Internship at
National Health Mission, Madhya Pradesh

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Internship Report

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Organization name: National Health Mission, MP

About NHM

The Union Cabinet vide its decision dated 1 st May 2013 has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission. Outcomes for NHM in the 12th Plan are synonymous with those of the 12th Plan, and are part of the overall vision. The endeavour would be to ensure achievement of those indicators in Box 1. Specific goals for the states will be based on existing levels, capacity and context. State specific innovations would be encouraged. Process and outcome indicators will be developed to reflect equity, quality, efficiency and responsiveness. Targets for communicable and non-communicable disease will be set at state level based on local epidemiological patterns and taking into account the financing available for each of these conditions.

At the State level, the Mission functions under the overall guidance of the State Health Mission (SHM) headed by the State Chief Minister. The State Health Society (SHS) would carry the functions under the Mission and would be headed by the Chief Secretary. ♣ The District Health Mission (DHM)/City Health Mission (CHM) would be headed by the head of the local self-government i.e. Chair Person Zila Parishad / Mayor as decided by the state depending upon whether the district is predominantly rural or urban. Every district will have a District Health Society (DHS), which will be headed by the District Collector. At the city level, the Mission or Society may be established based on local context. Existing vertical societies for various national and state health programmes will be merged in the DHS. ♣ The management of NUHM activities may be coordinated by a city level Urban Health Committee headed by the Municipal Commissioner/ District Magistrate/ Deputy Commissioner/ District Collector/ Sub-Divisional Magistrate/ Assistant Commissioner based on whether the city is the district headquarter or a sub-divisional headquarter as may be decided by the state. This would facilitate coordination with other related departments like

Women & Child Development, Water Supply and Sanitation especially in times of response to disease outbreaks/ epidemics in the cities.

NRHM- Health Systems Strengthening:

- **Reproductive, Maternal, New-born, Child Health and Adolescent (RMNCH+A)**

• All schemes and programmes that constituted RCH-II would be absorbed into the NHM. The NHM provides an opportunity to build on past work and renew the emphasis on strategies for improving maternal and child health through a continuum of care and the life cycle approach. The inextricable linkages between adolescent health, family planning, maternal health and child survival have been recognized. There is additional focus on adolescence as a distinct „life stage" and the strategy is to increase knowledge and access to reproductive health services and information for adolescents and to address nutritional anaemia.

• Another dimension of the continuum of care which will receive attention is the linking of community and facility-based care and strengthening referrals between various levels of health care system to create a continuous care pathway. All these aspects are embodied in the „Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India". The main strategies for RMNCH+A include services for mothers, new-borns, children, adolescents and women and men in the reproductive age group.

- ***Maternal Health:***

Key strategies include improved access to skilled obstetric care through facility development, increased coverage and quality of ante-natal and post-natal care, increased access to skilled birth attendance, institutional delivery; basic and comprehensive emergency obstetric care through strengthening of carefully prioritized health care facilities. This will be done through mapping and identifying health facilities as "delivery points" and strengthening them for delivery of comprehensive package of RMNCH+A services. The purpose is to ensure

universal access to all populations in a district. Wherever required, private providers would also be contracted-in to supplement services through public health facilities. Multi-skilling medical officers with specialist skills will be needed to provide emergency obstetric care. The Janani Suraksha Yojana (JSY) which enables institutional delivery will be modified in the NHM period to synergize with the new Food Security legislation. Another key goal is to move towards UHC through an expanding comprehensive package of free and cashless services currently covering all pregnant women, and sick infants up to the age of one year, in government health institutions through Janani Shishu Suraksha Karyakram (JSSK), thereby reducing financial barriers to care and improving access to health services by eliminating OOP expenditure in all government facilities.

