platform is designed for horizontal and vertical expansion, aligned in line with data requirements of Ayushman Bharat for integration.
- The Platform is hosted to cater 10 crore individual records, 5 lakh geographical units, 12 thousand concurrent users. Presently, the usage is 6.6 crore individual records, 2.5 lakh geographical units and 2 thousand concurrent users. The same platform can handle the HWC data for next 5 years at the current capacity.

Implementation Partners (If any)

State Health Department is the implementing agency of UHC IT Platform.

Financial Implications

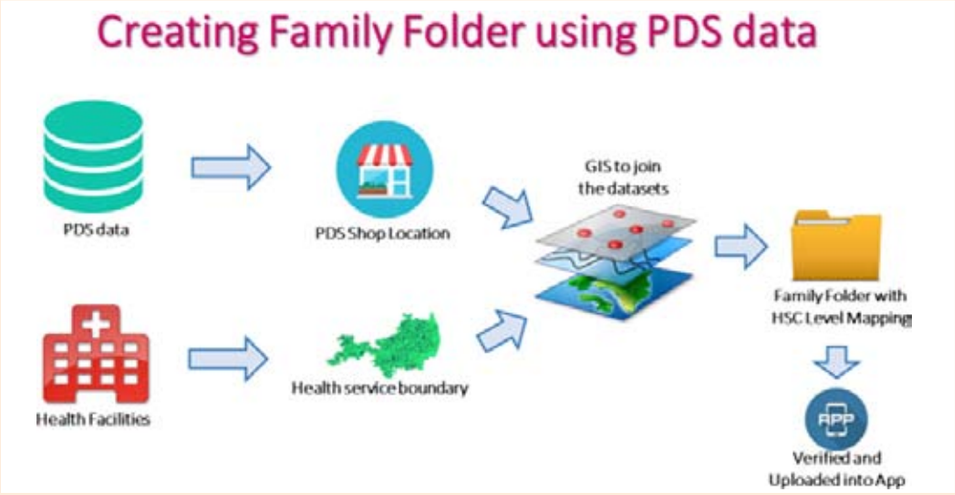
Universal Health Coverage IT platform has been established by incurring Rs. 44,74,075.62. Inhouse contributions like training, baseline database creation, internet connectivity, hardware, mentoring are strengthening the Platform.

Contact Details

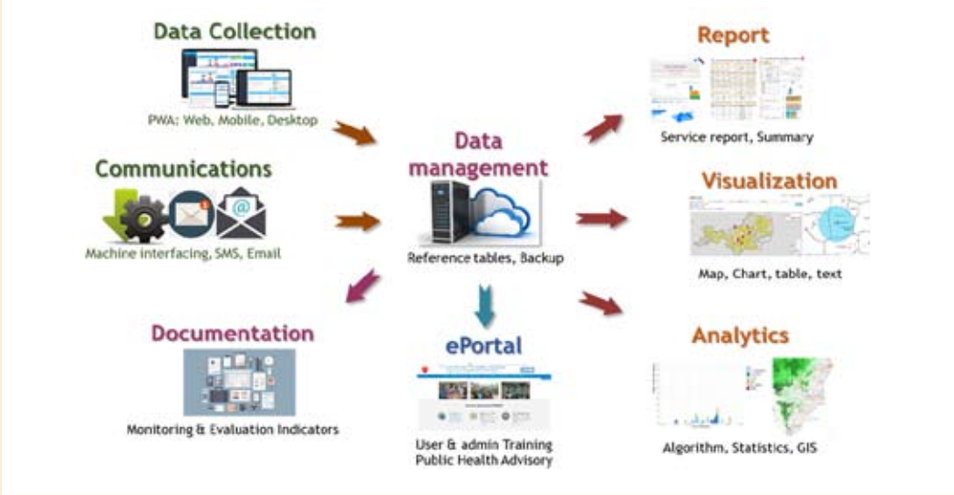
Mission Director, National Health Mission

or

Medical Officer SPMU (UHC&MCH),
O/o DPH & PM
Email: mospmu@gmail.com
Phone: +91-9894726160



Creation of Family Folder using e-PDS data



Module based approach for integration of existing and new health applications in phased manner

TELANGANA-IT INITIATIVES

e-BIRTH

Problem Statement

There exists no system to track birth registration at the state level. Real time birth registration would facilitate us to analyse and identify aspects that need close monitoring and improvement.

Programme Description

Government of Telangana has issued orders in December 2018, making it mandatory for all hospitals, Government and private to notify births and deaths in e-birth application. All Government and Private hospitals were provided logins by District Medical and Health Officer. A total of 2918 hospitals are registered on the portal of which 2107 are private hospitals and 811 are Government hospitals.

Programme Outcomes

In Telangana, around 5.8 to 6 lakh deliveries are expected every year and real time data updation is more than 85% (5 lakh deliveries in a year) on this portal. e-birth portal gives administrators at State and District level, consolidated data that can be drilled down to the block and village level. Infact, details from this portal on c-section % across hospitals have allowed the health department to initiate “FocusPrimi” that emphasizes on normal delivery of Primi cases as a key area to reduce the prevalent high C-section rates in Telangana.

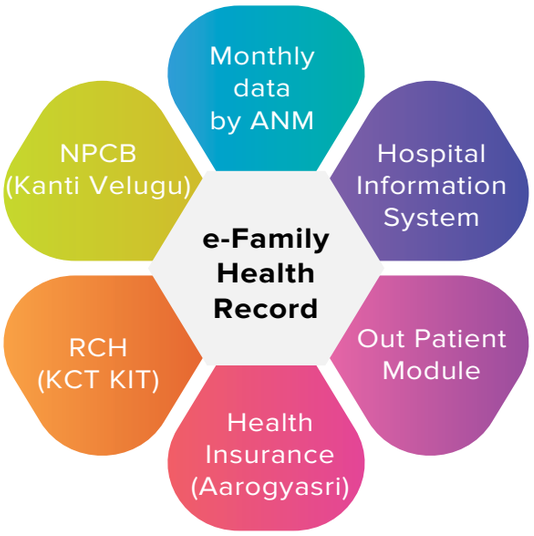
e-FAMILY (Electronic Health Record)

Problem Statement

The services which a citizen at various levels in hospitals are captured in different systems and the information in these systems never gets integrated at one place to give entire health condition of the individual. In order to plan and improve service delivery, understanding of what services are being availed by the citizens becomes important to create a Data Base which creates an electronic health record of an each individual.

Programme Description

The main aim of e-Health project is to have the e-Health record/data base of the citizens of the State. In Telangana in the year 2014 ‘samagrakutumba survey” (comprehensive household survey) was taken up in which each family member wise details are collected and a unique family ID was assigned. This information allowed to link individuals to family health record.



e-Family Health Record is envisaged as a platform to provide critical inputs to understand the health status of a family or a geographical unit as well. e-family record generated should have (i) data base of all citizens of the state with unique ID lined with unique family ID (ii) disease profile of individuals (iii) Health services availed under various health schemes (iv) Health services that need to be offered to the family (e.g., Vaccinations that are due / Follow up after surgery under Aarogyasri/ Monthly medication for hypertension etc.)

Health related data is updated from two basic sources in this portal:

1. Monthly village level data updation by ANM, in the hand held tab, (that is preloaded with village level households), on details about, pregnant pregnant woman registered, regular medicine issuance for Hyper tension, diabetes etc. This set of information allows us to understand various health issues at the village level and details of causes of death helps us take up preventive and IEC activities. For example, basing on this data, death audit of TB cases and awareness and screening activities get planned.
2. Integration of data from other portals e.g., PHC- OPD details, KCR kit, Aarogyasri, Kanti Velugu, Basti Dawakhana – OPD etc., by linking member wise details to the family ID to collate information that would give health status of the family.

Programme Outcomes

Data is obtained from 11,797 villages and 3.07 crore population is covered through various other applications. Thus, the data from various other applications is integrated to this platform thereby creating individual and family health record.

The data is used for (i) planning remedial actions in disease hot belts like promotive and preventive activities (iii) disease outbreak monitoring (iv) monitoring the performance of field functionaries (v) assess disease burden in a small area.

The above details, disease burden, is available for any particular day and also for any particular village.

Family Health Profile

CAUSES OF DEATHS DUE TO DISEASES (1.1.2019 to 30.9.2019)

Scalability

The Programme is scalable though out the country with a very user-friendly software. The Tablet PC available with ANMs and Medical officers can be used for this purpose.

Implementation Partners

M/s Tata Consultancy Services and M/s Frux IT Systems are the software development partner.

Financial Implications

The development of software costed Rs. 5.00 lakhs and maintenance is Rs. 2.00 lakhs per month. The Tablet PCs are distributed under e-hospital and RMNCH+A program.

Contact Details

Email: mdnhmts@gmail.com,
cionhmts@gmail.com

EMERGING INITIATIVES

RMNCAH+N

MISSION RI ARUNACHAL RI STRENGTHE-NING Intervention Arunachal Pradesh

Problem Statement

In Arunachal 25% (49/197) of the health facilities are very hard to reach. 41% (9/22) districts having % FI less than 40% as per NFHS-4 (2015-16). State has decided to conduct Intensive RI/MI in all the districts under the concept Mission Pratiraksha. 2016 - Total 17 confirmed Measles outbreaks & 1 Rubella outbreak. At the outbreak area, 85% children aged 1-4 years have not received a single dose of MCV. 2017 – Total 8 confirmed Measles outbreaks with 5 deaths.

Programme Description

State Level Interventions

- Customized Plan for RI Strengthening drafted with Arunachal Context.
- RRTs (WHO) deployed for need assessment.
- State level master training on microplanning, data review & HW handbook (new) TOT with national level facilitators with WHO support done for DRCHOs & 1 identified MO/district.
- 3 SMOs & 6 RRTs from WHO deployed in 22 districts for stewarding the activity for 2 month. The team has visited 61% (120/197) PUs.
- The State has tracked the program intensively.
- The State has funded printing of planning formats & workshops (micro planning & HW training) at all 197 health facilities along with head-counting activities at all the villages/hamlets of the state.

District Level Interventions

- District level baseline microplan assessment meeting, mid-term review & final review done in all 22 districts.

Health Facility (PU) Level Interventions

- 197 Health facilities identified as planning units (PUs) in 22 districts.
- 80% (158/197) of identified PUs are Cold Chain Points (CCPs). Rationalization of cold chain points & vaccine distribution system.

Contact Details

Email: drdimong@gmail.com

STATEWIDE ROLLOUT AND UPTAKE OF ANTARA

LAUNCH October 2017	PHASE – I Dec. 2017	PHASE – II March 2018	PHASE – III June 2018
Launch of Antara Roll out to Medical Colleges	Antara available at all Medical Colleges & District Hospitals	Antara available at Primary Health Centers across the State	Antara available at UPHCs and selected Health Sub Centers across the State

Problem Statement

Bihar ranks low on key FP health indictors including mCPR (modern Contraceptive Prevalence Rate) and Unmet need for spacing methods. Sterilization continues to be the dominant mode of family planning in the state, accounting for over 87% of FP clients.

Programme Description

Antara injectable was introduced in October 2017 along with Centchroman Tablets.

This has led to an improved access and higher uptake of the method for spacing for its inherent advantages of confidentiality and privacy compared to other methods and its availability up to the Health Sub Centre (HSC) level.

Programme Outcome

So far, as of August 2019:

- 100% of DHs, 97% of SDHs, 41 % APHCs, 51 % HSCs, 76% UPHCs and 85% of PHCs are providing MPA services.

Antara trends since inception (Oct'17 to Aug'19):

- 2,62,228 clients (dose 1) have availed Antara since roll out.
- 4,24,427 doses of Antara (including 4 and more) have been administered in the state.
- Reported second-dose as of August'19 is 58.8% against the first-dose.

Financial Implication

Funds received under Mission Parivar Vikas.

Results

Efficient planning, adequate stock with a robust FPLMIS system has led to improved access and efficient utilization of Antara.

Scalability

State implemented the project with a focus on scaling up the activity up to the community level. State plans to increase accessibility further and have trained manpower at each point of service delivery.

Besides these activities, special focus is being laid to provide counseling and follow-up care and the State has also signed a Memorandum of Understanding with a development partner that will help track clients (who gives their consent) for follow-up counseling and help with side effects if any and also for reminding for subsequent doses.

Contact Details

Email: ed_shsb@yahoo.co.in

FERRIC CARBOXY MALTOSE UTILIZATION in Severe Anaemic Pregnant Women

Problem Statement

Despite impressive socio-economic growth, anaemia is still a major public health concern in Gujarat. Maternal mortality and morbidity due to anaemia in pregnant women continues to be cause for concern.

Programme Description

According to National Family Health Survey IV, 51.3 percent pregnant women suffered from Hb less than 11 gm/dl, while severe anaemia prevalence was 1.5 percent. Hence, specific interventions aimed at reducing maternal mortality due to anaemia but also improve pregnancy outcomes was necessary.

Challenges faced

Lack of evidence-based research studies/ guidelines for large-scale implementation of injection Ferric Carboxymaltose (FCM) in pregnancies:

- Scarcity of documented practices on effective use of FCM for pregnant women in public health systems.

Process followed

The pilot project for FCM was started in Vadodara Corporation in 2017-18, and was subsequently rolled-out in districts like. Sabarkantha, Dahod, Mahisagar, Vadodara, Vadodara Corporation etc. after training of Medical Officers by Dr Vinit Mishra and the IKDRC team. FCM was also added in EDL to ensure accessibility of the medicine to treat severe iron deficiency in pregnant women in public health care institutions.

The targeted population: 13.5 lakh pregnant women, 12.3 lakh women in labour and 12 lakh infants are directly affected by the intervention. It will also lead to achieving one of the three Goals of Universal Health Coverage of Quality of Care.

The innovative aspects of the project

- Capacity building, monitoring guidelines and inter-personal communication trainings of Medical Officers to encourage utilization of FCM.
- Inclusion of injection FCM in Essential Drug List of the state Health department.

Scalability

A significant improvement in haemoglobin levels over a period of three weeks: from mean haemoglobin of 9.07±1.15 to 11.17±2.34.

Effective large-scale use of injection FCM in the state led to incorporation of injection FCM in Government of India guidelines for Anaemia Mukta Bharat and Intensified National Iron Plus Initiative.

Contact Details

Email: addir1.health.fw@gmail.com

STRENGTHENING MIDWIFERY SERVICES to Improve Maternal Health

Problem Statement

Institutional Deliveries in Public institutions have tremendously increased in last decade in Gujarat especially in Medical College Hospitals (MCH). Urban health system is also not well-developed leading to additional burden on MCH. Hence, it is important to develop strategies to ensure quality intrapartum care.

