Internship at
National Health Mission, Madhya Pradesh

By

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We perceive this opportunity as a big milestone in our career development. We will strive to use gained skills and knowledge in the best possible way, and we will continue to work on their improvement, in order to attain desired career objectives.

Thank you

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1. Background

1.1 The broad principles and strategic directions of National Health Mission (NHM) encircling two Sub-Missions, National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) intended dynamically to guide States towards ensuring the attainment of universal health care access through strengthening of health systems, institutions and capabilities.

1.2 The Twelfth Plan provides the broad guidance for this and also incorporates the comments and suggestions from the Planning Commission, various Ministries, and state governments. This is intended to lay out the approach for the National Health Mission for the period 2012-2017 and beyond.

1.3 The 2006 Implementation Framework has served the Mission well and has guided the NRHM so far and for NUHM has been approved by the Cabinet on May 1, 2013. These Frameworks guide the NRHM and the NUHM in so far and are not inconsistent with any of the provisions of the NHM Framework.

2. Vision and Core Values of the NHM

2.1 Vision of the National Health Mission "Attainment of Universal Access to Equitable, Quality and Affordable health care services, accountable as well as responsive to people's needs, with effectual inter-sectoral convergent action to address the wider health social determinants".

2.2 Core Values preserve the health of the vulnerable, poor and disadvantaged, and move towards a correct based approach to health through entitlements and service guarantees reinforce public health systems as a basis for universal access and social protection against the financial costs of health care. Build environment of reliance between people and providers of health services. Give power to community to become active participants in the process of attainment of highest achievable levels of health. Institutionalize transparency and accountability in all mechanisms. Advance efficiency to optimize use of existing resources.

3. Goals

3.1 The key goals of NHM will be towards enabling and achieving the acknowledged vision, making the system responsive to the needs of citizens, building a broad based inclusive joint venture for realizing National health goals, focusing on the survival and well being of women and children, reducing disease burden and ensuring financial protection for households.

4. Outcomes

4.1 Outcomes for NHM are part of the overall vision to ensure achievement of following indicators:

a. Reduce MMR to 1/1000 live births
b. Reduce IMR to 25/1000 live births
c. Reduce TFR to 2.1
d. Prevention and reduction of anemia in women aged 15–49 years
e. Prevent and reduce mortality & morbidity from communicable, non- communicable; injuries and emerging diseases
f. Reduce household out-of-pocket expenditure on total health care expenditure
g. Reduce annual incidence and mortality from Tuberculosis by half
h. Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
i. Annual Malaria Incidence to be <1/1000
j. Less than 1 per cent microfilaria prevalence in all districts
k. Kala-Azar Elimination by 2015, <1 case per 10000 population in all blocks

