Internship
at
National Health Mission,
Punjab

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Contents

Goals:

Outcomes for NHM in the 12th Plan are synonymous with those of the 12th Plan, and are part of the overall vision. The endeavor 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.

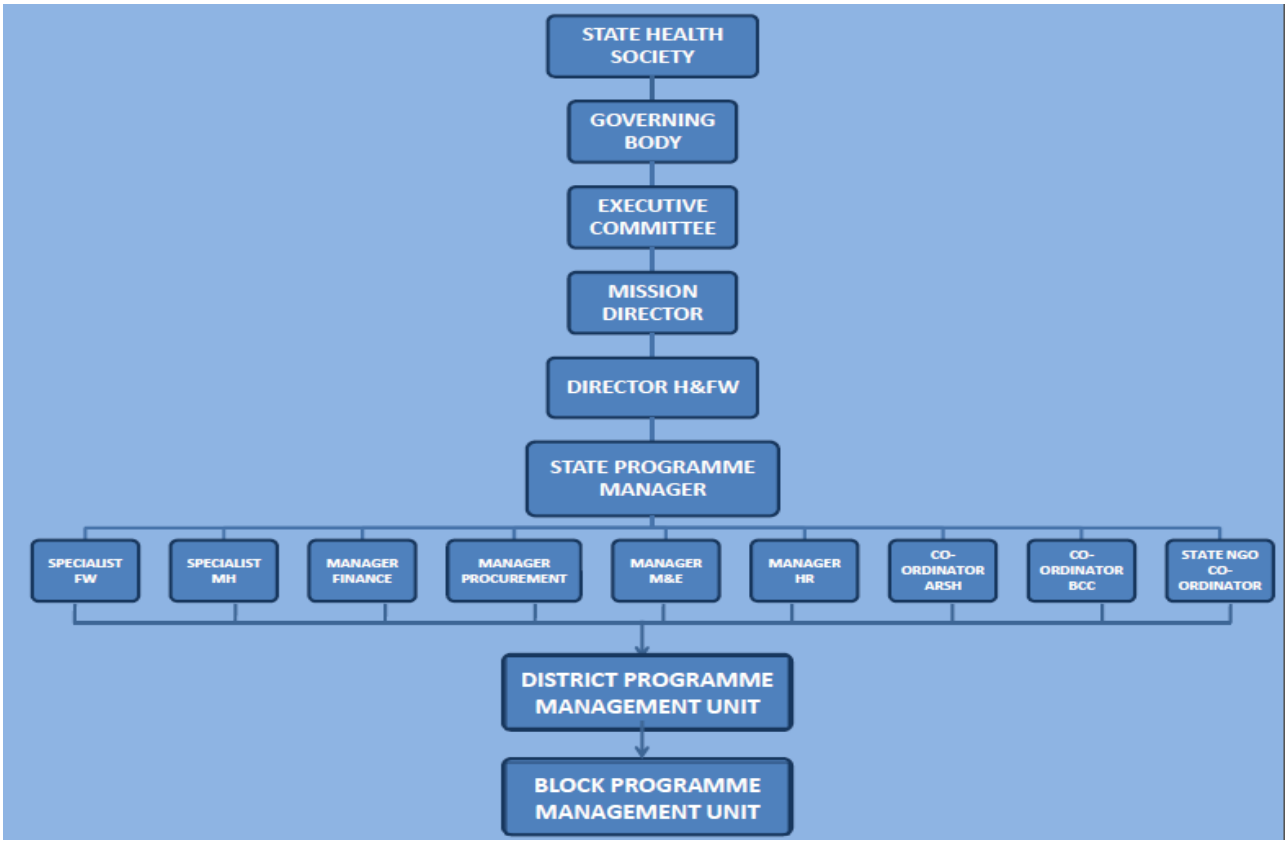
Box-1

1. Reduce MMR to 1/1000 live births
2. Reduce IMR to 25/1000 live births
3. Reduce TFR to 2.1
4. Prevention and reduction of anaemia in women aged 15–49 years
5. Prevent and reduce mortality & morbidity from communicable, non- communicable; injuries and emerging diseases
6. Reduce household out-of-pocket expenditure on total health care expenditure
7. Reduce annual incidence and mortality from Tuberculosis by half
8. Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
9. Annual Malaria Incidence to be <1/1000

10. Less than 1 per cent microfilaria prevalence in all districts

11. Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

Organogram of National Health Mission, Punjab



Source: NHM, Punjab website

State profile:

Health Indicators of Punjab

Demographic, Socio-economic and Health profile of Punjab State as compared to India figures:

The Total Fertility Rate of the State is 1.8. The Infant Mortality Rate is 34 and Maternal Mortality Ratio is 172 (SRS 2007 - 2009) which are lower than the National average. The Sex Ratio in the State is 893 (as compared to 940 for the country). Comparative figures of major health and demographic indicators are as follows:

Indicator	**Punjab**	**India**
Total population (In crore) (Census 2011)	2.77	121.01
Decadal Growth (%) (Census 2011)	13.73	17.64
Infant Mortality Rate (SRS 2013)	26	40
Maternal Mortality Rate (MMR bulletin 2011-13)	141	167
Crude Birth Rate (SRS 2013)	15.7	21.4
Crude Death Rate (SRS 2013)	6.7	7
Natural growth rate (SRS 2013)	9	14.4
Sex Ratio (Census 2011)	893	940
Child Sex Ratio (Census 2011)	846	914
Total Literacy Rate (%) (Census 2011)	76.68	74.04
Male Literacy Rate (%) (Census 2011)	81.48	82.14
Female Literacy Rate (%) (Census 2011)	71.34	65.46

Health Infrastructure of Punjab

Particulars	Required	In position	shortfall
Sub-centre	3463	2951	512
Primary Health Centre	577	449	128
Community Health Centre	144	132	2
Health worker (Female)/ANM at Sub Centres & PHCs	3400	4199	*
Health Worker (Male) at Sub Centres	2951	1694	1257
Health Assistant (Female)/LHV at PHCs	449	388	61
Health Assistant (Male) at PHCs	449	265	184
Doctor at PHCs	449	457	*
Obstetricians & Gynaecologists at CHCs	132	66	66
Physicians at CHCs	132	59	73
Total specialists at CHCs	528	279	249
Radiographers at CHCs	132	123	9
Pharmacist at PHCs & CHCs	581	878	*
Laboratory Technicians at PHCs & CHCs	581	482	99
Nursing Staff at PHCs & CHCs	1373	2062	*

(Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI)

Since 2005, the National Rural Health Mission has resulted in an unprecedented strengthening of the public health system with focus on health infrastructure, human resources, service delivery, program management, monitoring and communitization.

Deployment of ASHAs across rural areas has changed the paradigm of the way services are delivered at doorstep of the people. The Government of Punjab has effectively harnessed the resources of NRHM and scaled up initiatives such as the Universal Immunization Programme, skilled care at birth, Emergency Obstetric Care, IMNCI (Integrated Management of Neonatal and Childhood Illnesses), NSSK (Navjat Shishu Suraksha Karyakram), FBNC (Facility Based Newborn Care), and referral transport services. Demand side financing initiatives such as the JSY (Janani Suraksha Yojna) and JSSK (Janani Shishu Suraksha Karyakaram) have helped in reducing out of pocket expenses on healthcare of women and children. Indeed, the Government of Punjab has gone beyond the provisions of NRHM for maternal and child health by introducing the MKKS (Mata Kaushalya Kalyan Scheme) and the free treatment of all girls up to the age of five years in public facilities.

Punjab has made great progress in infant and newborn care. The infant mortality rate of the State is far below the national average. The State has planned to track each and every child till the first year of age with a view to ensure child survival and hence, further reduce the IMR as per the target for 2015. The burden of infectious diseases in children is an important determinant of morbidity and mortality among young children. The major contributors to child mortality being pneumonia, diarrhea and malnutrition, the incidence and severity of both pneumonia and diarrhea show a socioeconomic gradient due to exposure to risk factors related to the environment, such as lack of clean water, sanitation, indoor air pollution and overcrowding, and to impaired immune response caused by inappropriate feeding practices, lack of exclusive breastfeeding, artificial feeding and under nutrition.

It is important to keep in mind the three key indicators of optimal Infant & Young Child Feeding Practices, i.e. initiation of breastfeeding within one hour of birth, exclusive breastfeeding for the first six months and timely and appropriate complementary feeding after six months along with continued breastfeeding.

Current rate of these practices remains low and is a challenge to increase in the coming five year plan.

Malnutrition is still widely prevalent in preschool children and is a direct or indirect underlying factor in about 60% of the deaths in under-five children. Wasting, stunting and micro-nutrient deficiencies have important consequences on children's susceptibility to infectious diseases and cause development delay which, if continued, is irreversible.

Lack of food is not the only cause for deficiency. It can also be due to inappropriate infant feeding and care, poor access to health care, and exposure to insanitary and unhygienic conditions.

From conception to the third year of life, disruption of brain development, caused by illness, poor nutrition or high stress levels can have an important effect on the child's ability to reach its physical, sensory, motor, cognitive, language and socio-emotional potential.