Programme Description

Major objectives of innovations are as follows.

- Operationalizing Dedicated MLCUs (Midwife Led Care Units) at Medical Colleges.
- Strengthening Urban DH/SDH/CHC labour rooms with

Strong Midwifery Training in place: NPM training programme is offered in six nursing colleges across the state. This training made >300 NPM available for this model.

Implementation Process

- State level informal consultations to sensitize senior policy makers.
- Pilot project in four municipal corporations.
- Alternative Birthing Positions workshop for midwives.

Programme Outcomes

- Midwives conducted 45% of all vaginal deliveries at Surat Medical College Hospitals. during Feb-July 2016.
- Inborn SNCU Admissions reduced from 1145 to 798 during Apr-Jun 18 and Apr-Jun 19 for 1836 and 1849 deliveries.
- Admissions reduced in children with birth weight > 2500 grams (714 vs 440), preterm children 34-37 weeks (241 vs 143), Meconium Aspiration Syndrome (20 vs 12) and Sepsis (19 vs 12).

Scalability

This model has potential for replication for improving MNH care.

Implementation Partners

UNICEF Gujarat has supported conceptualization, planning and operationalization of MLCUs in urban areas and Fernandez Foundation supported alternative Birthing Position workshop.

Financial Implications

Major costs are for MLCU development, HR cost & trainings for skill updation leveraged from state and NHM budget.

Contact Details

Email: sukh.vairagi@gmail.com

OPERATIONALIZING OBSTETRIC ICUs

Problem Statement

Based on Maternal Death Review analysis for year 2014-15, nearly 90% of women reached to some health care facility before death. However, many of these facilities did not have required facility to handle life threatening complications. Present initiative documents efforts made towards improving quality of critical care in obstetrics to improve maternal health in Gujarat.

Programme Description

Objective

- To establish Obstetric Intensive Care Units (Obs ICU) in Medical College.
- To develop standardize treatment protocols in all Obstetric ICUs.
- To develop Information Technology enabled monitoring system.

Structure of Obs ICU

Human Resource: 1 Intensivist, 4 Medical Officers, 12 Staff Nurses & Monitoring & Evaluation assistant under supervision of Head of Department Obstetrics of the medical college.

Equipments: Each Obstetric ICU have standard list of 26 equipments as per national guidelines.

Infrastructure: One-time infrastructure up gradation cost sanctioned for every Obs ICU.

Implementation Partners

UNICEF Gujarat has provided continuous support to Government of Gujarat in operationalizing Obstetric ICUs and documentation of Initiative. Currently, UNICEF is supporting development of monitoring of parameters from Obstetric ICUs to develop appropriate responses to reduce maternal mortality within facility as well as across the board.

Annual Performance of Obstetric ICU:

Total of 9016 pregnant women with life threatening complications were admitted in 20 Obstetric ICUs in year 2018-19.

Financial Implications

National Health mission provided initial funding for innovating with three medical colleges. Presently out of 20 Obstetric ICUs, Seven are funded by NHM while remaining 13 are from state budget.

Conclusion

Obstetric ICUs have proved game changer in improving quality of care at tertiary care institutions. In days to come constant supportive supervision and delivery of required services at of these centers will help in improving maternal health in Gujarat.

Contact Details

Email: drbipinnayak@gmail.com

ACHIEVING MDG FOR REDUCTION IN MMR

Problem Statement

Maternal Mortality Ratio (MMR) in Gujarat was exceptionally high in 1990 with 202 women dying during child birth per one lakh live births. Despite of numerous efforts the MMR in the state has declined to 122 in SRS bulletin 2010-12. This reduction in Maternal Mortality Ratio was at the average rate of 04% per year.

Programme Description

Gujarat has committed itself to the UN target for the Millennium Development Goals (MDGs) for MMR at 100 per one lakh live births by 2015.

Challenges Faced

Geographical and socio - cultural diversity to ensure antenatal registration and services:

- Infection control practices in community and at health institutes.
- Availability of specialists – obstetrician, anaesthetists, paediatrician in public health institutes.
- Availability of blood transfusion services in public health institutes.
- Lack of informed referral system.

Process Followed

The MDR monthly and annual for cause and place of deaths was primarily is given priority to relocate resources for accessible maternal health services across the state. Restructuring First Referral Units, Blood Storage Units and capacity building was carried out since year 2013. Tracking of each pregnant and high risk mothers through (ASHA) and Female Health Worker (FHW / ANM) was ensured and monitored by Medical Officers and Taluka Health Officers through effective utilization of Information Technology platform.

Innovative aspects of the project

1. Effective use of IT – State specific MCTS
   a. Name based tracking of each pregnant woman.
   b. Ensuring reporting of maternal deaths.
   c. Early identification, tracking and management of High Risk Mothers.
2. Strengthening Maternal Death Review
3. Ensuring Qualitative services:
   a. Identification of High Priority Taluka.
   b. Strengthening CEmONC services.
   c. Strengthening Blood Transfusion Services.

Scalability

Comprehensive efforts and continuous monitoring of maternal health services has steeped reduction in Maternal Mortality Ratio, an average reduction of 13%. 373 pregnant women in a year and 1865 pregnant women in last five years.

Contact Details

Email: addir1.health.fw@gmail.com

SAVING MOTHERS-CARING FAMILY: First Referral Units

Problem Statement

Maternal Mortality Ratio (MMR) in Gujarat has declined from 172 per one lakh live births in 2001-3 to 91 in 2014-16. Special efforts are needed in implementing Comprehensive Emergency Obstetric Neonatal Care services to bring about a significant decline in maternal and child mortality. Many pregnant women and neonates die due to repeated referral or due to non-availability of specialists or health services.

Programme Description

Generally, CEmONC services are provided at First Referral Unit level and above. A functional FRU impacts availability of qualitative maternal and neonatal health affecting the overall mortality and morbidity.

Since the state has a population of 6.5 crore (Census 2011), about 129 First Referral Units (FRU) are ideally needed in Gujarat. As such, the state has opted for restructuring existing FRUs in a phased manner.

Time line of Implementation

103 FRUs were identified in the first phase in. Google Map was also used to identify functional FRUs within 50-km distance from each delivery point to ensure adequate coverage. for which the number of CEmONC facilities has gradually increased to 132 FRUs in 2017-18.

The innovative methodology

1. The state has considered various co-factors to ensure availability of comprehensive emergency obstetric and neonatal care services within the 'Golden Hour'.
2. Special requisition to allow blood storage units at First Referral Units (with less than 2000 units per year consumption).
3. District-level functionaries are actively involved in ensuring that all areas have access to good telecommunication links, as well as improving road connectivity/ transportation facilities in these areas.
4. The 'Plan-Do-Study-Act' (PDSA) measures are being considered to ensure accessible and qualitative CEmONC facilities across all designated FRUs.

Programme Outcome

These continuous measures have resulted in making available C-Section facilities in 83% (115) of designated FRUs. 388 maternal and 7416 infant death per year have been averted by providing CEmONC service.

Contact Details

Email: addir1.health.fw@gmail.com

COMPREHENSIVE CALL CENTRE (104)

Programme Description

National Health Mission (NHM) established a 24 x 7 Comprehensive Call Centre (27 seats) in 2016 with the objective of improving mother and childcare services through a single contact point for monitoring, ensuring traceability and providing information related to pregnancy and child immunization. Using toll free number -104, any citizen can get health advice/ information, avail counselling services, request directory information, or lodge a service complaint against any public health facility:

- Beneficiary can dial toll free 104 and connect to a Health Advisor/ Counsellor or a Doctor who addresses health related queries using medical health software applications.
- The grievances if registered at 104 are forwarded to the concerned authority and after resolution of grievances complainant is informed about the grievance redressal.
- Maternal and Infant Deaths are reported by ASHAs through 104.
- Folllow-up of RBSK vehicles/ teams, TB Patients, Counselling of Tobacco addicts is done through Comprehensive Call Centre.
- Interdepartmental Convergence- for food related grievances.
- ANC, PNC and Immunisation SMS & Voice Messages are sent to beneficiaries.
- Satisfaction and Feedback Surveys are conducted.

Financial Implications

MOHFW through ROP Approvals.

Programme Outcomes

- Total 2,99,257 calls have been received on 104 - since 2016 to till 22nd Aug'2019.
- Facilitated timely corrective actions and getting desired outcomes.
- Tracking of services of beneficiaries during ANC, PNC & Immunisation.
- Reduction of patient load to some extent at DH & tertiary care institutions.
- Follow-up with TB patients.

Scalability

Model is scalable and can be replicated in other states.

Contact Details

Email: md-hp-nrhm@nic.in

Bifurcation of Inbound Calls					
Health Advice Calls	22,550	24,441	31,658	14,353	93,002
Medical Advice Calls	6,357	6,046	6,083	2,578	21,064
Counselling Advice Calls	681	559	346	255	1,841
Total Health Related Calls	**29,588**	**31,046**	**38,087**	**17,186**	**1,15,907**

"OPERATION SUNSHINE" REDUCING NEONATAL CHILD MORTALITY UNDER PROJECT MANSI A PPP initiative

Problem Statement

About 26 lakhs newborn dies within 28 days globally out of which 6 lakhs dies in India. It states that 80% of deaths are not due to only illness like Pneumonia, diarrhoea, sepsis but also those babies which are born premature, low birth weight babies, breast feeding problem and are classified as high risk newborns. Most of these deaths are preventable if proper antenatal care, institutional delivery, timely referral and after discharge appropriate home based care is ensured by the Sahiya's/ ASHA's.

Programme Description

"Operation Sunshine" is an innovative digital platform for real time tracking system of high risk newborns or mothers through mobile android based application software with an integrated approach **for reducing neonatal child mortality under Project MANSI – PPP initiative under Jharkhand NHM.**

With the scale up of MANSI from one block to 10 block the focus was more on identification and tracking of all high risk cases till they are cured which emerged as a major challenge for the project.

Implementation

MANSI Community Health Facilitators are provided tablets with loaded application in English and Hindi which works off line also. Operation Sunshine dashboard is an online web portal at tatamansi.

Programme Outcomes

1. There has been 16% increase in the identification of high risk case.
2. With early identification of high risk case, timely referral, appropriate home based care and community case management there is an accelerated decline in deaths by 47% in same period of time.
3. First time such kind of application being deployed for High risk case management with an integrated approach.

Scalability

The project has been scaled up across all district of Jharkhand.

Implementation Partners (If any)

Project MANSI and the Operation Sunshine innovation is a joint initiative of Tata Steel Foundation, American India Foundation with active support of Jharkhand- NHM Community Monitoring Cell –Jharkhand.

Financial Implications

Technology development and deployment cost (14 lakhs), Support system cost (7 lakhs) is provided by the consortium of Tata Steel Foundation and American India Foundation.

Contact Details

Email: amit.kumar@tsrds.org
anupam.sarkar@aif.org

IMPROVING THE EFFICIENCY OF NBSU-SNCU NETWORK SERVICE DELIVERY by Re-distribution of Case Load Through Mentoring at Kolar District

Problem Statement

Kolar SNCU is overcrowded with doubling of babies under warmers. At least 30% of admissions were referrals from NBSU for Oxygen support or jaundice management in term babies. Mentoring the NBSU-SNCU network to optimise the resource utilisation by reducing the inappropriate referrals to SNCU and increasing the back referrals to NBSUs leading to increase in high intensive care bed availability in SNCU.

Programme Description

- NBSU gap analysis was done as per FBNC Operational Guidelines to assess gaps in infrastructure.
- NBSU doctors & nurses were trained for Emergency newborn care.
- Equipments were procured/repaired.
- Quarterly discussion of NBSU morbidity data.
- To & fro transport system between NBSU & SNCU.

Programme Outcome

- 20% reduction in patient days in SNCU due to less referrals from NBSU.
- Back referral of stable babies (term babies with no O_2) for completion of antibiotics and phototherapy decongesting SNCU. Back referral rate of 10%.
- Better data collection of NBSU teams.
- Improved team spirit between NBSU & SNCU.
- SNCU had fewer babies with doubling & antibiotic usage reduced by 20% and also treatment outcome of the unit improved.

Scalability

Back referral of babies from SNCU to NBSU is a novel concept. This can reduce overcrowding in SNCU so that they can concentrate on managing sick neonates with existing Human Resource.

Implementing Partners

This was part of Strengthening of Facility Based Newborn Care Services – taken up in collaboration with National Neonatology Forum – Karnataka.

Financial Implication

- Not applicable as existing resources were used with no new infrastructure/ human resource involved.
- Costs required are primarily for back referral ambulance which can be handled by making a policy to use '108' ambulance service or Nagu magu for back-referrals.

Contact Details

Deputy Director Child Health

INITIATIVE TO IMPROVE CARE SEEKING BEHAVIOUR OF YOUNG WOMEN for Sexual and Reproductive Health at 12 RKSK Facilities

Problem Statement

Young women aged 15-24 years constitute 19% of total female population. Evidence suggests that 53% of married young woman experience pregnancy between 15-17 years of age as Contraceptive prevalence is only 18% among married young women. Rural young women are apprehesice to discuss SRH issues, only 7% of young women are reported receiving amy information and majority of young women unaware of menstrual hygiene GoI MP in collaboration with Ipas Development Foundation (IDF) is strenghtening SRH services under RKSK intervention in 12 Blocks.

Fact Sheet

- Intervention sites: 12 RKSK facilities which are based in five districts.
- 29 female youth leaders are identified in this project to cater 328 villages.
- These 328 villages are surrounded to 12 facilities.
- Intervention started from Oct. 2018.
- House listing was done of 328 villages through youth leaders and identified 66,763 young women ages 15-24yrs in these villages.
- Youth leaders organized one to one and group meeting and sensitized 63,972 women on SRH issues till September 201 where majority of young women were less than 19 years (68%) and 32% were 19 -24years.
- Developed the referral linkages at identified 12 RKSK facilities where youth leaders sent young women for counselling and treatment during their community meetings.
- Youth leaders referred 28,230 young women at identified 12 RKSK facilities where 18,212 got services on menstruation, contraception, RTI, STI & safe abortion services.

Contact Details

Email: ddrksknhm@mp.gov.in

INITIATIVE TO DEVELOP MODEL COMPREHENSIVE ABORTION CARE (CAC) Center at Lady Elgin Hospital, Jabalpur

Problem Statement

Induced abortion has been legal in India for a broad range of conditions since the passage of the Medical Termination of Pregnancy (MTP) Act 1971. The national policies and guidelines further articulated the need for ensuring access to Comprehensive Abortion Care (CAC) for women.