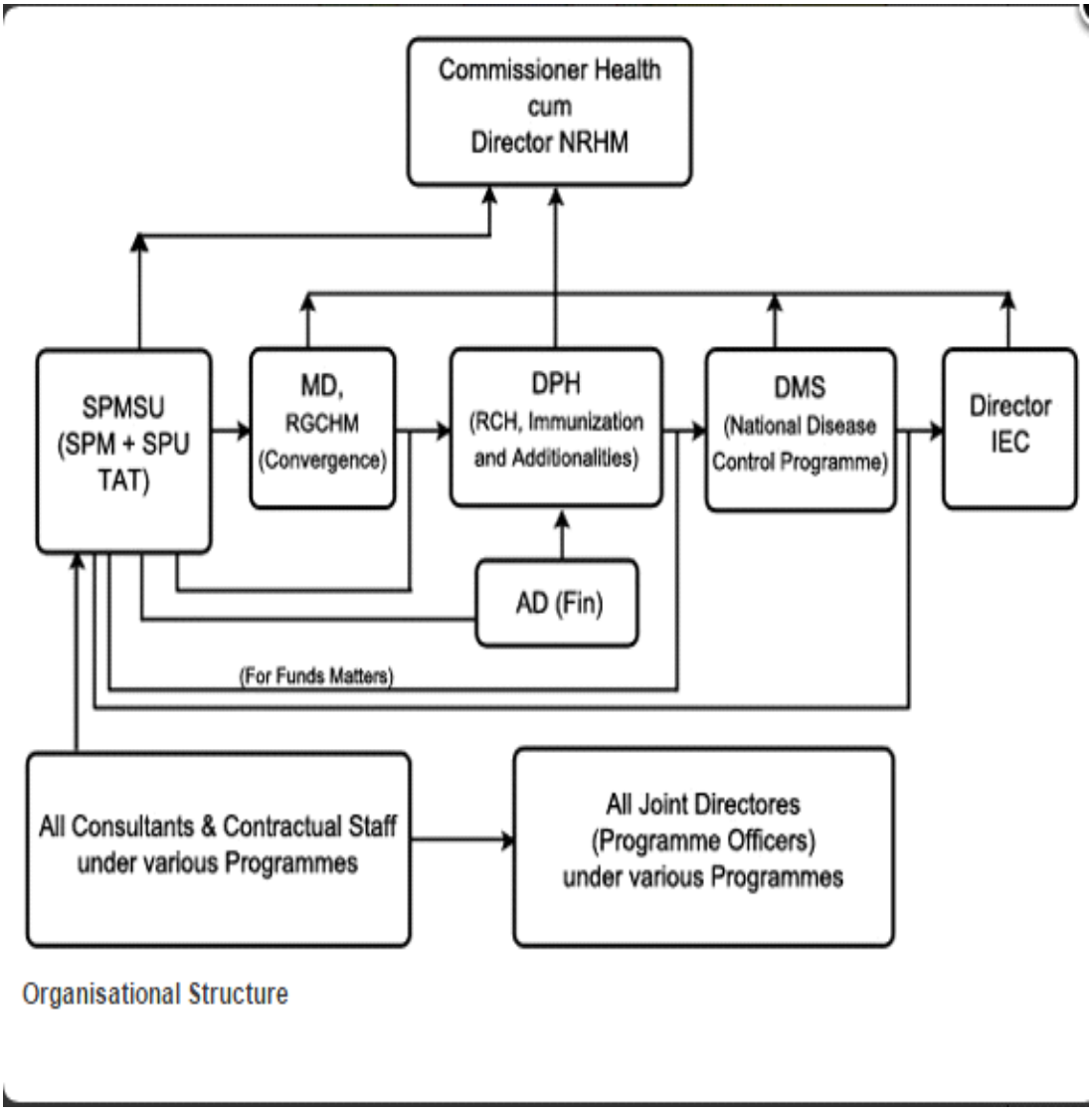
5. Organization and Organogram

5.1 About the Organisation:

5.1.1 The National Rural Health Mission (NRHM) is an initiative undertaken by the government of India to address the health needs of under-served rural areas. Launched in April 2005, the NRHM was initially tasked with addressing the health needs of 18 states that had been identified as having weak public health indicators. The Union Cabinet vide its decision dated 1 May 2013, has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an overarching National Health Mission (NHM), with National Rural Health mission (NRHM) being the other Sub-mission of National Health Mission.

5.1.2 The National Health Mission (NHM) encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the newly launched National Urban Health Mission (NUHM). The main programmatic components include Health System Strengthening in rural and urban areas- Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs.

5.2 NHM, MP-Organogram



Organisational Structure

6. Strengthening of Health System

6.1 Adoption of the Indian Public Health Standards: This defined not only the service package that each facility must provide, but also specified the minimum inputs required to ensure quality of care, in terms of infrastructure, equipment, skilled human resources, and supplies. It was an assurance to the states of financing the gaps between available levels of these inputs and the levels needed to achieve the IPHS norms. A substantial increase in these inputs was driven by facility surveys to identify gaps and then planning and financing to close these gaps.

Quality standards have been defined with respect to clinical protocols, administrative and management processes and for support services. The Operational Guidelines for Maternal and Newborn care published by the Ministry of Health and Family Welfare comprehensively defined such quality standards for RCH care.

6.2 Skill gaps and Standard Treatment Protocols: Skill sets and standard treatment protocols required for provide quality RCH services and training packages that would provide these skill sets were designed. These include the Skilled Birth Attendance (SBA) training package for ANMs, the Navjat Shishu Suraksha Karyakram (NSSK) and the IMNCI packages for ANMs, the Home Based Newborn Care (HBNC) for ASHAs, and the Emergency Obstetric Care (EmOC) package for doctors. These training packages also introduced the standard treatment protocols in each of these areas.

6.3 Hospital Management Societies (RKS) and untied funds: The mandatory creation of a hospital management society (Rogi Kalyan Samiti) and empowering this body with untied funds has allowed public participation also contributed to improved quality of care. RKS members were trained and sensitized on quality of care issues. Before the onset of NRHM, many states generated funds from user fees; however the untied grants to all public health facilities were made available under NRHM which reduced financial barriers to access of health care. This is clearly evident from the increased utilization of indoor and outdoor services at health facilities.

6.4 Quality Improvement Programmes: NRHM also supports initiatives for building quality management systems. These range from formation of quality assurance committees which use check lists and periodic monitoring visits to assess quality gaps, to more structured quality management systems leading to a third party audit and quality certification- either using ISO 9001: 2008 or NABH. Till date, 82 facilities have been certified by ISO, nine facilities have been certified by NABH and 446 facilities are under process of certification.

7. Service Delivery Strategies

7.1 Reproductive, Maternal, Newborn, Child Health and Adolescent (RMNCH+A) Services

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

7.1.2 Another dimension 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 in the 'Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India'. The chief strategies for RMNCH+A include services for mothers, newborns, children, adolescents and women and men in the reproductive age group.