- ***Gender Based Violence:*** The consequences of gender based violence against women include physical injuries, reproductive health problems, and mental health. Because women are most often seen for the provision of reproductive and child health services, this is a starting point to identify women who are at risk for or who are subject to domestic violence. The steps towards enabling a system wide response to gender based violence (GBV) include: sensitize and train frontline workers and clinical service providers to identify and manage GBV, train ASHAs to identify and refer/counsel cases of GBV in the community, develop effective referral mechanisms from primary care to secondary and tertiary canters, with assured services, build functional referral linkages and create follow up mechanisms with government departments and NGOs providing legal and social welfare services and women's support groups in the district.

- ***New-born and Child Health:*** This will be through a continuum of care from the community to facility level and include the provision of home based new-born and child care through ASHAs and ANMs, supplemented by AWW, and community level care for acute respiratory infections, diarrhea, and fevers, including home remedies, first contact curative care, or referral as appropriate. Essential new-born care and resuscitation at all delivery points through establishment of New-born Care Corners and skilled personnel will be ensured. Facility Based Care for sick new-borns will be provided through the establishment of New-born Stabilization Units and Special New-born Care Units. This includes strengthening public health facilities and accrediting private providers to manage referrals. Institutional care for sick children and provision for management of children with Severe Acute Malnourished (SAM) at Nutrition Rehabilitation Centers (NRC) will be linked to

community based care for SAM. Infant and Young Child Feeding (IYCF) and nutrition counseling to support early and exclusive breastfeeding, complementary feeding, micronutrient supplementation and convergent action will be also encouraged through platforms like VHSNC, VHNDs etc. Reporting and reviewing of child deaths (under five years) is another area of attention.

- ***Universal Immunization:*** Sustaining Pulse polio campaigns and achieving over 80% routine immunization in all districts will be emphasized. Introduction of new and underutilized vaccines will be considered on the basis of recommendations of the National Technical Advisory Group on Immunization (NTAGI). Improved cold chain management would be ensured with adequate densities of Ice Lined Refrigerators (ILRs) and deep freezers. Adequate number of vaccination sessions and sites, and logistics arrangements to reach all such sites especially in remote areas will be a key area of intervention. Surveillance of vaccine preventable diseases would be integrated with IDSP and name based monitoring of children done through the MCTS system.

- **C*hild Health Screening and Early Intervention Services**:* The purpose is to improve the overall quality of life of children 0-18 years through early detection of birth defects, diseases, deficiencies, development delays including disability and provide comprehensive care at appropriate levels of health facilities. These services will be delivered through the Rashtriya Bal Swasthya Karyakram (RBSK). RBSK will cover at least 30 identified health conditions for early detection, free treatment and management through dedicated mobile health teams placed in every block in the country. District Early Intervention Centers (DEIC) will be set up to provide further screening and management support to children detected with health conditions and make appropriate referrals. The mechanism to reach all the target groups of children for health screening will be through enabling facility based newborn screening at public health facilities, by existing health manpower, and community based newborn screening at home through ASHAs during home visits. Children six weeks to six years would be screened periodically by dedicated Mobile Health Teams at the Anganwadi Center. Further, in Government and Government aided schools children six years to 1 8 years will be screened. This intervention will not only halt deterioration of the condition but also reduce the OOP expenditure among the poor and the marginalized. Additionally, the Child Health Screening and Early Intervention Services will also provide country-wide epidemiological

data on the 4 Ds (i.e., Defects at birth, Diseases, Deficiencies, Developmental Delays and Disabilities). This is important to inform planning in the future, for area specific services. Public health institutions, private sector partnerships and partnerships with NGOs will be encouraged to provide specialized diagnostics/tests and services and to fill gaps in services. Such institutions would be reimbursed for services as per agreed costs of tests or treatment. In addition to the direct provision of such services, the state will enable convergence with ongoing schemes of other relevant ministries. Patient transport network supported under NHM will be used to transport sick children to higher facilities.