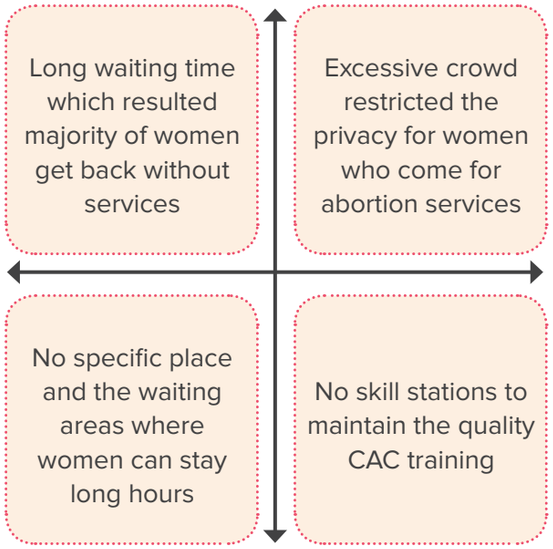
Government of MP in collaboration with Ipas Development Foundation in 2016 developed a model CAC center at Lady Elgin Hospital, Jabalpur.

Skill stations for CAC training room

- Developed six skill stations at CAC training room to improve the quality CAC training so that post training medical officers can start the services immediately.
- Effective utilization of the time of Medical officers (trainees) skill stations and understand the core subjects of the CAC.

This intervention has resulted in not only increased number of women served, but maintained the quality services for women. Strengthening the facility in terms of both intervention, separate CAC services and developed skill stations in CAC training rooms. It results in better outcomes in terms of services provision and quality training.

Reason for developing Model CAC Centre



As a result of this intervention:

- 38% cases per month have increased. The average cases.
- Women's satisfaction is very high as they have started getting privacy, adequate sitting arrangement, proper counselling, changing room, rest room and other amenities in one place.
- Reduction in waiting time for CAC services.

Contact Details

Email: maternalhealthrch@gmail.com

CARE COMPANION PROGRAMME FOR MATERNAL AND NEWBORN HEALTH

An Initiative for Capacity Building of Family Caregivers

Programme Description

CCP aims to empower families to adopt healthy behaviors when they spend time in healthcare settings. As families gather at facilities, this is an effective form of activating the practice healthy behaviors at a time they need it most. By teaching family caregivers high-impact skills, the Programme helps in reducing preventable post-discharge complications.

At present, the CCP focuses on Maternal and Newborn Health and has been implemented across all 51 District Hospitals in MP. CCP trainers (nurses and counsellors) conduct regular, structured sessions in ANC OPD, PNC wards, post-op wards, and SNCU wards. The staff conducting the trainings were trained through a rigorous curriculum to become engaging health educators for low literacy populations. Flipcharts, videos, and handouts (prepared by medical and creative experts) are used by the staff to conduct sessions. The training targets not only the mothers - but the fathers, grandmothers and other relatives within facility as they are key influencers of health behaviors. The family caregivers are also able to opt in to receive health messages and videos on WhatsApp after they return home - simple health queries are also answered with this service. From March 2019 to September 2019, over 66,000 caregivers have been trained in the State.

Scalability

The CCP is a simple yet effective programme with a broad impact on health systems, providers, and of course patients. Previous evaluations of the CCP show a significant increase in practice of key healthy behaviors (i.e. KMC by 84%), a 57% decrease in post-discharge neonatal hospital readmissions, and a 24% decrease in post discharge neonatal complications. Staff find the training in groups in a standard format to be efficient, saving them time overall by answering most of the mothers and families questions during the session. The programme has a vast potential for scale to other medical condition areas and facilities.

Implementation Partners

Care Companion Programme (CCP) is a Madhya Pradesh State initiative, implemented by NHM-MP, in partnership with YosAid Foundation. The programme was originally conceptualized by Noora Health.

Financial Implications

No information provided.

Contact Details

Email: maternalhealthrch@gmail.com

STRENGTHENING OF CHILD DEATH REVIEW SYSTEM

Using CDR Software

Problem Statement

Every year more than one lakh children under the age of five year die in Madhya Pradesh (SRS 2017), it is important to systematically collect and review data to prevent such child deaths. Prompt reporting and review of child deaths (0-59 months) can provide insight into: to identify the bottlenecks of health services, to recognise key gaps and to evaluate trends in causes of child mortality. Before 2015, in Madhya Pradesh there was no proper mechanism of getting child death data from community, blocks to District and state level as per GoI Guidelines of Child Death Review.

Programme Description

Web based reporting system for CDR was launched in August 2015 for data entry at block level. Implementation was started first from SNCU, established across the state, followed by block level handholding and trainings.

Programme Outcomes

- All 51 districts and 313 blocks are reporting in software.
- 72% neonatal deaths, 18% infant deaths and 10% child deaths have been notified since launch.
- Till date 1,25,481 child deaths have been reported in software. 44,325 deaths from community and 81,156 deaths from Government health facilities.
- Out of 44,325 community deaths, 21,992 cases have been reviewed by ANMs & Out Of 81156 facility deaths 36,127 cases are reviewed by Medical officers.
- 7,554 verbal autopsies and 5,883 social autopsies have been conducted for community deaths to elicit medical and social causes.

Scalability

- Software is designed based on National Guidelines of CDR.
- No additional Human resource is required for implementation.
- No cost is involved in development and implementation of software.
- Auto generation of compiled report is done within no time.
- Reports can be downloaded for analysis and taking corrective measures at different level health officials.

Implementation Partners (If any)

Only NHM.

Financial Implications

No cost was involved in development and implementation of software.

Contact Details

Email: ddchnhm@mp.gov.in

IDENTIFICATION OF HRPW AND BATCHING AND MATCHING

for Safe Institutional Deliveries

As Per SRS MMR Bulletin - 2015-17 maternal mortality of Madhya Pradesh is 188 per lakh live births which is quite higher than national average (122 per lakh live births). State has committed to reduce it to 70 per lakh live birth by 2030 under Sustainable development Goal.

Programme Description

To improve the quality ANC department of health and family welfare, has started Batching and Matching of high-risk pregnant women with service provider and with facility for institutional delivery.

Programme Outcomes

- Eligible couple tracking by ASHAs for menstrual cycle.
- 90% ANC registration against the annual target.
- All ANMs are providing ANC services at VHNDs At least 85% ANC registration in first Trimester.
- High Risk Pregnant women identified by ANMs.
- Regular sector meeting on Saturday
- All sectors have batching and matching plan.
- Gynecologist CHC visit plan
- Facility wise monthly delivery plan
- 100% HRPW tagged with facilities for safe delivery.
- 100% entries in Anmol/RCH portal.

This RCH mirror portal is integrated with RCH portal so that the entry in RCH Mirror portal automatically will transfer to ANMOL and RCH portal. RCH mirror portal has following characteristics:

- ANM will get month wise EDD calendarLine list of PW.
- Sector medical officer will get the line list of All PW.
- Each facility will get the line list of matched PW for delivery.
- Gynaecologist will get the month wise line list of PW to be delivered in her facility.
- Dashboard for Sector, Block, District and State level.
- Payment gateway for Conditional cash transfer scheme.

Batching and Matching of HRPW with facility will reduce in-appropriate and multiple facility referrals. Also helps in reducing normal delivery load on L3 delivery point so that the High-Risk cases will get proper attention. Over all impact of batching and matching would the early identification of pregnancy, high risk factors and delivery of each cases at appropriate facility with real time monitoring at each level.

Contact Details

Email: ddmhnhm@mp.gov.in

ADOLESCENT HEALTH INFORMATION through story books in form of comics

Programme Description

Madhya Pradesh is implementing the Peer Educator Component of Rashtriya Kishor Swashya Karyakram (RKSK) in 13 districts of the State to promote health and wellbeing of the adolescents.

National Health Mission, MP, in partnership with United Nations Population Fund (UNFPA) conducted consultation with adolescents and Saathiya to understand exact expectations from job aids for conducting monthly sessions and they suggested that material should have pictures, less text and in form of story.

Based on the recommendations from Saathiya and adolescents, 24 comics were developed on 8 key thematic areas namely Nutrition, Substance misuse, Physical and emotional changes during adolescence, sexual and reproductive health, child marriage, mental health, gender based violence and self-awareness.

Salient features of the comics

- 3 comics for each of the 8 themes.
- Branding of Saathiya as Madhav and Muskan characters across all the comics.
- Interesting storylines developed for each comics keeping in mind the audience. Scripts developed by professional writers.
- Only 2-3 key messages are delivered in each comic making it easy to remember. Suspense created at the end of each comic to raise curiosity and ensure participation in subsequent monthly sessions.
- Mentoring chain used effectively to provide comics in each of the program village on monthly basis.
- Monthly Cluster level mentoring cum review meetings with Saathiya and ASHA are used for comic distributions and practice session on upcoming months comic.

Programme Outcomes

NHM, MP has received positive feedback from the field on village level session and some of the key impact of comics on village sessions are as follows:

- More than 70% Saathiya are conducting monthly session with their groups using comics.
- Comics are not only read by the adolescent in the group but also by other adolescents not enrolled in group as well as parents contributing to increased awareness and knowledge on adolescent health issues in villages.
- Saathiya and ASHA participation increased in cluster meetings and more than 75% Saathiya participate in monthly mentoring meetings.

Contact Details

Email: ddrksknhm@mp.gov.in

MATERNITY WING MANAGEMENT INFORMATION SYSTEM (MW-MIS): Monitoring Tool for Assessing labor Room Practices and Decision Making

Problem Statement

Quality of Maternal and New-born care during intra and immediate postpartum period is a big concern. MMR in the country has reduced from 310 (2001-03) to 167 (2013) and IMR from 66(2001) to 34 (2016). Still the indicators are too high

Problem Description

Maternity Wing ManagementInformation System was developed in April 2016 to capture evidence-based best practices that should be performed for every pregnant woman and new-born coming to the facility.

Programme Outcome

MWMIS expects to achieve

A transparent system for monitoring of services delivered to the mother and new borns to enhance the Quality of Care around birth

MWMIS also facilitates the decision making process, by generating facility-wise dashboard indicators; thus easing the process of supervision and monitoring in the labor and Maternity wards

MWMIS improves accountability of service providers through improved recording, reporting and utilization of data for supervision and monitoring.

MWMIS will help to attain the targets as specified in LAQSHYA a “Labor room Quality Improvement Initiative”.

Implementing Partners

Maternal Health Division , Department of Health and Family Welfare, Government of Madhya Pradesh ,IT Cell , Madhya Pradesh and Jhpiego

Financial Implications

One-time cost for developing the MWMIS application is around 5 lacs which include the cost of server as well as software. Cost of HR also needs to be considered as Data entry operators will have to be posted for data entry work.

Scalability

The Project has the capacity for replication at all the health facilities

Contact Details

Email: maternalhealthrch@gmail.com

LEVERAGING TECHNOLOGY FOR IMPROVED SERVICE PROVIDER COMPETENCY

Programme Description

The Government of India launched the LaQshya program in December 2017 to reduce preventable maternal and neonatal mortalities and morbidities by improving the quality of healthcare services, timely identification and referral of complications around the time of birth.

During baseline assessment of LaQshya facilities in Februay-March 2019, it was observed that apart from infrastructure, Human Resources, documentation, equipment's gaps, there is urgent need to improve skills and knowledge of staff posted in labour rooms on key labour room practices to achieve LaQshya certification. Government of Punjab with support of USAID-Vriddhi planned to implement this blended learning approach to improve knowledge and skills of health providers in LaQshya Facilities.

Safe Delivery App

Safe Delivery App has a self-assessment module which is called my learning platform. It contains 3 levels of examination for each module i.e. familiar, proficient and expert level. After achieving expert level, a case study based exam gets unlocked and if the score is above 70%, the user will get safe delivery champion certificate.

Scalability

After these encouraging results Government of Punjab has decided to scale this initiative across all delivery points to improve knowledge and skills of all staff nurses and Medical Officers on key maternal and neonatal signal functions.

In the words of Dr. Avneet Kaur, Director Health Services, Punjab, "One reason for the successful roll out of this app is that the App instantly give results to the user. This is a huge encouragement for the nurses, we are also felicitating the champions at the state level, which is providing motivation to more and more facility staff to use the App and take the certificate exam".

Dr. Inderdeep Kaur, Program Officer (MCH) in the Directorate of Health Services, Punjab believes that "The quality of safe delivery app training at state level, continuous motivation and guidance by senior state and district level authorities and strong endorsement by the medical colleges including Head of Department of O & Gand sharing safe delivery champion certificates in the state WhatsApp group where facility providers are connected resulted huge dividend to the state which witnessed highest number of safe delivery champions in the country".

Contact Details

Email: cppnhmpunjab@gmail.com

INNOVATIVE UTILIZATION OF TECHNOLOGY FOR ANTARA (IC-IM, DMPA) Clients for Retention, Continuation and Follow-up

Problem statement

Antara programme was rolled out in July 2017 in Rajasthan. A large number of **Drop outs** were observed due to non-remembrance of next due dose by the clients, anxiety related to side effects, and lack of follow-up mechanism by service providers.

Programme Description

To address these issues, an online application was developed in July 2018 with the following features:

- In less than a minute a DEO can enter a client's case and subsequent dose can be updated in less than 15 seconds.
- In built system for pre-recorded phone calls and sending reminder next dose SMSs in Hindi to clients at fixed interval: 1st: registration, 2nd: 83rd, 3rd 90th Day, 4th 97th day, 5th 111th day, 6th 118 day:
- Utilization of line-listing data for data triangulation and analysis. Antara Raj is the only portal which provides age and parity wise distribution of clients along with longitudinal follow-up trend of individual client.
- Utilization of clients' data for counselling.
- Generation of structured Due List for followup & counselling.
- Covers all facilities upto PHC level (SC module in selected facilities).
- Facility to search, track, and add subsequent dose of any registered client across all facilities of Rajasthan.

Programme Outcome

From July 2018 to Sept 2019 total 2,27,697 doses were reported. Out which of which 78% doses line-listing is updated into the portal. 86% of users data (1,07,850/1,24,439) have already been updated. Continuation rates of 2nd dose increased from 49% (Aug-18) to 61 %(Sept-19) and similarly continuation rate of 3rd dose increased from 56% (Aug-18) to 68% (Sept-19).

Financial Implication

Initial Development cost was born by IPE Global. After one state level training, other district level trainings were clubbed with ongoing IT/FPLMIS trainings with no additional budget.

Scalability

Initially it was designed only for MPV districts of Rajasthan, but within 3 months it was scaled up throughout the Rajasthan and can be scaled up rest of the country.