i. Maternal health: Basic strategies include improved access to skilled obstetric care through facility development, increased quality and coverage of ante-natal and post natal care, increased access to skilled birth attendance, institutional delivery; basic and comprehensive emergency obstetric care 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 in a district. Private providers would also be contracted-in to supplement services wherever required through public health facilities. Multi-skilling medical officers will be needed to provide emergency obstetric care. The Janani Suraksha Yojana (JSY) enables institutional delivery. Another goal is to move towards UHC through an expanding package of free cashless services currently covering all pregnant women, and sick infants up to the age of one year through Janani Shishu Suraksha Karyakram (JSSK), thereby reducing financial barriers improving access to health services by eliminating OOP expenditure in all government facilities. Strengthened emergency response and patient transport systems for improving access to institutional care, including assured availability of referral and transport services with respect to inter facility transfers and out referrals. Improved monitoring of care in pregnancy will be enabled by mother and child name based information systems, and facility and community based Maternal Death Reviews (MDRs) will be emphasized. Comprehensive women's health including pregnancy related morbidity, care for non communicable diseases among women including screening and treatment of women for common cancers such as cervix and breast would also be emphasized.

ii. Access to safe abortion services: The focus would be to improve access to comprehensive abortion care, including post abortion contraceptive counselling and services, by expanding the network of facilities providing Medical Termination of Pregnancy (MTP) services. MTP services would be provided at least in every 24×7 facility in every block and in every facility upgraded for

FRU services (also Level 3 services). Multi-skilling of providers will include use of Manual Vacuum Aspiration (MVA) and medical abortion.

iii. Prevention and Management of Reproductive Tract Infections (RTI) and sexually Transmitted Infections (STI): Key strategies include: prevention of RTI/STI to be included in BCC interventions for community health education and as part of adolescent health education, provision of diagnosis and treatment services at health facilities, syndromic management at 24×7 and lower levels, and laboratory and diagnostic based services at Level 3 facilities. Special focus would be given on linking up with Integrated Counselling and Treatment Centres (ICTCs) and establishing appropriate referrals for HIV testing and RTI/STI management.

iv. 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 centres, 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.

v. Newborn and Child health: This will be through a continuum of care from the community to facility level and include the provision of home based newborn and child care through ASHAs and ANMs, supplemented by AWW, and community level care for acute respiratory infections, diarrhoea, and fevers, including home remedies, first contact curative care, or referral as appropriate. Essential newborn care and resuscitation at all delivery points through establishment of Newborn Care Corners and skilled personnel will be ensured. Facility Based Care for sick newborns will be provided through the establishment of Newborn Stabilization Units (NBSU) and Special Newborn Care Units (SNCU). This includes strengthening public health facilities and accrediting private providers to manage referrals. Institutional care for sick children and provision for management of Severe Acute Malnourished (SAM) children at Nutrition Rehabilitation Centres (NRC) will be linked to community based care for SAM. Infant and Young Child Feeding (IYCF) and nutrition counselling 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.

vi. 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.

vii. Child 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 identi fied health conditions for early detection, free treatment and management through dedicated mobile health teams placed in every block in the country. District Early Intervention Centres (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 Centre. Further, in Government and Government aided schools children six years to 18 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, De ficiencies, 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.

viii. Adolescent 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 counselling 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 Centres 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 counselling, 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 counselling will be provided by dedicated and trained

counsellors. There will be enhanced focus on vulnerable and marginalized subgroups. 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 anaemia 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 helminthic infestation, information and counselling for improving dietary intake and preventing intestinal worm infestation.

ix. 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). Post-partum IUCD will be emphasized as a key spacing method to leverage the increase in institutional deliveries while ensuring appropriate counselling and quality of services. In addition to existing providers, AYUSH doctors will also be trained for IUCD services. Male involvement including male sterilization would be promoted. Distribution of contraceptives at the doorstep through ASHAs and other channels will be actively promoted. Improved family planning service delivery including access, availability and quality of services; counselling services through dedicated counsellors; improved technical competence of the providers and increased awareness among the beneficiaries would be ensured. Month-long national campaigns on the eve of World Population Day would be continued every year in all states/ districts across the country. The compensation scheme for sterilization acceptors to cover loss of wages to the beneficiary and also to the service provider (and team) for conducting sterilizations would be continued. The clients will be insured in the eventuality of deaths, complications and failures following sterilization and the providers/ accredited institutions will be indemnified against litigations in those eventualities under the National Family Planning Indemnity Scheme (NFPIS). The State Quality Assurance Cell would be responsible for management of claims under the NFPIS scheme. Additional strategies to be adopted in the high fertility states are: the promotion of healthy spacing after marriage and between the births by engaging ASHAs as the motivator and counsellor for the community; intensification of skill building strategies for family planning providers; involvement of private providers as appropriate to increase the use of spacing and limiting methods; substantial expansion in facilities and providers offering the full range of contraceptive services; and BCC activities that focuses on improving access and reducing unmet need. addressing the declining sex ratio:x. Improving the adverse child sex ratio will be crucial and strategies that lie within the domain of health include: stricter enforcement of the PCPNDT Act, improved monitoring and sensitization of the medical community, and a greater role for civil society action in addressing son preference, addressing neglect of the girl child in illness care, observing sex ratios in hospital admissions for illness in children, and providing proactive support for girl children through the ASHA and Anganwadi

system. xi. Cross cutting areas: BCC and addressing social determinants is complementary to all the above strategies. Human resources and infrastructure requirements for RMNCH +A services would be integrated with the facility strengthening component. Continuous training, technical support and supervision of the RMNCH+A programme and management support through Programme Management Units at the national, state, district and block levels, SIHFW, SHSRC and District Knowledge Centres will be critical.