HIV infections in children pose a serious challenge. The incidence of HIV transmission from mother to child is not very alarming (0.12%) (NACO Report, December 2012). Even though the incidence of HIV infection has declined in Punjab, there is a need to strengthen advocacy for prevention of parent to child HIV transmission.

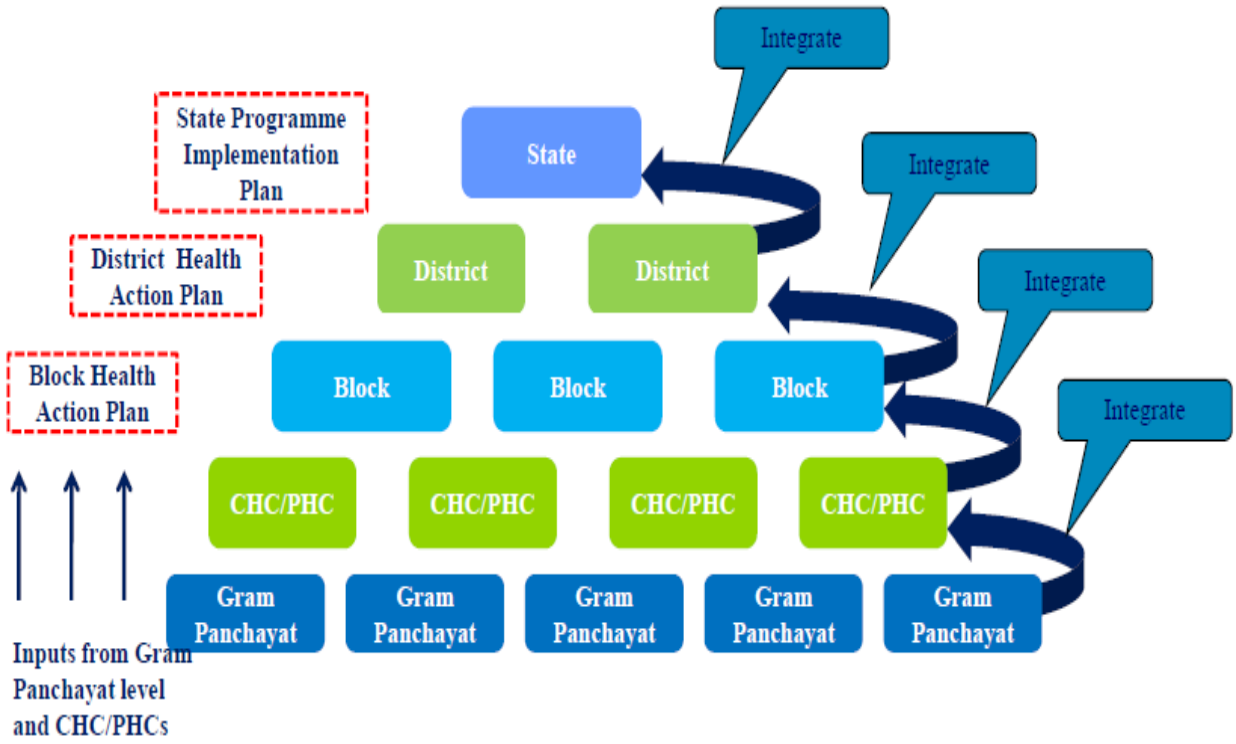
PIP of NHM, PUNJAB

State Programme Implementation Plan is a document to be prepared by States annually which helps them in identifying and quantifying their targets required for programme implementation for the proposed year. The documents are then finalized in the NPCC (National Programme Coordination Committed) meeting for Administrative approval , Resource envelope is created and accordingly conveyed to the state. On finalization of the budget in the NPCC Meeting , it becomes an Official document available in the Ministry's site for general viewing.

Planning and Approval Process of PIPs

Bottom up Approach District:

District State Integrate Integrate Integrate District Health Action Plan State Programme Implementation Plan A bottom up approach is followed for preparing the State PIP wherein the inputs are taken from block, CHC/PHC and Village level to prepare a District Health Action Plan(DHAP). These DHAPs are then consolidated to prepare a State PIP.