Contact Details

Email: spm_raj.nrhm@yahoo.com

HAUSALA SAJHEDARI: Giving Impetus to Private Sector Engagement for Family Planning Services

Problem Statement

As part of the global FP2020 commitment, Uttar Pradesh (UP) in India is expected to contribute over 12.4 million new Family Planning (FP) users, which is 10% of the global commitment.

Programme Description

GoUP rolled out Hausala Sajheedari, a web-enabled e-governance digital platform' in UP that addresses the entire value chain from online application for accreditation, verifications, approvals, online MOU, maintaining digital data of FP beneficiaries by the accredited private providers, to submission of online claim and online reimbursement of claims using PFMS systems of GoI.

The portal provides real-time information through a simple dashboard for quick stock taking and review of progress and grievances. The model has a robust verification process, which mandates physical verification of the facility to assess infrastructure and assures that mandatory norms defined by the FP sub Committee of DQAC are met with. Mandatory physical verification of 10% FP clients by team from DPMU and CMO before approving claims.

Programme Outcome

More than 7 lakh additional users of FP services from accredited private sector hospitals in UP. In FY2018-19 there is 21% female sterilization performed as compared to 1% in FY 2014-15. Similarly the male sterilization contribution by private sector under the programme is 18% to the overall male sterilization numbers reported by the state in the HMIS in FY2018-19 which was almost 0% in FY 2014-15. 39% clients served were from SC/ST community whereas 54% of the FP clients were from BPL category.

Financial Implication

A strategic purchase model with zero CapEx and the cost of reimbursement is also fixed and decided by NHM-GOI. This model demonstrates responsible use of public money towards providing the quality family planning services to the marginalized section.

Scalability

The programme has already been scaled in all 75 districts and well positioned in playing a complementary role in shouldering responsibility with the government in providing free/low cost family planning services to poor population. Government of Odisha and MP are in the process of replicating similar PPP model.

Contact Details

Email: pspcellup@gmail.com

EMERGING INITIATIVES

ABHWC

IMPORTANCE OF STANDARD OPERATING PROCEDURE IN URBAN PRIMARY HEALTH AND WELLNESS CENTRE

Problem Statement

There were no SOPs for Urban PHCs till so far. SOPs are very important for a health worker. It is a step by step instructions compiled by an organization to help workers carry out complex routine operations. SOPs aim to achieve efficiency, quality output and uniformity of performance, while reducing miscommunication and failure to comply with regulations. It is a guide for all.

Programme Description

Strategy adopted to develop SOPs for the UPHCs.

A committee comprising of State Quality Assurance Cell and State NUHM cell was entrusted to develop the SOPs .The SOPs were accordingly developed and disseminated. While developing the SOPs, the following points were prioritized so that it is explicit:

Objective of SOPs

The objective of SOPs is to improve efficiency & quality of the health worker for doing his/her activities/responsibilities by laying out a set of Standard instruction for any regular work.

Process of Writing SOPs

Basic Steps to be followed while preparing SOPs:

1. Introduction of the title or activity.
2. About the goals and objectives of particular activity (SOP).
3. Committee details/responsible persons those who are to follow the SOP.
4. Responsibility/ Expectation from the committee or a person.
5. Expected outcomes and analysis of the outcomes.

SOP Dissemination

These SOPs were then circulated through the District Urban Health Coordinator (DUHCs) to all the NUHM covered districts of Assam and thereby UPHCs.It was also ensured that a monitoring mechanism was put in place to monitor the implementation of the SOPs.

Expected and Actual Outcomes

SOPs will facilitate the health workers to remember their routine work to ensure continuity in the absence of any worker:

- It will also ensure quality standards of all services provided in the UPHC.
- It will improve patient satisfaction.

Scalability

It will be scaled up to all the 14 NUHM covered districts of Assam covering all the Urban Primary HWCs.

Contact Details

Email: qualitynhmassam@gmail.com

EAT RIGHT INDIA MOVEMENT AT HWCS

Problem Statement

'Eat Right India' Movement, an initiative undertaken at Health and Wellness Centres (HWCs) to spread awareness amongst the public regarding the importance of consuming safe and healthy foods to curb food borne diseases and enable them to adopt a healthy lifestyle.

Programme Description

Various awareness activities for the public regarding importance of eating healthy and safe food in collaboration with The Food Safety and Standards Authority of India (FSSAI) were undertaken at the HWCs. Workshops for testing food items for detection of food adulteration, organising seminars, importance of fortified foods and harmful effects of high intake of sugar, salt and oil and testing of food items brought by community members from their homes to check for adulteration through a food testing van stationed at all HWCs. In order to strengthen the HWCs with dental and AYUSH screening services, RBSK and RKSK programme has been re-structured wherein the dental surgeons and AYUSH doctors have been stationed at all HWCs. This would also require skill building of primary health care team in understanding the importance of eating safe and healthy and enabling an identified health worker to undertake food adulteration activities at HWCs in collaboration with FSSAI.

Programme Outcomes

Presence of a full-fledged, pro-active operational Food Safety Cell comprising of staff adequately trained in food adulteration and well-equipped mobile food sampling van available at HWCs as per roster for ascertaining adulteration in food items has resulted in an increase in number of food samples received for testing in mobile testing van from 10-20 food samples to 110-120 after collaboration with HWCs. The success is documented with the number of queries being received from the residents regarding checking of adulteration of food articles. This has also resulted in an increase in community participation in creating awareness and people practising healthy eating habits.

Scalability

Using PHC teams at HWCs has the potential to scale this effort in other states as HWCs become operational.

Implementation Partners

National Health Mission, Chandigarh in collaboration with FSSAI.

Financial Implications

Activities carried out by Food Safety Cell.

Contact Details

Email: nrhmchd@gmail.com
sangeeta.ajay26@gmail.com

FOOD FORTIFICATION INITIATIVE

Problem Statement

In Haryana prevalence the of anemia in among children is 71.7% and for non-pregnant and pregnant women is 63% and 55% respectively as per NFHS-4. There is also high prevalence of Neural Tube Defects (NTDs) in the State. which points out that Iron and Folic acid supplementation programmes have not been very successful thus, Food Fortification Initiative was taken up to address these micronutrient deficiencies.

Programme Description

A three-phase strategy was adopted over a five-year period. In Phase 1, a cross-sectional household survey with biomarker data (hemoglobin, ferritin, red blood cell folate and serum folate and vitamin B12) among non-pregnant women of reproductive age (18-49 years), birth defects surveillance, a supply chain analysis, a community needs assessment, and community sensitization was conducted in 2016-17. In Phase 2, the implementation of the wheat flour fortification project, monitoring of the fortification project and continuation of birth defects surveillance is being done.

Programme Outcomes

The key finding from the surveys highlight that the majority of the population surveyed was vegetarian (87%) and wheat was used as the staple food (98%). Most of households (96%) possess ration cards and around 63% utilized PDS for purchasing wheat grain. The prevalence of folate deficiency was 11.3% (95% CI: 9.2, 13.9) for serum folate, and the prevalence of RBC folate insufficiency was 78.6% (95% CI: 74.8, 82.5). A total of 58.3% (95% CI: 54.2, 62.5) of women were vitamin B12 deficient.

Distribution of fortified wheat flour in Public distribution System (PDS) was started in 2018. Based on the positive feedback from beneficiaries and increase in the off take of fortified wheat flour (96%) compared to wheat grain (80%), the Government of Haryana scaled up this Programme in 2019. Phase 3 will be conducted once there is a continuous use of fortified wheat flour by beneficiaries for at least 18 months.

Scalability

This initiative will help create a feasible, affordable, sustainable and a scalable model.

Implementation Partners

WHO, Health/NHM-Haryana, WCD/ICDS, Public Distribution, Education Departments.

Financial Implications

State Budget of respective Departments.

Contact Details

Email: ddshsrc@gmail.com

INTEGRATION OF SPATIO-TEMPORAL FRAMEWORK IN STRENGTHENING PUBLIC HEALTH SURVEILLANCE SYSTEM

Problem Statement

Despite several efforts to improve the availability and access of quality health care to people especially those residing in rural areas, the state of Jharkhand is faced with the challenge of high mortality, low immunization of children and expectant mothers and low institutional delivery due to remote geographies.

Programme Description

A spatial mapping of ASHAs from 32,000 villages of Jharkhand distributed across 5 regions and 24 districts around 188 community health centers was conducted. For the first time, the catchment area of 38,000+ ASHAs was demarcated and mapped across the geography with the rationale of equal work load distribution, accessibility and geographical isolation.

Unique code provided to ASHAs with spatial information helps in smooth flow of information and in mapping of attributes associated with the ASHA such as the education and social status and facilities they are equipped with.

Programme Outcome

As an attempt to make this information accessible, an application “PLA Dashboard” (www.plajharkhand.com)has been developed and integrated with the “National Health Mission, Jharkhand” website (http://jrhms.jharkhand.gov.in/). Integrated spatially, the MIS record gets reflected at the village to Health Sub Centre (HSC), Cluster, Block, District and State level.

Scalability

The application is easily scalable to strengthen measurement of ASHA’s performance and streamlining of payments.

Implementing Partners

National Health Mission, Jharkhand and Ekjut

Financial Implications

The application is funded by Children Investment Fund Foundation, UK in collaboration with NHM, Jharkhand.

Contact Details

National Health Mission, Jharkhand and Technical Partner, Ekjut, Chakradharpur

NAMMA SAMUDAYA

An Android Based Integrative Community Activity Platform in Bengaluru City

Problem Statement

Time and again, international and national health organisations including Indian Council for Medical Research (ICMR) have highlighted the need for good data quality in healthcare in India. A community database for easy visualization of health and demographic parameters is essential in urban health planning.

Programme Description

We modified the vulnerability assessment tool for ASHAs from the "Guidelines and Tools for Vulnerability Mapping & Assessment for Urban Health-2017" in consultation of dept of community medicine, Bangalore Medical College & Research Institute, to:

- Enable collection of more granular data.
- Use as a tool for population enumeration.
- Create family health folders.

Namma Samudaya is an android based application for household level vulnerability mapping and health assessment using the modified tool. The Community based Assessment Checklist (CBAC) for non communicable diseases has been linked to this application for avoiding multiple visits. The collected data is geotagged and enables Medical Officers and the managers plan community based activities effectively.

This enables integration of all surveys under single platform and linking to the existing Public Health Information and Epidemiological Cell (PHIEC) of BBMP and thereby linking the community to the health facilities.

Programme Outcomes

Data of 25,000 households and CBAC of 20,000 individuals completed through the platform. It has made possible effective outreach through understanding the distribution of vulnerable population and health parameters at a better resolution.

Implementation Partners

Department of Community Medicine, Bangalore Medical College & Research Institute.

Financial Implications

Rs. 4.5 lakhs from the funds for vulnerability assessment (app development, training, M&E).

Contact Details

Email: cpmobbmp@gmail.com

BUILDING COMMUNITY OWNERSHIP ON HEALTH

Health Review and Planning System Led by Ward Health Sanitation and Nutrition Committee (WHSNC) and ASHAs

Problem Statement

Need to strengthen the effectiveness and accountability of ASHAs and coordination with Ward Health Sanitation and Nutrition Committee (WHSNC).

Programme Description

A redistribution of work area of ASHAs across state, was undertaken to make it 'One ASHA per Ward', as per the panchayat ward. ASHA was made Coordinator of WHSNC (Ward Health Sanitation & Nutrition Committee) of each ward with a population of 1500. Based on a State Government GO (in March 2019), a process of Ward Health Review, has been started, which is to be organized by ASHA. ASHA presents the ward health report of previous month and review and planning of health activities is done. JPHN/ JHI in charge of ward provides technical inputs.

Subsequently, Monthly Panchayath Health Review is organized by Health Inspector at Panchayath/ Municipality/Corporation level, attended by LSG members, ASHAs, Medical Officers and other health workers of Allopathy and AYUSH systems, with consolidation of all Ward Health Review reports submitted by the JPNHs. State has increased the additional monthly honorarium to ASHAs that is provided from state budget, to Rs. 4500 per month. A system for evaluation of her work by community, on 9 criteria, has been put in place, in which ASHA has to get signature from 80% households of her area as validation before receiving the incentive.

Programme Outcomes

These initiatives have resulted in ward and panchayat level health care review, planning and accountability system, which is owned and led by Panchayats and Municipal bodies, and facilitated by ASHAs and WHSNCs.

Scalability

Its scalability outside the state will be based on the improvements in health outcomes seen in due course.

Implementation Partners

State NHM team and Department of Health have worked with Local Self Governance Institutions, other departments and ministries of state.

Financial Implications

No separate financial allocation were made.

Contact Details

Email: kmseena@gmail.com

PROJECT PUNCHIRI: Oral Health Among Students in Kannur District

Problem Statement

Untreated dental caries among the school going children andlimited awareness and adoption of practicesfor maintaining oral hygiene.

Programme description

The project was conducted in 124 government schools in the district from November 2018 to February 2019. RSBK Nurses were trained to detect any abnormalities in the children's teeth. Thereafter, dentists examined the children who have been referred by the RBSK nurse from various schools. Parents/ care givers were interviewed for their knowledge levels and the practices regarding oral health following which clinical examination of children was conducted. The specialized oral health examination was performed in order to check for caries, dental fluorosis, malocclusion, developmental anomalies and oral hygiene status. The examination was carried out in schools under fluorescent torch light with the patient sitting in the upright chair.

Programme Outcomes

In the duration offour months, around 47,531 children were screened in the district. Around 22% of students were identified with some dental issues, out of which almost 58% of children were referred to higher facilities for prompt and advance treatment. The parents/ caregivers were given oral health education classes in order to enhance the oral hygiene of their wards.

Scalability

There is good integration with RBSK program, which can facilitate scaling up.

Contact Details

Phone: +91-944731150

"OUR VILLAGE, YOGA VILLAGE"- "SAMPOORNA YOGA GRAMAM" (SYG)

Problem Statement

A survey carried out among the community found that adults 1 out of 3 have hypertension, 1 of 5 have or falls in the risk group of diabetes; study revealed that 45-69 years age group of over two third of the population (67.7%) is either diabetic or pre-diabetic.

Programme description

SYG is a holistic initiative in order to bring awareness on healthy lifestyle and improve their skills through Yoga practices covering all wards in Muhamma Panchayat, Kerala. The project is aimed to propagate the potentials of Yoga as a people's movement driving it to be an integral part of people's life to achieve holistic health and wellbeing intend to reach out to 30000 population across 16 wards

Programme Outcomes

Muhamma Grama Panchayat was declared as Sampoorna Yoga Gramam bytraining 23575 no. of people out of 30000 population. Positive outcomes as from participants comprising of Senior citizens pointed out that there was a decrease in pain related to joint inflammation, improvement in body flexibility, movement etc. De-Stress, weight management, enhancement in physical and mental health was shared by student participants.