7.2 Control of Communicable Diseases:

7.2.1 The NHM will continue to focus on communicable disease control programmes and disease surveillance. The strategies, interventions and activities under each programme as also the resource envelopes have been approved already for the years 2013-17. The strategies, interventions and activities will be appropriately adapted and fine-tuned to meet the distinct challenges of urban settings. The Flexipool for Communicable Diseases will facilitate the states in preparing state, district and city specific PIPs.

i. ***The National Vector borne diseases Control Programme (NVBDCP)*** is an umbrella programme for prevention and control of vector borne diseases viz. Malaria, Japanese Encephalitis (JE), Dengue, Chikungunya, Kala-Azar and Lymphatic Filariasis. Of these, Kala-Azar and Lymphatic Filariasis have been targeted for elimination by 2015. The states are responsible for programme implementation and the Directorate of NVBDCP provides policy guidance and technical assistance, and support to the states in the form of funds and commodities. The Government of India provides technical assistance and logistics support including anti-malaria drugs, DDT, larvicides, etc. under the programme. State Governments have to meet other requirements of the programme and to ensure effective programme implementation. There would also be a thrust on identified geographic areas where the problems are most severe. Strategies employed would include early case detection and prompt treatment, strengthening of referral services, integrated vector management, use of Long Lasting Insecticidal Nets (LLIN) and larvivorous fishes. Other interventions including behaviour change communication will also be undertaken.

ii. ***Revised National Tuberculosis Control Programme (RNTCP):*** The goal is to decrease mortality and morbidity due to TB and reduce transmission of infection until TB ceases to be a major public health problem in India. Objectives of the programme are to achieve and maintain cure rate of at least 85% among New Sputum Positive (NSP) patients and achieve and maintain case detection of at least 70% of the estimated NSP cases in the community. The current focus of the programme is on ensuring universal access to quality TB diagnosis and treatment services to TB patients in the community and now aims to widen the scope for providing standardized, good quality treatment and diagnostic services to all TB patients in a patient-friendly environment, in which ever

health care facility they seek treatment from. The programme has made special provisions to reach marginalized sections including creating demand for services through specific advocacy, communication and social mobilization activities.

iii. ***National Leprosy Control Programme (NLEP).*** Key activities include diagnosis and treatment of leprosy. Services for diagnosis and treatment (Multi Drug Therapy, MDT) are provided by all primary health centres and government dispensaries throughout the country free of cost. ASHAs are involved in bringing leprosy cases from villages for diagnosis at PHC, following up cases for treatment completion, and are paid an incentive for this. To address the problem in urban areas, Urban Leprosy control activities are being implemented in 422 urban areas with a population of over 100,000. These activities include MDT delivery services and follow up of patient for treatment completion, providing supportive medicines, dressing material and monitoring & supervision.

iv. ***Integrated disease surveillance Programme (IDSP)*** is being implemented in all the states for surveillance of out-break of communicable diseases. Surveillance units have been established in all states/districts (SSU/DSU), with a Central Surveillance Unit (CSU) established and integrated in the National Centre for Disease Control (NCDC), Delhi. Weekly disease surveillance data on epidemic disease are being collected from reporting units such as sub-centres, PHC, CHC, DH and other hospitals including government and private sector hospitals and medical colleges. The data are being collected on 'S' syndromic; 'P' probable; & 'L' laboratory formats using standard case definitions. Over 90% districts report such weekly data through a dedicated e-mail/portal. The weekly data are analyzed by SSU/DSU for disease trends. Whenever there is rising trend of illnesses, it is investigated to manage and control the outbreak.

7.2.2 Communicable diseases need a special focus in urban areas, where disease transmission is facilitated by high population density. Poor urban management, lack of implementation of construction/building laws, issues relating to water supply, poor waste disposal practices etc have a direct bearing on vector breeding. Diseases like TB which are transmitted through droplets have a higher incidence in crowded habitats. The NUHM, with a focus on urban areas, will enable heightened attention on prevention and control activities of communicable diseases

7.2.3 Integration of communicable disease programmes will occur at six levels:

i. The district plan and facility strengthening plan for disease control programmes will be integrated with the overall strategy. For each of these programmes, there is a facility development requirement and a community action component. A strategic district plan would be able to ensure that both components are put in place.

ii. The BCC strategy will be integrated with the BCC strategy for the ASHA and VHSNC.

iii. Each programme could manage and maintain its own information system with the condition that the data from each system shall be exported to a common data warehouse. The current web-portal would be modified to allow data entry through multiple formats and routes of entry, and serve as a portal of access to information in different systems. The IDSP data, the data from the Disease Control programmes, from the health care facilities and the mortality data will be taken together to build an information base of all diseases in the district.

iv. The district/city plan will specifically address prevention and control of other communicable diseases with a significant prevalence specific to a district or city, other than the national disease control programmes. Progress review of the communicable disease programmes will be undertaken by the state, city and district health societies.

v. Institutional mechanisms for capacity building, knowledge management and vi. technical support at state and national levels will be developed, but at the district/ city level activities would be integrated into the broad heads indicated earlier.