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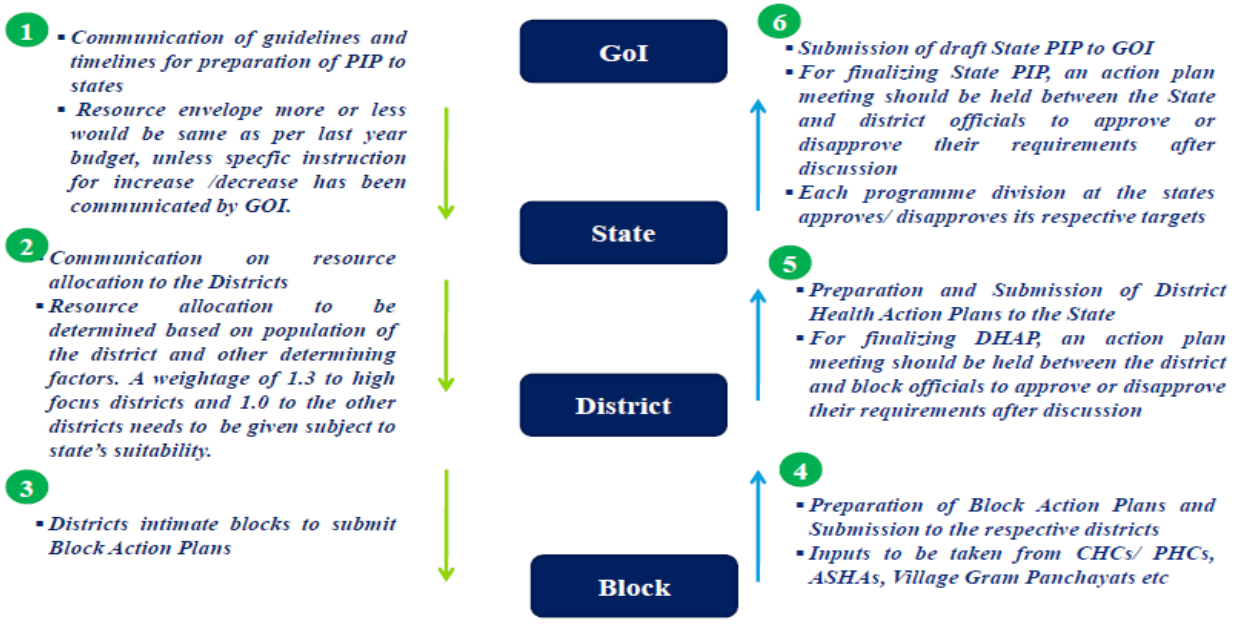
PIP preparation- Key Steps:



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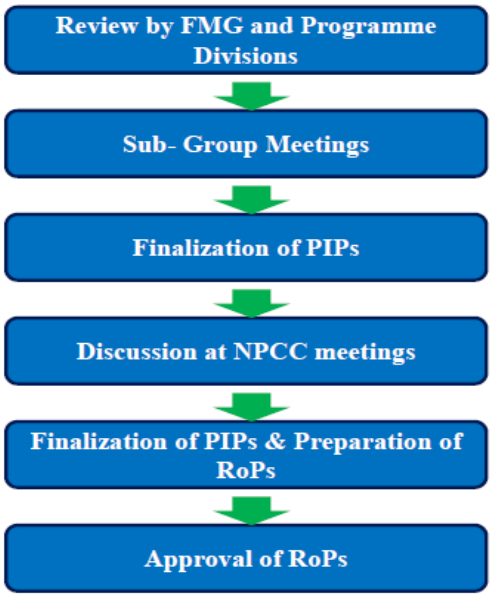
PIP Approval – Key Steps:

Following are the steps involved in the finalization of PIPs after their submission to the Center by the States:



After submission of PIPs by the states to the GOI, the FMG and respective programme divisions at GOI level review them in detail.

Pre- appraisal/ sub group meetings are held with state officials to discuss their demand of the budget as per the targets decided, compare with previous year acheivements.

Based on the suggestions made in the sub group meetings, PIPs are revised.

NPCC meetings are held at Ministry or discussion on the PIPs where each State makes a proposal through presentation. These meetings have representatives from each division to approve/ disapprove the targets and inappropriate proposals.

Suggestions made in the NPCC are incorporated in the form of Record of Proceedings (RoPs) and PIPs are finalized.

The SSMD approves the RoPs and sends them to the states by 31st March of the year.