Scalability

The idea is to replicate the success of "SYG" model across Kerala as in a phased manner by training at least 50% of population in each Grama Panchayat.

Implementation Partners

NAM, NHM, ISM department, Homeopathy Department, LSG Department, Govt. of Kerala

Local NGOs and support group

Financial Implications

Met by NAM and Gram Panchayat and local sponsorships

Contact Details

Email: namkerala@gmail.com

HUB AND SPOKE MODEL: Improving Accessibility to Diagnostics at Primary Care Level in District Khandwa

Problem Statement

Non availability of Lab Technicians and infrastructure is a major issue in providing diagnostic services at Primary Health Centres.

Programme Description

Diagnostic services are expanded by following the hub and spoke model, creating 7 hubs (Central Diagnostic Unit) at 5 CHCs and 2 PHCs (where lab technicians were available) covering 27 PHC-HWCs (spokes). Samples are collected from the spokes during OPD hours, transported to the nearest hub by transporter (staff or field worker) and the reports are brought back to the spoke facilities in evening. Before setting up hubs, detailed gap assessment was done to know the availability of diagnostic equipment, logistics and supplies; capacity of lab technicians and other requirement. The District Health and Wellness Committee known as District Arogyam Committee ensured logistics availability. Capacity building of lab technicians was done by attaching them to diagnostic lab of District Hospital for a week to enhance their skills. Certain challenges faced include overburdening of LTs at hubs, and delays in sample and report transfer as it is dependent on transportation system. Adopting Khandwa model, state has scaled up hub and spoke model to all HWCs of 51 districts where lab technicians are not available.

Programme Outcomes

Number of diagnostics made available at PHCs have increased from 19 to 48 tests. Hub and spoke model helped to minimize the movement of the patient and improved the timeliness of reporting.

Scalability

The model has potential of scalability when implemented with commensurate planning to maintain quality of transportation and hub strengthening.

Implementation Partner

National Health Mission, Madhya Pradesh; USAID-MCSP/JHPIEGO

Financing mechanism

In the initial phase, District Arogyam Commtiee (DAC) coordinated with Rogi Kalyan Samiti (RKS) to provide INR 90 per day for transporting sample and bring report back to the spoke. State has made provision of Rs. 300/ per day for the transporter for the time being by utilising free pathological services funds under laboratory strengthening activity, to ensure sustainability.

Contact Details

Email: drtiwari.hwc@gmail.com

IMPACT OF COMMUNITY HEALTH OFFICERS PERFORMANCE in Health and Wellness Centres on NITI Aayog Indicators

Problem Statement

The public health care delivery system largely focuses on provision of care related to RMNCH+A & few communicable diseases. The conditions together represent merely 15% of all morbidities. Death from NCDs accounts nearly 62% of all mortality among men and 52% among women. Further, health care is largely sought at the level of district hospitals and people are availing care from private sector that leads to high Out of Pocket Expenditure (OOPE). To address this morbidity burden, reduce OOPE and for ensuring continuum of care state has positioned trained Community Health Officers (CHOs) at SHC-HWCs.

Programme Description

State undertook evaluation of CHOs actively in SHC-HWCs in NITI Aayog indicators in Osmanabad district of Maharashtra from April 2019 to August 2019.

State has posted Community Health Officers at SC- HWCs. The members of primary care team at SHC-HWCs are trained in a set of skills are focusing on preventive and promotive health along with providing a package of services of high quality, using standard treatment protocols with assured referral. All the population above 30 years of age are screened for hypertension, diabetes and common cancers and free of cost treatment is provided.

Programme Outcomes

The Percentage of ANCs registered within the first trimester increased from 89.67% to 93.24% and Percentage of Pregnant Women (PWs) registered for ANCs to total estimated pregnancies are also increased from 91.88% to 95.02%.

Percentage of newborns breastfed within one hour of birth increase from 95.80% to 99.18%. Percentage of live babies weighed at birth increased from 99.69% to 99.94 %.

Tuberculosis (TB) case notification rate (Public and Private Institutions) as against estimated cases increased from 57.24% to 78.75%.

Scalability

This model is scalable and can be used as regular monitoring mechanism for HWCs where CHOs are posted.

Contact Details

Email: shsrc.gom@gmail.com

ENGAGING COMMUNITIES IN HEALTH AND WELLNESS CENTRE ACTIVITIES

Problem Statement

To make Comprehensive Primary Health Care services available close to community, Health Wellness Centres are being established under Ayushman Bharat, by transforming Health Sub Centres (SCs) and Primary Health Centres (PHCs). Local communities need to be engaged actively in HWC's activities, for better awareness of services available, and their participation in Health Promotion.

Programme Description

During the initial process of establishing HWCs, an awareness Programme is conducted at village level, in every HWC on a pre-fixed day. The community members, elected representatives, are invited. Information is shared and discussions are held on various issues, such as; a) Rationale for HWCs –changes in disease pattern and need for comprehensive primary health care and importance of wellness activities such as Yoga, b) Role of CHOs, their qualification, the 6 months training, etc., c) Inter-sectoral Coordination and Convergence with NREGS, PHED, Social Welfare, PRI, etc., d) Potential areas for role of community; maintaining clean hospitals, counseling resistant families for accessing health services like immunization, and in ensuring safety of staffs and facility, e) Services under HWCs particularly on the NCDs – screening for Hypertension, Diabetes and Common Cancers (oral, Breast & cervical), and Referral Facilities. Initially the teams from state conducted Programmes in each village, later districts and Blocks themselves conducted them.

Programme Outcomes

Awareness Programmes were held in 27 villages, in 1st phase, and in 58 facilities in 2nd phase, with a participation of 30 to 80 people. These Programmes helped in building communication and team spirit with community, and in creating ownership of the HWCs, in the community. This initiative helped in monitoring of ongoing infrastructural development works, giving feedback to concerned MOs, and CMO of the district, and help in timely completion & operationalization of the facility. Uptake of healthcare services increased, esp. regular check-ups for NCDs increased.

Scalability

All components are already integrated into HWC model, requiring additional sensitization and orientation of PHC teams.

Financial Implications

No separate budget was available. Expenditures were made from the IEC funds under HWCs.

Implementing Partners

Manipur Govt., JHPIEGO, RRC.

Contact Details

Email: shms99@gmail.com

JOINING HANDS WITH COMMUNITY for Quality Health Services at Health and Wellness Centers

Problem Statement

Low institutional delivery is a key concern of the State of Nagaland, with NFHS-4 reporting 33%institutional delivery. The available infrastructure at the Sub-Centreis not conducive forconducting delivery at the facilitiesdue to lack of functional labour room, unavailability of trained HR, community faith in home delivery and poor transportation facilities in the rough terrain.

Programme Description

Village leaders and other influential individuals were oriented on community participation as a mechanism to improve health outcomes through Health and Wellness Centres (HWCs). Village Health Committees (VHCs) took charge of upgradation of existing sub centers into HWCs. These committees ensure funding transparency and construction/upgradation of existing Sub-Centers. VHCs also contributed to the construction of a community kitchen adjacent to HWC for the use of family members. This effort has benefitted 82727 populations in the catchment areas of these 49 HWC-SHCs facilities.

Programme Outcomes

VHCs were involved in monitoring of construction of wellness rooms at HWCs. Most of upgradation work has been completed with full transparency, as many local priests/other influential individuals in the village are members of these health committees. Further, village councils serve as a monitoring body in carrying out any development in the village. 49 HWC-SHCs have an adjacent community kitchen constructed through community support and in 19 HWC-SHCs out of 49 operationalized HWC-SHCs, CHOs have started conducting institutional delivery. Patientsare using the community kitchen for boiling water, cooking food, etc. This has helped in promotion of institutional deliveries in the HWC-SHCs. This initiative helps in strengthening the Communitisation Act and to create more community ownership for ensuring health services.

Scalability

State will propose this initiative under NHM PIP to scale-up across the state.

Implementation Partners

USAID-MCSP/JHPIEGO

Financial Implications

Funds were provided under NHM.

Contact Details

Email: nagalandhwc@gmail.com

COMPREHENSIVE APPROACH FOR STRENGTHENING NCD SERVICES through Health and Wellness Centres

Problem Statement

State Level Disease Burden Initiative (ICMR 2017) indicate that non-communicable diseases (NCDs) increased from 30% to 55% and deaths caused due to NCD shave increased from 38% to 62% between 1996 to 2017 in Odisha.

Keeping this in view Odisha Government initiated universal screening of NCD services in July 2018.

Programme Description

An NCD campaign was carried out during the month of March 2019 to ensure that all eligible individuals are screened for NCDs. The campaign was implemented at all primary level facilities of seven Population Based Screening (PBS) districts.

Each facility which served as the focal point for screening with an average daily target of 120 cases, all villages under each facility were allocated to 5 fixed camp days, wherein individuals were mobilized on the respective days for screening. The last two camp days were dedicated to mop up rounds.

Public announcements were made at the beginning of the campaign while Inter-Personal Communication was strengthened through ASHAs. Banners and large displays were displayed at health facilities. During the campaign, ASHA sundertook home visits to complete population enumeration, completion of CBAC formats and mobilization of 30+ individuals for screening during the assigned 8 days.

All service providers in the facility were engaged in NCD screening. In the non-PBS districts, the MPW-F (regular and contractual) from nearby SHCs/health facilities were mobilized to the camp venue. The data entry in the NCD application was ensured on a daily basis by incentivizing MPW-F.

Monitoring mechanism was formed at each level for supportive supervision. State-level monitoring teams were assigned districts to monitor screening and data updation activities.

Programme Outcomes

By the end of the financial year, 34.9 lakh 30-plus population (22% of eligible) was screened out of which (17.6 lakh) were done in the NCD application.

Scalability

The model is easily scalable.

Implementation Partners

State NHM, Odisha, Tata Trust and USAID-MCSP/JHPEIGO

Financial Implications: NHM PIP

Contact Details

Email: spmnhmodisha@gmail.com;
npcdcsodisha@gmail.com

EMERGENCY HEALTH RESPONSE FOR CYCLONE FANI

Problem Statement

Extremely severe cyclonic storm FANI caused massive devastation affecting 1.65 crore people, damaging 5 lakh houses and about 1,031 health facilities in 9 highly affected districts

Programme Description

The health systems emergency response activities were categorized into three components A) Pre-cyclone preparedness B) Alertness during cyclone involved functioning of 24X7 control rooms at all levels, deployment of medical team at cyclone shelters, immediate rescue operations and provisioning of dry food for 3 days.3) Post-cyclone health response-, utilisation of ASHAs and Gaon Kalyan Samitis (GKS) for community mobilisation and cleanliness drives, psycho-social counselling at community, active participation of all line departments and review mechanism at state and district level.

Programme Outcomes

- Surgeries at Capital Hospital OT and 778 medical relief camps were conducted.
- 270 mobile health teams, 87 additional Medical Officers and 366 paramedics deployed in affected areas.
- 200 mothers delivered at public health facilities and over 1 lakh patients treated for minor ailments and injury. SNCU services restored within 48 hours.
- Clearing of fallen trees and other heavy debris within a week; restoration of overhead water supply within 10 days at all hospitals.
- Dialysis Unit services at District Head Quarters Hospital, Puriresumed within 10 days.
- Routine Immunization programme continued uninterrupted.
- Over 22,340 cleanliness drives conducted with active participation of ASHAs, MAS, Gaon/ Ward Kalyan Samiti.
- Over 1.28 lakhs water sources sanitised and over 40 lakhs halogen/ chlorine tablets with airtight containers and more than 24 lakhs sanitary napkins distributed.

Scalability

Strengthening emergency surveillance and establishment of early warning response system (EWARS) always pays dividend by preventing outbreaks and in turn saving lives.

Implementation Partners

UN Agencies, NIMHAN and NNF.
NCDC, RMRC & WHO, Ministry of H&FW Department and Line Departments

Financial Implication

According to “Damage, Loss and Need Assessment” report, the damage, loss and recovery cost including Building Back Better (BBB) estimated to be Rs. 469.8 crores for entire health sector

Contact Details

Director Public Health,
Email: dph.orissa@gmail.com,

PALLIATIVE HEALTH CARE SERVICES

Problem Statement

In the State of Telangana, it is estimated that around 12 to 15 patients per village are in need of Palliative Care Services.

Programme Description

The aim is to enhance the provision and access to quality services response to the life threatening conditions such as cancer and other non-cancer (Cardio Vascular, HIV, Stroke, Spinal cord injuries, neurological problems and organ failures) etc. through a three pronged strategy i.e. a) In Patient care; b) Out Patient care; c) Home based Care Services. Currently, 8 District level Health Facilities, 40 Primary Health Care Services and 500 Sub Centers are covered with Palliative Health Care Services. Palliative home care vehicles are providing services within radius of 40 kms from the identified in patient facility (DH/AH or CHC). ASHAs were trained for two days on Palliative Care and identification of the patients who are in need of Palliative Care. Once the patient is referred by ASHA, the Palliative Care Team provides required curative treatment followed by palliative care. After the death of the patient, it continues in the form of support to the family. Home based care is a vital component, where care is provided for pain control, symptom and infection management, training of caregivers in physiotherapy and management of common symptoms and supply of assistive aids and appliances.

Programme Outcomes

In the duration from April 2018 to June 2019, around 7,727 patients were provided with care and support through inpatient and outpatient care and around 16,822 Home Care Visits were provided through Home Based Care units (2,880 home visits per month).

Scalability

As the state has strengthened existing facilities and outreach vehicles for providing palliative care using NHM funds, the model has potential for scalability.

Contact Details

NHM Telangana

EMERGING INITIATIVES

HEALTH SYSTEMS STRENGTHENING

SHRAMYOGI SWASTHYA SEWA

Problem Statement

A healthy workforce is vital for the productivity and economic development of a country Over the last two decades, the UT of Daman and Diu and Dadra and Nagar Haveli have seen tremendous industrial growth. Migrants, a significant proportion of workforce have a higher tendency of obscuring illness and occupational diseases due to lack of education, lack of knowledge of available health facilities, language barriers, poor economic status and cultural factors.

Programme Description

"Shramyogi Swasthya Sewa" launched in May 2018 provides healthcare to industrial labourers at their doorsteps. This comprises of a mobile medical unit in the UT which was contributed by the industrial units of Daman & Diu and Dadra & Nagar Haveli under CSR. Required manpower comprising of a doctor, para- medical worker and pharmacist was arranged by the Health Department. The vehicles were appropriately branded to spread awareness about the facility amongst the target group.