7.3 Control of Non Communicable Diseases (NCD)

7.3.1 NCDs account for 53% of the total deaths (10.3 million) and 44% (291 million) of disability adjusted life years (DALYs) lost in India. By 2030, NCDs are projected to cause up to 67% of all deaths in India. Most NCDs have common risk factors such as tobacco use, unhealthy diet, physical inactivity, alcohol use and require integrated interventions targeting these risk factors. The rising burden of NCDs calls for concerted public health action. In addition to clinical approaches, preventive action and policy responses involving multiple stakeholders are required, and the NHM will need to address the growing burden of non communicable diseases.

7.3.2 The schemes and interventions under the non communicable diseases that would be implemented upto the district hospital would be financed through a Flexible Pool for noncommunicable diseases under NHM.

i. ***National Programme for Prevention and Control of Cancer, diabetes, Cardiovascular diseases and stroke (NPCDCS):*** Primary care includes primary prevention of hypertension and diabetes, screening for these diseases and secondary prevention by routine follow up with medication to prevent strokes and ischemic heart disease. This needs to be linked through two way referral linkages with appropriate secondary and tertiary care providers. Cardiac Care Units for treatment of Ischemic heart disease, stroke and other cardiovascular

emergencies, and facilities for diagnosis and treatment of chronic kidney diseases including dialysis will be made available at district hospital level. For cancer control, one dimension is care at the primary level, i.e. prevention, promotion, and early detection, assisted access to higher specialist care, guidance and support. Another dimension is to create a network of hospitals that could provide free care for cancer patients. Most of the latter is in the tertiary sector, but a number of district hospitals should also be able to provide cancer treatment. Facilities for screening of common cancers (Cervical Cancer, Breast Cancer and Oral cancer) and Day Care Centres for chemotherapy prescribed by Tertiary level cancer hospitals would be provided.

ii. ***National Programme for the Control of blindness (NPCB):*** The NPCB would be part of the NCD flexi-pool under the overarching umbrella of the NHM. The focus in the 12th Plan period would be to consolidate gains in controlling cataract blindness and also initiate activities to prevent and control blindness due to other causes. Key strategies are to increase public awareness about prevention and timely treatment of eye ailments; with a special focus on illiterate women in rural areas; continuing emphasis on primary healthcare (eye care) by establishing Vision Centres in all PHCs; active screening of population above 50 years through screening camps; transporting operable cases to eye care facilities; screening of school age children for identification and treatment of refractive errors (in synergy with the RBSK); with special attention in under-served areas; provision of assistance for other eye diseases like Diabetic Retinopathy, Glaucoma and childhood blindness through use of laser techniques, corneal transplantation, Vitreoretinal Surgery, construction of dedicated Eye Wards and Eye Operation Theatres (OT) in District Hospitals and in NE states and few other states as needed, use of Mobile Ophthalmic Units, at district level for patient screening & transportation; and strengthening of existing Eye Banks and Eye Donation Centres. NGOs will be involved and the private sector will be contracted-in where required.

iii. ***National Mental health Programme (NMHP):*** The existing District Mental Health Programme would be integrated into NHM, and expanded to cover all districts in a phased manner. In addition to managing common mental problems, severe mental diseases, and mental emergencies, new components like suicide prevention, workplace stress management, adolescent mental health and college counselling services will be included. Services for alcohol and substance use, rehabilitation of the mentally ill community and home care for chronic and enduring mental illness will be provided and synergies will be built with RMNCH+A to identify and manage post partum depression. 108 Ambulance services will be made available to transport patients to the District Hospital in an emergency and a country wide mental health help line will be set up. Day Care Centres, Residential Continuing Care Centres, and Long Term Residential Continuing Care Centre will be provided in selected districts in this plan period. The provision of mental health in NHM will entail the provision of an integrated package of care to be delivered at various levels. Outreach services will be provided by community