- **A*dolescent Health:*** Adolescent Health programmes include the following priority interventions: Iron and Folic Acid (IFA) supplementation, facility-based adolescent health services, community based health promotion activities, information and counseling on sexual and reproductive health (including menstrual hygiene), substance abuse, mental health, non-communicable diseases, injuries and violence including domestic violence. These interventions will be operationalized through various platforms including Adolescent Friendly Health Clinics (AFHC), VHNDs, Schools, Anganwadi Centers and Nehru Yuva Kendra Sangathan (NYKS), Teen Clubs and a dedicated Adolescent Health Day. Outreach activities aimed at information provision and health promotion will be through Peer educators and mentors. Provision of nutrition counseling, treatment for RTIs/STIs, appropriate referrals and commodities such as IFA tablets, condoms, Oral Contraceptive Pills (OCPs) and pregnancy kits for all adolescent girls and boys at the AFHCs. Information and counseling will be provided by dedicated and trained counselors. There will be enhanced focus on vulnerable and marginalized sub-groups. Menstrual hygiene practices will be promoted in rural areas through use of sanitary napkins. This is to be combined with building adequate knowledge and information about the product through ASHAs. Provision of Weekly Iron and Folic acid Supplementation (WIFS) for addressing nutritional anemia among adolescent boys and girls in rural and urban areas would be part of the National Iron Plus Initiative. The scheme also includes nutrition and health education sessions, screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility. There would be provision for biannual de-worming (Albendazole 400mg), six months apart, for control of helminth infestation, information and counseling for improving dietary intake and preventing intestinal worm infestation.

- ***Family Planning:*** Meeting unmet needs for contraception through provisioning of a range

of family planning methods will be prioritized. A differential approach between the high fertility states and the rest will be followed. In high fertility states the aim is to reduce fertility to replacement levels and states which have achieved replacement levels will sustain it. Family planning services would be utilized as a key strategy to reduce maternal and child morbidities and mortalities in addition to stabilizing population. Post-partum and post abortion contraception would be a priority. All states would be encouraged to focus on promotion of spacing methods, especially Intra-Uterine Contraceptive Devices (IUCDs). Postpartum IUCD will be emphasized as a key spacing method to leverage the increase in institutional deliveries while ensuring appropriate counselling and quality of services.

Facility Based Service Delivery A Facility Development Plan has the following components: Infrastructure, equipment, human resources, drugs and supplies, quality assurance systems and service provisioning. While the Indian Public Health Standards (IPHS) guides the facility strengthening plan in terms of specifications, appropriate increases in Human Resources, beds, drugs and supplies commensurate with caseloads will be made. Facilities prioritized for development on account of high caseloads, would receive additional inputs. Excess staff would be redeployed from facilities with low caseloads. New construction would be planned not just on the basis of population norms, but also consider other factors such as utilization of existing facility, existence of other facilities (public as well as private) and disease burden. State investments in technical support agencies or capacity building programmes to ensure building designs that conform to health care requirements would be needed. In the plan for developing health care facilities, efforts would be to review the entire set of facilities as an integrated care network in rural and urban areas. The facility development plan would normally include the provision of AYUSH services. The important principle of co-location of AYUSH services in health facilities would continue to be supported. Provision for supply of AYUSH drugs to support the human resource deployed would be made.

Community Processes, Behaviour Change Communication, and Addressing Social Determinants

ASHA The ASHA component would continue to be strengthened, while preserving the principles of voluntarism, local residency, community based selection, and the three key roles of facilitation for health care services, community level care provision including counseling and interpersonal communication for behaviour change, and social mobilization, especially for the marginalized to access essential health care services. Each of these roles reinforces the

other. Community mobilization will also include action in convergent areas such as importance of sanitation facilities and health and hygiene education programs, in schools and Anganwadi centers. While there is substantial experience with the ASHA programme in rural areas, ASHAs in urban areas would be a new feature. Broadly selection processes and roles would be similar but would be tailored to the urban context as appropriate. They would be selected at the level of 200-500 households, using community based selection mechanisms.