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Key Timelines- Preparation & Approval of PIPs:

Activity	**Timeline**
• Communication of Resource envelope to Districts by the State	10th December
• Submission of District Plans based on Village/Gram Panchayats/ Block Panchayat Samiti Plans	31st December
• First Draft PIP to be submitted to State Health Mission	15th January
• Receiving of PIP in MOH&FW, GOI	Third week of January

- Pre-appraisal/ sub-group meetings at Center Last week of January up to Mid February
- Discussion at NPCC meetings Mid February to Mid March
- Submission of RoPs to AS&MD by the Group Leaders of the Sub- Groups
- Approved RoPs sent to the states after ASMDs approval

State-Specific Goals:

Punjab's MMR at 172 (SRS 2007-09) has improved from 192 (SRS 2004-06), while the IMR at 30 (SRS 2011) has decreased from 38 (SRS 2008). TFR has also decreased from 1.9 (SRS 2008) to 1.8 (SRS 2011).The following are the agreed goals and service delivery targets for the State of Punjab:

Punjab State Targets

INDICATOR	2013-2014	2014-2015
Maternal Health (MMR) SRS 07-09	105	95
Child Health U5MR(SRS 2011) IMR (SRS 2011) NMR(SRS 2011)	 30 23 19	 26 20 17
Family Planning TFR (SRS 2011)	Maintain same level	Maintain same level

Key Conditionalities and Key Incentives

Punjab has made significant progress in responding to conditionalities.

Following conditionalities shall be adhered to by the States and are to be treated as non-negotiables:

Mandatory disclosures

1. The State must ensure mandatory disclosure on the State NRHM website of the following and act on the information:
   - Facility wise deployment of all HR including contractual staff engaged under NRHM with name and designation.
   - Facility wise service delivery data particularly on OPD, IPD, Institutional Delivery, C-section, Major and Minor surgeries etc.
   - MMUs- total number of MMUs, registration numbers, operating agency, monthly schedule and service delivery data on a monthly basis.
   - Patient Transport ambulances and emergency response ambulances- total number of vehicles, types of vehicle, registration number of vehicles, service delivery data including clients served and kilometres logged on a monthly basis.
   - All procurements- including details of equipments procured (as per directions of CIC which have been communicated to the States by this Ministry vide letter No 'No.Z.28015/162/2011-H' dated 28th November 2011.).
   - Buildings under construction/renovation –total number, name of the facility/hospital along with costs, executing agency and execution charges (if any), date of start & expected date of completion.

- Supportive supervision plan and reports shall be part of mandatory disclosures. Blockwise supervisory plan and reports should be uploaded on the website.
- NGOs/PPP funded under NRHM would be treated as 'public authority' and will fall under the ambit of the RTI Act 2005 under Section 2(h

2. State/UT to ensure that JSY payments are made through Direct Benefit Transfer (DBT) mechanism through AADHAAR enabled payment system/Core Banking Solution where DBT mechanism has been rolled out. Further, cash payment or bearer cheque payment is henceforth disallowed across the States.
3. Timely updation of MCTS and HMIS data including facility wise reporting
4. Line listing of high risk pregnant women, including extremely anaemic and Low Birth Weight (LBW) babies.

Key Conditionalities

5. As agreed, the following key conditionalities would be enforced during the year 2013-14.

a) Rational and equitable deployment of HR1 with the highest priority accorded to high priority districts and delivery points.

b) Facility wise performance audit2 and corrective action based thereon.

c) Performance Measurement system set up and implemented to monitor performance of regular and contractual staff.

d) Baseline assessment of competencies of all SNs, ANMs, Lab Technicians to be done and corrective action taken thereon.

e) Gaps in implementation of JSSK may lead to a reduction in outlay upto 10% of RCH base flexipool.

Incentives

6. Initiatives in the following areas would draw additional allocations by way of incentivisation of performance:

a) Responsiveness, transparency and accountability (upto 8% of the outlay).

b) Quality assurance (upto 3% of the outlay).

c) Inter-sectoral convergence (upto 3% of the outlay).

d) Recording of vital events including strengthening of civil registration of births and deaths (upto 2% of the outlay).

e) Creation of a public health cadre (by States which do not have it already) (upto 5% of the outlay)

f) Policy and systems to provide free generic medicines to all in public health facilities (upto 5% of the outlay)

g) Timely roll out of RBSK (upto 5% of the outlay)

h) Enacting/adopting a bill like the Clinical Establishment Act, 2010 as per their requirement, to regulate the quality and cost of health care in different public and private health facilities in the State (upto 5% of outlay).

i) States providing more than 10% increase in its annual health budget as compared to the previous year will attract additional incentive.

j) States to implement the nurse practitioner model to strengthen the nursing services.

Key Learning :

- Importance of Programme Implementation Plan (PIP)
- Steps involved in preparation and approval of State PIPs
- Concept of District Health Action Plan and its purpose
- Revised PIP guidelines circulated to states and its requirements
- Broad contents of the PIP and the important aspects to be included
- Role of finance and accounts staff in the preparation of PIPs/ DHAPs