mental health nurses supported by the PHC which will also undertake case detection, management of common mental illness, stabilizing and referral of severe illness or emergency and providing medication refills. The CHC will provide outpatient services for walk in patients and patients referred by the PHC, inpatient services for emergencies and assessment, Medical and Social Care and Support to Continuing Care services and Counselling services. The District Hospital will offer outpatient services, inpatient services, child mental health service, specialist and counselling services, referrals for day centres, medium stay centres and long stay centres, disability certification by the psychiatrist, laboratory services including Therapeutic Drug Monitoring for psychotropic medications, training, supervision and support to taluk/CHC and primary health care staff at the PHCs, and conducting periodic outreach clinics at the CHC. Additional human resources include psychiatrists, clinical psychologists, trained psychiatric nurses, and counsellors. Existing staff, charged with supporting the programme will be trained appropriately. NGOs and CBOs will be involved in the provision of services such as counselling and managing selected interventions. iv. national Programme for the healthcare of the elderly (nPhCe): The aim of the NPHCE is to provide comprehensive health care to senior citizens through all levels of the health care delivery system including outreach services. In addition to services in 100 identified districts, 225 additional districts will be taken up, and the eight Regional Geriatric Centres will be expanded to 20. At the community level, ASHA will enable mobilization of elderly to screening camps and be trained to provide home based care. The sub-centre team will support home visits, IEC, related to healthy ageing, environmental modification, nutritional requirements, life style and behavioural changes, and support care givers in care for home bound/bedridden elderly persons, arrange for callipers and supportive devices from PHC to make patients ambulatory, and facilitate linkage with other support groups and day care centres etc. operational in the area. PHC/CHC will undertake periodic check-up of the elderly, and the information updated in a Health Card for the Elderly. Training will be integrated with the NPCDCS. The PHC will organize weekly Geriatric Clinics, conduct basic clinical assessments of the elderly relating to vision, joints, hearing, chest, and blood pressure, undertake simple investigations including blood sugar, etc, ensure provision of drugs to the elderly, and facilitate referral for further investigations and treatment to the CHC or DH. The CHC will be the first medical referral unit for patients from PHCs and below, organize bi weekly Geriatric Clinics, provide Rehabilitation Services and requisite equipment through a Physiotherapist/Rehabilitation worker, and organize referral to DH/Medical college. Geriatric Units are to be set up in 100 selected District Hospitals to conduct geriatric clinics through regular dedicated OPD. Other interventions at the DH include a ten bedded geriatric ward for in-patient care, facilities for laboratory investigations, provision of equipment and medicines for geriatric care, training of MOs and allied health staff at CHCs and PHCs, and referral services for severe cases to tertiary level hospitals/Regional Geriatric Centres. Given the scarcity of specialists in geriatric field, existing specialists in various fields who are either trained in geriatric or interested in the field will be utilized for managing geriatric clinic and geriatric wards. At all levels, there

would be synergy with other NCD programmes and interventions for the provision of diagnostics, equipments, consumables, medicines and services for geriatric care.

v. ***National Programme for the Prevention and Control of Deafness (NPPCD):*** The current pilot phase of the NPPCD in 192 districts, will be expanded to 200 additional districts. Its key objectives are to prevent avoidable hearing loss, early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness, rehabilitate persons of all age groups, suffering with deafness, and strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme, and develop institutional capacity for ear care services by providing support for equipment, material and training. This will be done through strengthening capacity of DH, CHC and PHC for Ear Nose Throat (ENT) and Audiology infrastructure; training of human resources, including an Audiometric Assistant/Instructor for the hearing impaired, management of hearing and speech impaired cases and rehabilitation at different levels of health care delivery system. Provision of hearing aid to hearing impaired children and conducting screening camps for early detection of hearing impairment, will be through RBSK and in convergence with the Ministry for Social Justice and Empowerment.

vi. ***National Tobacco Control Programme (NTCP):*** Interventions under the NTCP will be largely at the primordial and primary levels of prevention. Key thrust areas include training of health and social workers including ASHAs, NGOs, school teachers, enforcement officers; IEC activities; school based programmes; monitoring tobacco control laws; co-ordination with PRI/VHSNC for village level activities and strengthening/establishment of cessation facilities including provision of pharmacological treatment facilities at district level. The NTCP would emphasize tobacco cessation services at all levels of the healthcare delivery system. The NTCP would tap all possible opportunities to integrate tobacco control interventions with other health programmes to ensure most effective and efficient use of available resources. Through NHM, the NTCP would specially strive to reach out to the urban poor, tribals and populations in Left Wing Extremism affected areas as well as in underserved areas, who are prone to the menace of tobacco products including smokeless forms of tobacco.

vii. ***National oral health Programme (NOHP):*** A total of 200 districts in a phased manner would be taken up to strengthen the existing healthcare delivery system at primary and secondary level in order to provide promotive and preventive oral health care The district will be supported with equipment, human resources and consumables for a dental unit. States which already have a dental unit at district level would be enabled to set up such units at CHC level.

viii. ***National Programme for Palliative Care (NPPC):*** Palliative care improves the quality of life by alleviating pain and suffering, and may influence the course of the disease in patients with cancer, AIDS, chronic disease, and the bed ridden elderly. Palliative care strategies will be synergized with programmes for the care of the elderly and patients

with cancer and chronic diseases. Strategies for palliative care in NHM will use the continuum of care approach, through IEC, outreach and coordination of referral at the level of the PHC, out-patient and home-based care at the PHC and in-patient care through allocating specific beds at the DH, Medical College and Regional Cancer Centres. Additional human resources (medical officers, nurses and counsellors) would be provided for and appropriately trained in palliative care.

ix. ***National Programme for the Prevention and Management of burn Injuries (NPPMBI):*** Key objectives are to reduce incidence, mortality, morbidity and disability due to burn injuries, improve awareness among the general masses and vulnerable groups (women, children, industrial and hazardous occupational workers), establish adequate infrastructural facility and network for BCC, enable burn management and rehabilitation, and carry out formative research to assess behavioural, social and other determinants of burn injuries to facilitate need based program planning. Prevention would be through school based programmes, mass media programmes for general public and appropriate advocacy. District hospitals would be provided with six beds for burn units. Rehabilitation services would be provided through facility and community based rehabilitation services, and HR would be trained appropriately.

x. ***National Programme for Prevention and Control of Fluorosis (NPPCF):*** The programme will be expanded from the existing 100 to an additional 95 new districts. The key strategies are surveillance of fluorosis in the community, capacity building in the form of training and manpower support as required, management of fluorosis cases including surgery, rehabilitation and health education for prevention and control of fluorosis.