The vehicles move early morning to industrial units and "chawl" area as per pre- defined schedule seven days a week. Daily 100-150 workers avail their services. These mobile medical units provide both Outpatient Services for first aid, various ailments and chronic conditions, screen workers and their families for communicable and non-communicable diseases as well as counselling on Personal Protective Equipment (PPE), chemical Hazards, environment safety, healthy lifestyle, regular preventive checkups, health insurance, avoiding use of tobacco, smoking and alcohol.

Programme Outcome

More than 50,987 beneficiaries in UT of Dadra and Nagar Haveli and 36,229 beneficiaries in UT of Daman & Diu have availed services.

Scalablity

Active convergence between the Health Department and the Labour Department, on a common platform, could help in achieving maximum awareness generation on Communicable/Non Communicable diseases. Analysed data of these industrial labourers and their families could lead to identify prevalence of occupational and other diseases for policy corrections.

Cost Effectiveness

Early detection and prevention reduces out of pocket expenditure. Loss of wages is also avoided as the services are provided at their doorstep.

Contact Details

Email: gargivbch.sil@gmail.com

RS. 1 CESS SIN TAX ON LIQUOR FOR EMRT 108 AMBULANCE SERVICES

Problem Statement

Himachal Pradesh is a hilly state with vulnerability to Natural disasters and man made disasters and hence requires a robust transportation system to reduce the mortality and morbidity, In order achieve this Slate of Himachal Pradesh has envisaged the emergency medical response and transport society on 30/11/2009 to catalyse the emergency response, The state runs the 108 ambulance services under the EMRT society in the whole state of HP.

Alcohol consumption is a social and medical problem. To reduce the incidence of alcohol related diseases it is imperative to reduce (he consumption and to achieve this there was a need of hour to put a Sin tax on liquor consumption.

Programme Description

The State proposed a SIN TAX on every bottle of liquor sold in the slate. It is a Pigovian Tax by excise or sales Tax specially levied on certa deemed harmful to the society and individuals. A tax at the rate of Rs. 1/per bottle was levied in 2018-19 on every bottle of liquor sold in the state through Excise and Taxation department and the revenue thus generated to be credited to the EM RT Society for supporting the services taken up under the society.

Programme Outcomes

The revenue generated by putting SIN TAX is a cost benefit commodity as this is the first of its kind of initiative and tax levied on the liquor bottles as Rs. 1 per bottle has been a Pivogian Tax.

The amount generated by taxing the liquor is Seven Crorc Ninety Five Lac Thirty Thousand Five Hundred Ninety Nine.

Name of Commodity	Cess @Rs 1% No of items	Total Collections
Liquor bottles	7,95,35,099	Rs. 7,95,35,099

Since alcohol docs not come under the purview of GST but is covered under VAT, this type of SIN TAX can be levied and utilised for the benefit of health and health related promotional activities and become a supportive component of the state government to run emergency and in public health Programme in es.

Scalability

The Sin Taxes levied can be associated with other health related programmes and hence can he utilised for improving the diagnostics and transmission of vitals and screening tests of the patients when they are being transferred to a health facility from die point of pickups.

Contact Details

Email: md-hp-nrhm@nic.in

"OPERATION NAVAJEEVAN": A Novel PPP Model

Introduction

In August 2018, Kerala, India witnessed its worst flood in over a century, leaving many dead and thousands displaced. With the support of National health mission 'Operation Navajeevan,' a public-private partnership between the district health administration and local hospitals, was set up in Kozhikode to provide medical aid to flood victims. This study identifies pre-requisites, describes challenges, and depicts the epidemiology and of patients seen in these camps.

Aim

1. To identify prerequisites and challenges faced in running medical relief camps in a flood affected region.
2. Measures taken to avoid duplication of services.
3. To identify medical needs of the flood-affected population.
4. To prepare an ideal emergency medical camp (PPP) model.

Methods

A control centre with drugs & logistic unit was set up at district medical office to monitor and supervise various camps. A mobile medical documentation format was created to record details of each camp. Cases of patients seen at these camps were compiled and later analysed. The medical officer sent a report from each camp to the control centre each day to specify the daily difficulties faced by each camp. Mobile ICUs were kept on standby to respond in the event of emergent circumstances or surge demands.

Transfer protocol and treatment guidelines formulated and standardized.

Result

Over 2 weeks, approximately 40,000 patients were seen in 280 medical camps. Major medical issues included exacerbation of chronic illnesses due to loss of medications(18,490), acute respiratory infections (7451), psychiatric illnesses (5,327), trauma (3,736), skin infection (792), tropical fever (498), acute gastroenteritis (394), ACS (17). Of the cases of fever, 137 people were due to leptospirosis. Major challenges included a lack of training in disaster management and failure of documentation systems.

Discussion

A well organized control centre, improved training in disaster medicine, and reliable documentation systems are crutial for coordinating medical camps in disaster affected areas. Public private partnerships offer a model for providing medical relief in disaster settings.

Contact Details

Email: dpmkkdl@gmail.com

THE RAJYA SWASTHYA PORTAL: A Single Window for Ensuring Cost Effective and Quality Procurement & Timely Delivery

Problem Statement

Fragmented systems of procurement and supply chain management leading to wastage of public funds. In many public supply systems, breakdowns regularly occur at multiple points.

Programme Description

Madhya Pradesh has decentralized procurement policy (Drug Policy 2009), wherein rate contracts are done centrally and procurement is done decent rally by the drawing and disbursing officers at district level. The Rajya Swasthya Uparjan Portal introduced aims at procuring the most cost-effective items in the right quantities, selecting reliable suppliers of high-quality products, ensuring timely delivery and achieving the lowest possible total cost.

Programme Outcomes

1. Users: Implemented in 51 District hospitals, 51 CMHO stores, 53 Civil hospitals, 51 District Malaria officers, 326 CHC, 764 PHC, 833 drug distribution corners, 29 Urban PHC, 18 Directorate of Medical Education nodes, 4 Gas Rahat hospitals and Commissioner/Director Directorate of Handloom Bhopal users.
2. Online inventory: Equipment in 1710 health facilities is 20,693, with 83% uptime.
3. Equipment maintenance: Module on the uparjan portal to keep track of the activities of outsourced third party for equipment maintenance. Out of 18,886 calls of equipment maintenance received, 18774 have been closed.
4. Budget Outflow: The one to one mapping of drugs and equipment to FMR code has led to saving whilst ensuring purchase of only mapped items against the allocated budget.
5. Payment efficiency and Supplier participation: Marked increased.
6. Rate contracted items: The rate contracted drugs and consummables increased.
7. Lead time of supply: Improvement in the lead time of supply.

Scalability

Portal has several modules which have been implemented till PHC level and can be scaled.

Implementation Partner

CDAC Noida.

Financial Implication

There is lesser expenditure on drugs, equipment and consumables, however availability, of drugs and consumables and uptime of equipment has increased.

Contact Details

Email: mdnhm@mp.gov.in

COMPREHENSIVE ELDERLY CARE: Chandrapur Model

Problem Statement

India Ageing Report by UNFPA, 2017 mentions that 'When populations age rapidly, governments are often unprepared to mitigate the consequences; this has implications for the socio-economic and health status of the elderly'. There is a need to strengthen existing 'National Programme for Healthcare for the Elderly (NPHCE)' with patient centric approach to cater to the growing needs of elderly.

Programme Description

In Chandrapur, Maharastra a team was appointed at the community level to build capacity of existing NPHCE staff towards elderly care, monitoring and supportive supervision of Elderly clinics at PHC/ CHC and organizing activities at the designated Activity centers. The team is actively involved in health education and awareness generation activities in the community and at the Elderly clinics.

The team supports the community in identifying "Activity Centres for Elderly" (Mayechi Sawali) with in the community, mostly at village gram panchayat spaces managed by ASHAs and village volunteers run four days a week for 2-3 hours per day. Elderly enrolled in these centres are screened regularly for Chronic conditions and are facilitated for their visits to Elderly Care clinics at the nearest health care facility.

Following activities are undertaken at these designated Activity Centres:

a. **Physical activities:** Simple exercises, Pedo-cycling, shoulder pulley exercise, Stress balls exercise and Group engagement activities.

b. **Recreational activities:** Dancing, and singing, playing games, painting etc.

c. **Awareness sessions:** Nutrition, chronic diseases, Treatment adherence, elder abuse, welfare schemes etc.

d. **Intergenerational bonding:** Involving school children in various activities.

Programme Outcomes

Till date 85% of SDH/RH and 64% PHCs have functional weekly Elderly clinics wherein 13,347 elderly have been screened for various conditions like Hypertension, Diabetes, risk of fall, cognitive degeneration etc. 29 Elderly Activity Centers are functional wherein 388 elderly have been registered.

Scalability

This intervention builds on an existing National Programme (NPHCE) and uses existing resources at the community and facility level, making it a potential scalable model.

Implementation Partners

NHM Maharashtra in partnership with Tata Trusts.

Contact Details

Email: shsrc.gom@gmail.com

CARE COMPANION PROGRAM

Programme Description

Care Companion Program (CCP)- a Government of Punjab initiative in partnership with YosAid Innovation Foundation and Inspired by Noora Health, aims to engage family members by training them in basic medical skills that have the highest impact for improving a patient's recovery.

The Program focuses on educating and empowering people to be agents of change for their own health and wellbeing and has turned hospital hallways/wards into classrooms and taps into the most compassionate and willing resource available for care - the patient's own family. Till date under the program approx. over 1,15,252 patients and caregivers have been trained in the program.

Sessions are being conducted by the staff everyday in the hospitals, and the districts have started using CCP for creating awareness on local health issues like Malaria, dengue etc. Adding to the initiatives, State has decided to celebrate and create awareness on Global Iodine Deficiency Disorders Prevention Day for one month starting 21st October 2019 through CCP. Under this awareness will be created among patients/caregivers focusing on importance of taking Iodised salt, why is it important, what should be included in diet and what can its deficiency cause etc.

This program will be running in all the five condition areas of Care Companion Program thereby helping in creating awareness in pregnant mothers, children and general patients.

Programme Outcomes

By teaching the family high-impact yet basic medical skills to take care of their loved ones in the hospital and at home, it will empower families to help patients with a better recovery in the hospital and a healthier life at home.

Scalability

This will help in system strengthening by providing appropriate health education to family members and aim to improve patient satisfaction rate and faith of patients on public health facilities and hence is scalable initiative.

Implementation Partners

Care Companion Program (CCP)- a Government of Punjab initiative in partnership with YosAid Innovation Foundation and Inspired by Noora Health

Contact Details

Email: ccppunjab@gmail.com

QUALITY ASSURANCE IN CERTIFICATE COURSE IN COMMUNITY HEALTH FOR NURSES (CCHN)

Experiences of Implementing Mentorship and Quality Assurance (MQA) Model

Problem Statement

Government of India envisions transformation of sub-centers (SCs) to Health and Wellness Centers (HWCs) for strengthening primary healthcare system. Under this initiative, a total of 20,573 SCs and 3318 PHCs in Uttar Pradesh needs to be upgraded into HWCs through placement of a Community Health Officer (CHOs), who would undergo six-months Certificate Course in Community Health for Nurses (CCHN) developed by IGNOU at identified training sites known as Programme Study Centre (PSCs).To match this requirement of CHOs, UP needs to establish around 56 PSCs, of which 33are already operational.

Programme Description

After facing the challenges with the first batch and before increasing the number of PSCs a need was felt to develop a mechanism of quality assurance for operational PSCs.

State designed and implemented a MQA model in improving quality of Certificate course at the 33 Programme Study Centers. MQAs are carried out at all the functional PSCs since 2018, under which two MQA visits is conducted. MQA visits ensures infrastructural preparedness of the operational PSCs, timely completion of curriculum and thus, ensures the quality of teaching. It also establishes a structured feedback mechanism for students and academic counselors and periodic knowledge assessment of the students. Facilitates tracking system of fund utilization and creates an institutional mechanism of feedback to state for mid-course corrections.

Programme Outcomes

MQA model created mechanisms for sharing regular feedback with institutional and state level stakeholders for mid-course corrections and highlights key focus areas like infrastructural preparedness, quality of education imparted at the PSCs which includes the theory and clinical practice areas and adherence to financial and management practices. Thus, this model results in improving the CCHN result from 56% to 83% from July 2017 to July 2018.

Scalability

The Structured quality assurance mechanism model is scalable and helps in improving the quality and effectiveness of CCHN course.

Finacial Implications

No information provided.

Contact Details

Email: mdupnrhm@gmail.com

PATIENT SAFETY & QUALITY IMPROVEMENT through Inter-Departmental Convergence under Swachh Bharat Abhiyan

Problem Statement

The safety and quality of services provided by public health care facilities require efforts that transcend the boundaries of hospital jurisdiction. it important to identify the critical bottlenecks that hinder collaboration and eliminating them to streamline making it self-driven and sustainable.

Programme Description

1. Identify the concerned departments for collaborative efforts.
2. Create ownership of responsibilities among stakeholder departments to encourage a proactive role.

Process Flow

- Meeting convened by PS Health with secretaries of all concerned departments.
- Commitment of senior officials secured.
- Directives issued to district officials.
- District Magistrates sensitized on the issue.
- Continuous monitoring by the concerned departments on progress made in the districts.

Bottle Necks

1. Police and Fire services—Infrequent on site hands-on trainings provided in hospitals.
2. Disaster Management department-Trainings not provided in health facilities.
3. Municipal corporations- Infrequent audits and checkups.
4. Panchayati Raj institutions-Poor engagement with health related issues. Social audits not done.
5. Horticulture department -No plans for maintenance of planted trees and gardens and Long processing time for requests.
6. Public Works departments- Delayed response to requests for budgetary estimates.
7. Police-Inadequate support from home guards in facilities and inadequate crowd management support during emergency and disaster.
8. Ministry of Urban Department-Lack of awareness for compost pit for biodegradable waste.
9. Department of Excise- Delay In issue of licence for storage of spirit.
10. Department of Medical education-Poor emphasis on preventive aspects of medicine.

Way Forward

The SOP to detail the sequence of activities with clear roles and responsibilities with due mention of timelines for completion of each activity to make the process self-driven.

Contact Details

Email: gmqanhm@gmail.com

EMERGING INITIATIVES

NON-COMMUNICABLE DISEASES

PAN MASALA BAN: A Gateway to SLT Free Nation - An Experience

Problem Statement

GATS-2(2017) reveals that in the state of Bihar 25.9% adults use tobacco products, of which 23.5% adults use SLT including Pan Masala. Nearly 14.6% of children (13-15 years) use tobacco in any form.