7.3.3 In addition, NHM would also support interventions upto district hospital level, for other NCDs not specifically mentioned above. Programmes for NCDs would emphasize on continuity of care. At the primary level it would include preventive and promotive activities, including BCC, early screening, case detection and appropriate referral through outreach services, specialist consultation, and follow up with provision of essential drugs at the primary care level. For specialist referral, the primary health facilities must be linked to secondary and tertiary levels of care for each disease related group.

7.3.4 All aspects of care for NCD are part of the integrated district plan. However tertiary level care for NCD would not be supported through this flexi pool. The district hospitals may however draw some of their resources from non NHM sources to address NCDs.

7.3.5 The central approach to integrating NCD into the district/city health plan would be to define the pathway of care in an integrated care network for each disease category. This would imply defining

services available at the ASHA and outreach level, and the package of care in SHCs, PHCs, CHCs and district hospital, the BCC strategy and preventive public health measures.

7.3.6 Given the limitations in specialist human resource there would be a need to prioritize which facilities at a given level would be taken up for strengthening and providing assured referral services. Initially this service may be offered only at the district hospital, selected sub district hospitals and CHCs, and with skill building, supportive supervision, resource support, and additional human resources, the number of such facilities will expand, thereby reducing the time taken to access such care.

7.3.7 An important dimension is building accessible health records for patients requiring long term follow up at primary levels with occasional visits to the specialist in the higher facility. The programme will put in place indicators for monitoring process and outcomes and organize the analysis of information flowing in. This will be the responsibility of the programme management cells located within District, City and State Programme Management Units.

7.3.8 The NCD intervention in the district plan will get a boost from the supply of free drugs and diagnostics within the health system. The assurance that anti-diabetic drugs including insulin, anti-hypertensives, essential medicines for treatment of cardiovascular diseases, chemotherapy for cancer patients through day care centres, anti-asthmatics, anti-epileptics, anti-depressants and other basic psycho-active drugs, are available on a cashless basis to the poor will greatly expand the range of illnesses managed. An annual specialist consultation enabled through electronic medical records will improve quality of care. But even to reach this level would be a significant achievement.

7.3.9 Mainstreaming AYUSH is another key strategy that will increase the care available for NCD. AYUSH practitioners will be trained in preventive, promotive activities and screening for NCD, and integrating Indian system of medicine with modern systems of medicine in rejuvenation therapy.

8. Monitoring and Evaluation

8.1 There will be four major approaches to monitoring and evaluation. They include: use of data from large scale population surveys, commissioning implementation research or evaluation studies, use of HMIS data and field appraisals and reviews. Health outcomes, output and process indicators will be monitored.

8.2 The first will be through the using the periodic Population Health Surveys and Demographic Information. These include: The Sample Registration Surveys (SRS), Death statistics, National Sample Survey Organization (NSSO) data on cost of care and morbidity, DLHS and NFHS.

8.3 The second will be through the commissioning of special studies. There will be a concurrent evaluation study and an end of the project impact evaluation study. Both studies will be designed by an expert group drawn from multiple organisations, which shall act as a steering and advisory committee for the study. The studies shall be commissioned through a transparent process, based on robustness of study design, the quality of study team committed and the costs. All major components of the NHM will be independently evaluated, though in most cases an impact evaluation may not be possible.

8.4 The third is the use of data from the Health Management Information systems. This would be the most useful source of information for monitoring by district teams. Capacity for analysis and use of information would need to be rapidly built up.

8.5 The fourth approach would be through appraisal visits. Rapid appraisals by public health experts from varying types of organizations have added significant value to implementation. Most important of these is the Common Review Mission (CRM). Despite its limitations, there is evidence to show that CRM reports are a frequently cited and used form of evaluation information, more so than any other comparable sources of information. The CRM shall be strengthened and retained as an annual feature. Reports of integrated monitoring teams of the Ministry, the Regional Directors, and the Population Resource Centres (PRC) would also contribute to monitoring which in turn would lead to improved programme management

8.6 Both process and outcome indicators will be measured. Main outcome measures are mortality and morbidity rates which can be measured for diseases under the national disease surveillance system, supplemented by surveys.

8.7 Other than the outcome measures above, monitoring and evaluation must include progress with respect to other dimensions of achieving the goal of universal health care. These aspects of universal health care are measured as progress on three axes:

- The Cost Dimension is measured as Out of pocket expenditure on health care as a proportion of total health care expenditure. A key goal of UHC is to reduce OOP expenditure to less than 20% of total health expenditure.

- The coverage/access dimension is measured as the percentage of population-in-‹ need of specific services who are actually able to access these services. A key goal of UHC is that it should reach 100%. This includes preventive care.
- The service package dimension: This includes the list of assured services that ‹ are available on a cashless basis and the time/difficulty to access these services. A general principle is that quality primary care should be available as close as possible to where people live and work and emergency care should be available within the golden hour and the full package of assured services within the district.

8.8 Collection of disaggregated data is important to identify the socially and geographically disadvantaged. This is best obtained from well planned surveys with adequate sample sizes. As and when patient records become digitized, aggregated data can be automatically culled out from such records. Such disaggregation could become available even through existing reporting systems e.g. wherever MCTS is in place, annual disaggregated data can be made available and this disaggregation could apply to disadvantaged communities of geographical areas.

9. Health Management Information Systems (HMIS)

9.1 NHM envisages a functional health information system facilitating information for effective decision-making. A robust information system is essential for decentralized health planning. Lack of indicators and local health needs assessment have been decentralized analysis of data and for decision making at state, district, city and sub-recognized as constraints to effective decentralization.

9.2 The health management information systems would support regular district levels and enable local users in management of health service delivery and in routine activities.

9.3 Multiple information systems in various health programs need to be integrated for data exchange to facilitate comprehensive decision making. This requires integration of service delivery data (including HMIS, MCTS Hospital information Systems data, tracking data etc.), Nikshay with morbidity (IDSP), mortality (death reporting and MDR) and with other information systems data (human resource management systems, finance management systems, drug inventory and information for private sector regulatory systems, e.g., PCPNDT implementation). The output of these systems will be linked for display in GIS application for decision-making as well as provide flexibility to the users not only in developing their output reports but also in entering data in software and accessing information through various means.

9.4 The Centre have a national web-portal, which could “communicate with” the state and district level systems, from which it takes the requisite information.

9.5 Problems of data quality would be systematically studied by data triangulation from routine reporting systems with external surveys. Independent assessment of data quality by providing feedback through proper sampling and comparison of recorded and reported figures at each level by accredited agencies will also help in identifying issues.

9.6 Another measure is the dissemination of the analysis of key data elements like maternal or child mortality to community monitoring groups and obtain their assistance to correct information gaps.

9.7 An important step to improve data quality and utility is to actually use the data on a regular basis for planning and monitoring implementation of various programmes at all levels.

9.8 The integrated National Family Health Survey (NFHS) will provide district level data on key programme outcome indicators with a periodicity of three years. Efforts are made to obtain district wise data on vital indicators like CBR, CDR, IMR, NMR, U5MR, MMR, TFR etc. with fixed periodicity through a survey by Registrar General of India. The HMIS would be strengthened and expanded to provide data on a wide range of emerging programme components.

10. NHM Finance

10.1 Financial Management Group(FMG) working under NHM Finance Division of Ministry of Health & Family Welfare is involved in planning, budgeting, accounting, financial reporting, internal controls including internal audit, external audit, procurement, disbursement of funds and monitoring the physical and financial performance of the programme, with the main aim of managing resources efficiently and achieving pre-determined objectives. Sound financial management is a critical input for decision making and programme success. Accurate and timely financial information provides a basis for informed decisions about the programme, fund release and assists in reducing delays for smooth programme implementation.

10.2 FMG tries to ensure that all programmes receive their funds in a timely manner after adhering to all the GFR provisions and DoE conditionalties. Under NHM, it is the endeavour of the Government of India to build effective financial management capabilities for managing the funds provided to the State Health Societies. The States have also been encouraged to set up Financial Management Groups (FMG) at the State and Strengthen financial management capacities at District level.

11. List of abbreviations

AHS	Annual Health Survey
ANC	Ante natal care
ASHA	Accredited social health activist
BCG	Bacillus Calmette Guerin
CDC	Centers for Disease Control
DLHS	District Level Household and facility Survey
DPT	Diphtheria, Pertussis, Tetanus
EPI	Expanded program of immunization
FHW	Frontline Health Workers
FI	Fully Immunized
GNM	General Nurse Midwife
GoI	Government of India
GPS	Global Positioning System
HMIS	Health Management Information System
IDC	International Design Centre
IEC	Information Education Communication
IMR	Infant Mortality Rate
MCTS	Mother and Child Tracking System
MDGs	Millennium Development Goals
m-Health	Mobile Health
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
NFC	Near Field Communication
NFHS	National Family Health Survey
NGO	Non-government organization
NHM	National Health Mission
NIHFW	National Institute of Health & Family Welfare
NRHM	National Rural Health Mission
OPV	Oral Polio Vaccine
PNC	Post Natal Care
RCT	Randomized control trial
RI	Routine immunization
RGI	Registrar General of India
RMNCH	Reproductive, Maternal, New born, Child health
SDGs	Sustainable Development Goals
SEA	South east Asia
SBA	Special Birth attendant
STI	Sexually transmitted Infections
TBA	Traditional birth attendant
UIP	Universal immunization program

UNICEF	United Nations Children's Fund
VPD	Vaccine preventable disease
WHO	World health organization

12. References:

I	www.nhmmp.gov.in
Ii	www.health.mp.gov.in>nhm