Programme Description

The use of magnesium carbonate, nicotine among other additives is prohibited in any food product including Pan Masala. However, testing of pan masala products from Bihar by State food testing laboratory to contain magnesium carbonate. Thus State banned the manufacture, storage, transportation and sale of 15 prominent brands of Pan Masala (Rajnigandha, Rajniwas, Supreme, Pan Parag, Bahar, Bahubali, Rajshree, Raunak, Siggnature, Sir Gold, Shikhar, Vimal, Kamala Pasand, Pashan and Madhu).

Programme Outcomes

- Prevalence of Smoke Less Tobacco (SLT) reduced in the state. Leading to lower incidence of Oral Cancer.
- Pan Masala brands including SLT (Twin Pack) have vanished from the market.
- Spreading Awareness through media coverage.
- Point of sale (PoS) have become free from SLT.
- Outdoor advertisement of Pan Masala have been removed.

Scalability

Similar initiative needs to be undertaken in other states to strictly regulate and ban brands which contain toxic chemicals.

Implementation Partners (If any)

Socio Economic and Educational Development Society (SEEDS), a national level non-profit organization. Due to this GO-NGO collaborative efforts Bihar has taken rapid strides in tobacco control. With the continuous and rigorous efforts of SEEDS the major outcomes of tobacco control programme was significant decrease in Tobacco consumption in the state which has reduced from 53.5% in 2010 to 25.9% in 2017. Other significant achievement of this collaboration is technical and legal support in whole process of Pan Masala ban in Bihar.

Financial Implications

There are no financial implication in the process of Pan Masala ban initiative.

Contact Details

Email: ed_shsb@yahoo.co.in

"NAYAN AMRITHAM" Diabetic Retinopathy Screening Programme

Problem Statement

Diabetic Retinopathy (DR) is a common complication which can lead to total loss of vision. For DR effective treatment is possible if the condition is detected in the early stages. To address this problem, the state has introduced a new initiative "NAYAN AMRITHAM" to control blindness due to diabetic retinopathy.

Programme Description

The DR screening was done using a hand held Non mydriatic Camera capable of taking fundus photograph for the diagnosis and stages of diabetic retinopathy. This training was first given to staff Nurses.

The captured image is transmitted to a state retinopathy centre located in the RIO, manned by trained Optometrists to evaluate the picture and send back the diagnosis and advice on management. ASHAs play an active role in identifying the diabetic patients in the community and encouraging them to take part in the screening programme.

The screening is implemented in the newly established family health centres including eight primary centres, three secondary centres and one tertiary care centres in Thiruvananthapuram district of Kerala, targeting financially backward communities.

In the process of expanding the screening programme throughout the state, 52 Non mydriatic cameras were procured and installed at the selected FHCs/HWCs and approval was received for procuring 100 more cameras in ROP 19-20. 100 cameras will be supplied in November 2019 to the remaining districts. Total 14 state of Art Non mydriatic cameras were supplied to all state district hospitals from state Plan fund. State is planning to include retinopathy screening in all the family health centres.

Programme Outcomes

Till 7th July 2019, 5190 of patient were screened at the FHCs & Suspected DR & other eye diseases diagnosed through screening are 1206. A total of 38 laser treatments were done. A total of 53 staff nurses, 31 doctors and 425 ASHAs were trained. Total 33 on-site training sessions for staff nurses were conducted. Percentage of gradable images (in July 2019) are 92.72%.

Scalability

This is an eminently scalable model.

Financial Implications

The cost of one Non-mydriatic camera is Rs. 2.5 lakh

Contact Details

Email: bipingoyal@yahoo.com

ESTABLISHMENT OF POPULATION BASED RURAL STROKE REGISTRY IN LUDHIANA

Problem Statement

Disease and health registries involve ongoing data collection about aspects of the health or illness of individual people and can be used for etiologic research; intervention programme evaluation, quality improvement and health policy decision-making at local, state and national levels. Well established population-based stroke registries are lacking in developing countries particularly from rural areas.

Programme Description

The intervention was planned in Sidhwan Bet and Pakhowal in rural Ludhiana. A total of 265 ASHAs and 60 MPWs-Female/ANMs were trained under this activity. The trained frontline functionaries were the main respondents of all stroke cases in the registry. The cases reported by ASHAs were examined by the Neurologist for confirmation of stroke along with examination of the MRI/CT scan films or reports which were analyzed to assess the sensitivity of the methodology. With refresher training and repeated visits, the ASHAs were able to correctly identify more cases. The ASHAs felt empowered to refer stroke cases promptly to CT/MRI equipped hospitals. They could call the research team regarding any doubts. The rural registry utilized the presence of ASHAs in the villages to obtain information regarding cases of stroke in the villages. The cases were followed up by the research team at home or in the hospitals where they were admitted and salient information was collected with the help of a simple instrument. Information on stroke deaths was collected from the villages using verbal autopsy.

Programme Outcome

A total of 436 cases registered (excluding 102 Mimic) from December 2016, of which 359 were first ever strokes. Nearly 226 (52.3%) of cases were registered within 30 days. About 69 cases (15.9%) were registered in the first week, 137 (31.7%) in the first two weeks.

Scalability

A nationally representative population-based registry can bring quality information and provide insights on incidence, mortality, case fatality and details on disabilities due to stroke. This information combined with risk factors analysis can be used to modify the programme framework to address the stroke patients in the community.

Implementation Partners

CMC Ludhiana and Department of Health and Family Welfare, Punjab.

Contact Details

Email: sandhuss@rediffmail.com

EMERGING INITIATIVES

NATIONAL URBAN HEALTH MISSION

IMPORTANCE OF STANDARD OPERATING PROCEDURE IN URBAN PRIMARY HEALTH AND WELLNESS CENTRE

Programme Description

Assam team developed Standard Operating Procedures (SOPs) in Urban Primary Health & Wellness Centre because they are essential to lay down step by step procedure for health workers in carrying out their routine activities in health centre to improve quality and efficiency. Different SOPs were prepared in UPH & WC keeping in mind, so as to help all health workers to be aware of their duties & responsibilities and to carry out their routine activities efficiently. It will also playa key role in reducing errors and sustainability of the works will be maintained.

SOP's gives Quality output by achieving uniformity & consistency of performance and reducing miscommunication

Objective of Sops

Objective of SOPs is to improve efficiency & quality of the health worker while carrying out his/her activities/ responsibilities by laying out a set of Standard instruction for any regular work.

Process of Writing SOPs

Basic Steps to be followed while preparing SOPs:

1. Introduction of the title or activity.
2. About the goals and objectives of particular activity (SOP).
3. Committee details/responsible person or health personnel who shall follow the SOPs.
4. Responsibility/ Expectation from the committee or a person.
5. Expected outcomes and analysis of the outcomes.

Programme Outcomes

SOPs will facilitate the health workers to remember their routine work/other activity and will also ensure continuity of the activity in the absence of any worker. The outcome of having SOPs is that routine work/other activities are carried out by worker without supervision and with efficiency and thereby improving overall quality. It will also ensure quality standards of all services provided in the Urban PHC. It will improve the patient satisfaction.

Contact Details

Email: qualitynhm@gmail.com

VULNERABILITY MAPPING AND ASSESSMENT FOR URBAN HEALTH

Programme Description

The Vulnerability Mapping and Assessment explores the degree of vulnerability, health issues, health needs, health-seeking behavior and barriers faced by poor and marginalized communities in urban areas. The sequential mixed methods research design consists of both quantitative and qualitative assessments. A quantitative survey was conducted which includes two assessments - household/individual level and ward level assessment. Qualitatively PGIMER, Chandigarh conducted Focus Group Discussions (FGDs) of vulnerable groups purposively selected.

The assessment at household level identified key factors driving an individual/ household towards ill-health. Health status of the urban households is highly attributed to occupational vulnerability, social and residential vulnerability. This gives planners and service providers to devise a vulnerability reduction/ mitigation plan as per the needs of the local communities and to provide an opportunity to incorporate the necessary reforms in health policies. Vulnerability and its sub-dimensions varied by district.

Programme Outcomes

As a result State level policies and programmes has been tailored to the specific needs of the Districts. Based on these recommendations following steps were taken:

1. Urban Slum are prioritised and classified as Most Vulnerable, Highly Vulnerable and vulnerable.
2. To strengthen the basic infrastructure facilities, Bi-annual meetings with members of urban local bodies are being conducted under each U-PHC to resolve the issues at local level. Kayakalp programme has been implemented, 45 U-PHCs have been awarded for Kayakalp in FY 2019-20.
3. To increase awareness among community regarding provision of healthcare facilities, Documentary and TV Commercials are being regularly telecasted on various radio and TV channels, public announcements are being made at various bus stands, NUHM Branding on bus panels on 100 Haryana Roadways buses and advertisements in various cinema halls of Haryana also been planned.
4. To increase immunization coverage in urban slums, canopies provided to ANMs and e-rickshaw project has been implemented in Haryana which is GPS –enabled with provision of miking to broadcast health related messages.

Contact Details

Email: md-hr-nrhm@nic.in

SYSTEMS STRENGTHENING FOR BETTER URBAN HEALTHCARE DELIVERY through Collaboration with Medical Colleges

Problem Statement

Medical academicians can provide useful insights into the healthcare system. Almost each city in Karnataka has a medical college and can become nucleus of strengthening the primary health care delivery systems.

Programme Description

The department of Community Medicine, Bangalore Medical College & Research Institute [BMCRI] works closely with National Health Mission and Bruhat Bengaluru Mahanagara Palike in providing technical support in the areas identified to improve healthcare services:

- Trained manpower for planning and field level activities like subject experts in respective fields, postgraduate and undergraduate medical students, students pursuing Diploma in Health Inspector (DHI), student nurses.
- Field activities like: Pulse Polio campaign, Mission Indradhanush, surveys like Active Case Finding for TB, Leprosy Case Detection Campaign, Vulnerability assessment.
- Research activities like: time motion study to decrease wait time at UCHC, Awareness & Client satisfaction of NUHM at UPHC, Intermediate term evaluation of NUHM in BBMP, Focused Group Discussion on Drug Abuse & Illicit Trafficking.
- Convergence through Urban Health Training Centres: Health care services are being provided to the patients visiting Out Patient Department of the UPHC, assist in immunization sessions, ANC clinics, high risk pregnancy detection & in providing services at speciality OPDs like Medicine, Paediatrics, evening clinics of Surgery, Orthopaedics, Psychiatry.
- Space and resource persons for regular training activities.

Programme Outcomes

This collaboration creates a win-win situation for NHM and the medical colleges. Apart from availability of additional resources to the NHM, it has ensured that their teaching and research activities remain relevantto the changing health needs of the community and growing requirements of the healthcare delivery system.

Contact Details

Email: ddimmkar@gmail.com

EMERGING INITIATIVES

COMMUNICABLE DISEASES

SUPPORTING DR-TB PATIENTS THROUGH COUNSELLOR: SAKSHAM Pravah Project

Background

Treatment of Drug Resistance TB is complex public health problem and an obstacle to effective Tuberculosis TB control The Social factors associated with Loss to follow up in DR-TB are lack of social support, lack of counselling, no awareness regarding Treatment.

The project was started in Gujarat in September 2016 with the aim of providing psychosocial counselling to DR-TB patient and caregivers through Saksham DR-TB counsellors, based on the social structural approach to disease prevention and control.

Major role of counsellor is to provide pre-treatment counselling to Drug Resistant Tuberculosis (DRTB) patients and aid in early treatment initiation, conduct home visits for family counselling and successive visits to patient's home for follow up counselling.

Programme Achievements

Since inception, Saksham DR-TB counsellors in Gujarat have registered 97% DR-TB patients who were initiated on treatment by RNTCP for counselling services.

One of the major aims of DR-TB counselling is adherence to treatment and completion of treatment.

The counsellor reinforces the adherence messages and address barriers to adherence during every follow up counselling. Priority based follow up counselling visits are provided out of which more than 75% follow up visits are done at home, rest in health posts and other areas like religious places, market etc.

Saksham counsellors are alert about any instances of treatment interruptions and out of the total treatment interruption instances, 74% patients were counselled and were retrieved back on regular treatment. Adverse events due to DR-TB treatment being one of the most important reasons for treatment interruption, Saksham counsellors are also focusing on ADR referrals so as to ensure prompt management of ADR's and 92% of the referred cases were medically managed.

Saksham counsellors have linked 1461 DR-TB patients to various social protection schemes including Aadhar card, Ration card, Bank account, Ayushman Bharat, etc. Also, counsellors have linked 2457 DR-TB patients to nutrition support linkages like provision of milk, curd, eggs, protein powder, rice, dal, etc., through various private donors and NGO's in order to help them adhere to the treatment. Further, 3474 DR TB patient contacts referred for testing, out of which 92 were found to be M-TB positive.

Contact Details

Email: stogu@rntcp.org

TB FREE TALUKA INITIATIVES: COMMUNITY LED ACTION FOR TB CONTROL In 2 Taluka Each of 36 Districts

Programme Description

TB kills nearly 4.2 lakh persons, while nearly 27 lakh persons acquire TB every year. India has incorporated strategies to achieve TB elimination in National Health Policy 2017.

Social stigma and Low awareness regarding TB leads to late diagnosis, low TB case notification and success rate.

Processed deployed

- State level consultation workshop with district programme managers and district team was organized through video conference sensitizeing the District TB Officer regarding block wise detailed action plan.
- The districts submitted detailed activity wise planning based on National Strategic Plan (2017-2025), 9 key indicator wise activity planning and intensive IEC plan certified by respective Chief District Health Officer and District TB Officer.

Innovative aspects of project

- House to house Active case finding in high risk group areas by MPHW – ASHA – Community Volunteers and complete evaluation of presumptive.
- Active case finding activities in general population has been carried out in TB free taluka for early detection of cases, 6,71,1572 houses covered in the screening additional 616 TB case has been diagnosed and link for treatment.
- PHI (Peripheral Health Institution) wise DMC (Designated Microscopy Centre) has been established to better accessibility for quality assured diagnosis and all diagnosed patients link for treatment at all PHI (Peripheral Health Institution).
- Universal Drug susceptibility testing, HIV screening, Diabetes screening offer to all diagnosed cases as per programme guideline.
- All diagnosed TB patients are linked for drug susceptibility testing through Cartridge Based Nucleic Acid Amplification Test (CBNAT).
- Contact screening of all diagnosed sputum smear patients.
- Geotagging of all TB cases initiated through Nikshay (A case bas web base Notification system) to identify Hot spot and Cold spot up to village level.

Scalability

- State level, State TB Forum and District level, District TB Forum (36) has been constituted in the state to accelerate TB control activities and help to reduce social stigma and community engagement in large scale more over Block, TB Forum (72) also has been constituted in assigned TB free Block.

Contact Details

Email: stogu@rntcp.org

INTENSIVE TUBERCULOSIS CASE FINDING ACTIVITIES IN HEALTH CARE PROVIDER/ WORKER FOR EARLY CASE DETECTION

Background

The Risk of developing tuberculosis (TB) as an occupational disease is well established among Health Care Workers (HCWs) this risk is most likely due to frequent exposure to patients with both diagnosed and undiagnosed infectious Tb disease. The risk of ongoing transmission exists if patients have not been put on treatment yet, or if the treatment is ineffective. The transmission of TB to HCWs in health care settings has been reported from virtually every country of the world. Regardless of the local TB incidence. Studies from India have also shown a substantially higher TB incidence among health care workers. The risk of transmission varies by setting. Occupational group, the Tb burden, patient population and the effectiveness of TB infection control (TB IC measures).

Intervention

Intensified case finding activity was carried out in public sector health care workers of Gujarat, India with aim to diagnose undiagnosed TB cases in health institutes (PHC, CHC, SDH, DH and Medical College). Necessary permission was taken from respective departments of the State & Institute to under taken activity. Health care workers were mapped at their work places of health institute. Four symptoms complex (cough, fever, weight loss & night sweat) was applied to screen health workers by trained doctors. Positive in any symptom complex was asked to give sputum sample, which was tested on Xpert MTB/RIF assay as well as on X-ray chest PA view for those who got Mtb not detected result.

Results and Lesson Learnt

Out of total 1,47,701 total Health Care workers, around 92% were screened for any of four symptoms. 2,152 (2%) were identified as presumptive tuberculosis. 1,280 (59%) out of 2,152 presumptive tuberculosis subjected for Xpert MTB/RIF assay. It diagnosed 15 microbiologically confirmed tuberculosis cases and 2 clinical tuberculosis cases & 1 EPTB case. All tuberculosis cases were put on appropriate treatment regimen.

Conclusion

Screening HCWs at high risk of TB is likely to reduce transmission; and with earlier diagnosis & treatment, prevent serious illness & disability. Given the overall inadequate human resource for health, introducing screening of HCWs for TB is crucial.

Contact Details

Email: stogu@rntcp.org

"TB MUKT HIMACHAL" MOBILE APP:

Tool for HP State's Mission to Meet Targets of Ending TB

Problem Statement

There is delay in diagnosis and initiation of TB treatment due to lack of awareness about the symptoms of TB disease and lack of information about available diagnostic and treatment services in the public sector. Internal evaluation activities under Revised National Tuberculosis Control Programme across different districts in Himachal Pradesh reported delay in diagnosis.

Programme Description

Government of Himachal Pradesh to meet the target of Ending Tuberculosis by 2021 launched a new scheme "Mukhya Mantri Kshay Rog Nivarna Yojna" (MMKRNY) to fill gap in infrastructure, knowledge gap about TB, systematic screening of population about TB symptoms and optimum utilization of information technology. An android based "TB Mukt Himachal" App has been developed having several features on IEC and availability of diagnostic and treatment facilities on TB. App is LIVE on Google Play Store for free of cost downloading on any android device.

Programme Outcomes

Over 750 downloads have been made by the users till date with the number of downloading increasing in each months. App has been very useful for the users to know about diagnostic and treatment services. Users can access nearest DMC and CBNAAT along with details of Laboratory Technicians. The App has been very well received and appreciated by individuals, panchayat heads and all other stakeholders at State, District, Block, Panchayat and Village levels and making people becoming more aware about TB symptoms, causes, diagnosis, management and prevention.

Scalability

TB free Himachal App is a user friendly App for general public, presumptive TB and TB patients and making them becoming aware of TB symptoms, tests and treatment and making individuals locate and visit the nearest test facility. It is a very important step for meeting the targets of ending TB under TB Mukt Himachal Abhiyan.

Implementation Partners

National Health Mission, HP with support from E-Tech Services Pvt Ltd.

Financial Implications

Nil to the State (The App was developed and is being maintained free of cost by the developer).

Contact Details

State TB Officer Himachal Pradesh.

MALARIA ELIMINATION DEMONSTRATION PROJECT (MEDP), DISTRICT MANDLA

Public Private Partnership Model

Problem Statement

Malaria is a major public health problem in India, especially in rural/tribal areas of India. India contributes ~80% of malaria cases in SEAR countries.

Programme Description

MEDP is a first-of-its-kind PPP with a goal to eliminate malaria from 1233 villages of Mandla district and use the lessons learnt for rest of country:

- **Deployment of Field workers:** Signing of the 3-party agreement between FDEC, Govt of MP and ICMR done on followed by operational planning, recruitments and trainings. FDEC India has deployed its 260 field workers – Malaria Field Coordinators (MFCs) and Village Malaria Workers (VMWs).
- **Capacity building & Other Activities:** Needs-assessment of 220 ASHAs was done for followed by training of all 1200+ ASHAs of Mandla. Track, Test, Treat, and again Track (T4) for active surveillance and case management.
- **Supportive supervision:** 3.8 lakh of Long-lasting Insecticide treated bed Nets (LLIN) were distributed in the community and routine of Indoor Residual Spray (IRS) activities were supervised by MEDP Mandla. From District authorities (District Magistrate, Chief Medical Officer, District Malaria Officer etc.) to National authorities (DG ICMR, Directorate of NVBDCP, Directorate of Health Services etc.) are being communicated with the data and are involved in regular discussions.

IEC/BCC Field staff is trained by experts from ICMR, NIRTH and GoMP.

MEDP is assisting the state government in organizing the large-scale RAHAT rotary camp in Mandla district and developing a mobile surveillance tool by the name of SOCH - Solutions for Community Health-workers.

Programme Outcome

From September 2017 to September 2019, tested 2,68,543 fever cases, treated 509 malaria cases, and demonstrated 83% reduction in indigenous cases in the entire district and 90% reduction in three blocks with highest burden of malaria. The project has also developed a National Model of Malaria Elimination based upon the learnings from MEDP and can be used as roadmap for malaria elimination efforts of Madhya Pradesh and India.

Implementation Partners

Government of Madhya Pradesh, ICMR & Research and Foundation for Disease Elimination and Control of India.

Contact Details

Email: rajvanshiharsh@gmail.com
smcs_bpl@rediffmail.com

NEAR REAL TIME SUPERVISION OF HOME VISITS UNDER PUBLIC HEALTH ACTION

Services for Notified Patients with TB

Background

India accounts for more than a quarter of the global tuberculosis (TB) burden. TB patients are notified under Revised National Tuberculosis Control Programme (RNTCP) using a case-based notification system called as Nikshay, an application in a mobile tablet. One tablet is provided to every Senior Treatment Supervisor (STS) responsible for supportive supervision, recording and reporting TB treatment for a population of 0.5 million.

After notification (both from public and private), patients receive "public health action support" (PHAS) which includes home visit, counselling of TB patients and family members, monitoring treatment adherence and follow-up, contact investigation and isoniazid chemoprophylaxis to eligible contacts, HIV counselling and testing, and drug susceptibility testing and finally linking to receive cash incentives under the direct benefit transfer for TB patients. In rural areas, the home visit must be performed by the STS preferably within a week.

Shahdol is a tribal district in east Madhya Pradesh where home visits by the STS were not happening. To address this, RNTCP Shahdol developed a rater-based web-form (using Open Data Kit (ODK) software synced to online ONA platform) to track the 'home visits' on real time basis. After receiving hands on training; since August 2018, the STS carries this mobile tablet during home visit and captures the following information: Nikshay identifier, date of home visit, geolocation of patient's home, number of household members, number of children <6 years, number of house-hold child contacts screened & received Isoniazide preventive therapy and any other adult house-hold symptomatic contact.

Benefits

Up to 500 records can be captured per month, questionnaire can be developed in local language (hindi), works offline, near-real time and objective assessment of home visits along with feedback and identification of hot spots for targeting active case finding.

Scalability

Since STS have a mobile tablet, this strategy has the potential to objectively assess home visits under PHAS and can be scaled up.

Contact Details

Email: akashranjan02@gmail.com

URBAN LEPROSY, A COMPLICATED AND MAJOR PROBLEM UNDER NLEP: An Initiative to Solve the Problem

Problem Statement

Incidence of leprosy in West Bengal is higher in urban areas than rural areas and it is estimated that over 2500 to 3000 new cases emerge every year in urban areas.

Programme Description

Health infrastructure and field staff in urban areas is inadequate as compared to rural areas.

Unlike in Rural areas where there is a streamlined referral mechanism from community to facility, in urban areas, patients report voluntarily to hospitals (tertiary level), get diagnosed there and are provided treatment i.e., MDT without any follow up.

These gaps lead to late detection of leprosy cases with high disability and poor treatment compliance among patients, which also in turn adds to active transmission at the community level.

Back Ground of the Initiative

Strengthening routine NLEP in urban areas involved the following steps:

- Incentivised Honorary Health Workers (HHWs) will screen the urban population in a phased manner which will include physical examination.
- Suspected cases will be referred to Urban PHCs where Medical Officers will confirm the diagnosis of the patients and initiate treatment.
- Complicated cases will be referred to Medical Colleges, District/Sub Divisional Hospitals.
- HHWs will also be responsible for follow up of the treatment.
- District Leprosy Officer (DLO) along with NUHM team will monitor the activity every month and will ensure supply of logistics.
- Designated person at UPHC will prepare a monthly report.

Programme Outcomes

Progress till date since June 2019

- Training initiated.
- Over 100 Urban MOs, 85 Epidemiologists and Programme Managers and a few thousand health workers have been trained.
- Funds have been allocated for IEC, logistics and mobility.
- In Durgapur Municipal Corporation 58 suspects have been referred by HHWs and 16 have been confirmed and initiated on treatment by MOs. No case of disability was reported.

Scalability

This initiative needs to be implemented for a fair length of time and then assessed.

Contact Details

Email: ddgl@nic.in

CRAFTING THE PROGRAMME:

People Connect NVHCP

Problem Statement

Awareness of Viral Hepatitis as an issue meriting recognition as a major public health burden is abysmally low. This is compounded by poor and delayed visibility such as added barriers to a cogent, coherent and robust response and positioning of NVHCP.

Programme Description

A comprehensive communication strategy has been crafted. IEC campaign, held at iconic twin venues of Victoria Memorial and Nandan was based on some rapid dip-sticks and interviews, focusing on information blitz on Viral Hepatitis and its modes of transmission and manifestations, prevention, testing and treatment and access to services. The campaign messages are split into four key pillars- know the facts, vaccination, testing and treatment and blood and injection safety. Campaign materials/routes are being used are posters, hoardings, tableaux, radio spots, plays (Third Theatre/Proscenium formats), info graphics and social media. IPC involved engagement of 966 counsellors across various programmes within the health system and beyond, a 10- point counselling tool has been developed as a job aid. A dedicated team of counsellors from designated treatment sites have been identified as touch points for all referrals, linkages and adherence. Special emphasis is being given to advocacy cum technical sessions focusing the programme in professional platforms like major events of API.

Programme Outcomes

Increased visibility and consequent increment in screenings and footfalls. The programme has come into public glare with large footfalls and media coverage of World Hepatitis Day. 60 counsellors especially trained for dedicated roles at treatment sites and surrounding health facilities, 1,14,598 attendees at AFHCs have been exposed to counseling, 221 counsellors already trained and content shared during their routine trainings. State is a regional hub catering to Viral Load Testing for States like Sikkim and Meghalaya.

Scalability

All districts are being progressively covered through the IEC campaign across the year. Taking it to scale is in tandem with programme expansion.

Implementation Partners

Liver Foundation West Bengal (for IEC campaign).

Financial Implications

1 crore.

Contact Details

Email: nvhcp.wb@gmail.com

EMERGING INITIATIVES

HEALTH CARE TECHNOLOGY

NOXENO

Problem Statement

Removal of Nasal Foreign Bodies (NFB) in the pediatric population is a difficult procedure for General Physicians (GP's) andpediatricians without adequate expertise in carrying out highly skilled nasal procedures. Withrepeated unsuccessful attempts, extraction becomes complex, dangerous and often warrants removal under sedation or general anesthesia.

Product Description

Noxeno is a Reusable Nasal foreign body removal device

Product Outcomes

Noxeno results in a per-removal cost of only 1/10th that of the current standard of care (INR 500 vs 5000), despite being 22% more effective in removal.

Scalability

Different foreign bodies (location and type) require different mechanisms to facilitate removal depending on their shape, size, texture and surface. However, not all cases of ear, nose and throat foreign bodies present in tertiary care centres such as AIIMS and hence the way forward would entail accessory devices that would enable clinicians in all clinical settings.

Contact Details

InnAcel, pooja@innaccel.com

Financial implications

Category	Noxeno	Katz Extractor	Standard of Care
Available in India	Yes	Yes	Yes
Single use device	Reusable	Single Use	Typically Reusable
Device Cost per removal	100 INR	5000 INR	0 INR
Procedure cost (avg)	500 INR	500 INR	500 INR
Total cost to patient (avg)/ procedure	600 INR	5500 INR	500 INR
Rate of OPD Success	90%	70%	50%
Cost per successful removal (Cost of removal * Rate of Success)	666.67 INR	7857.14 INR	1000 INR
Incremental Cost-effectiveness of successful removal Compared to standard of care. (Difference in cost/ difference in success rate)	250 INR	25,000 INR	N/A

BENEFITS

Easy

- Simple, two-step assembly
- Ergonomic, single-handed use for fast NFB removal

Safe

- Atraumatic tip design with soft sheath
- Integrated, tip-focused light for visualization

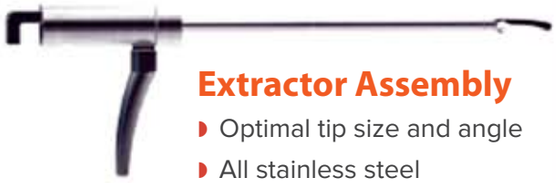
Durable

- Modular and replaceable components
- Robust component design and materials

PRODUCT FEATURES

Handle

- 5mm LED light
- Light button
- Replaceable batteries (2AAA)



Extractor Assembly

- Optimal tip size and angle
- All stainless steel
- Strong hinge for pull forces up to 20N
- Modular for easy reprocessing
- Autoclavable

Rubber Sheath

- Single patient use disposable
- Sterile
- Soft for patient comfort

ASMAN MP
National Health Mission

07

NATIONAL HEALTH MISSION

राष्ट्रीय स्वास्थ्य मिशन

Ministry of Health & Family Welfare
Government of India