NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
(2005-2012)

MADHYA PRADESH

Winning applauses by setting trends in health services

Department of Public Health & Family Welfare
Madhya Pradesh

F O R W O R D

It gives me great pleasure to document publication a few innovative health schemes and interventions of M.P. These are some of our eager efforts to bring our State in line with national health indicators and MDGs. This process of health reform will, I hope, be strengthened and improved with your valuable suggestions.

M. P. has hitherto being a high focus state due to its health indicators. With limited resources and rising expectations, we have constantly innovated to improve our health delivery system. The Government of M.P. has in recent years mead health one of the priority sectors. As a result our critical indicators are showing constant improvements.

I seek your valuable suggestions on the schemes outlined in this publication.

Mr. S.R. Mohanty
Secretary, Department of Public Health and Family Welfare,
Mantralaya Vallabh Bhawan, Bhopal (M.P.)

Department of
Public Health & Family Welfare
Madhya Pradesh

ROGI KALYAN SAMITI

Launched in 1995-96 ROGI KALYAN SAMITIs (RKS) are patient welfare societies. These are registered societies under the Madhya Pradesh societies registration act - 1973. It is a local decentralized management mechanism for the patient welfare especially for the Rural and poor patients.

Background

In the State of Madhya Pradesh, traditionally the delivery of health care has been within the domain of public sector. RKS was successfully experimented at the Maharaja Yashwant Rao Hospital (MYH) at Indore in the financial year 1995-96; the state initiated a scheme for citizen involvement in the management of state hospitals and health centres. The MYH was evacuated through a carefully calculated process of admissions and discharge. All the patients of the MY hospital were shifted to 12 hospitals situated all over the town of Indore, both government and private. The hospital was cleaned, refurnished and its facilities vastly improved before reopening it for public use. No government funds were used in the project, which cost a little over Rs. 45 lakhs.

Around a year after the experiment at the MYH in Indore, the State Government directed other districts to take up similar projects. In the first year, a handful of districts, especially those close to medical colleges adopted the scheme. By 1997-98, almost all the districts in the state had adopted it. All the committees were authorized to levy user charges according to their local conditions while remaining within the broad parameters laid down by the State Government.

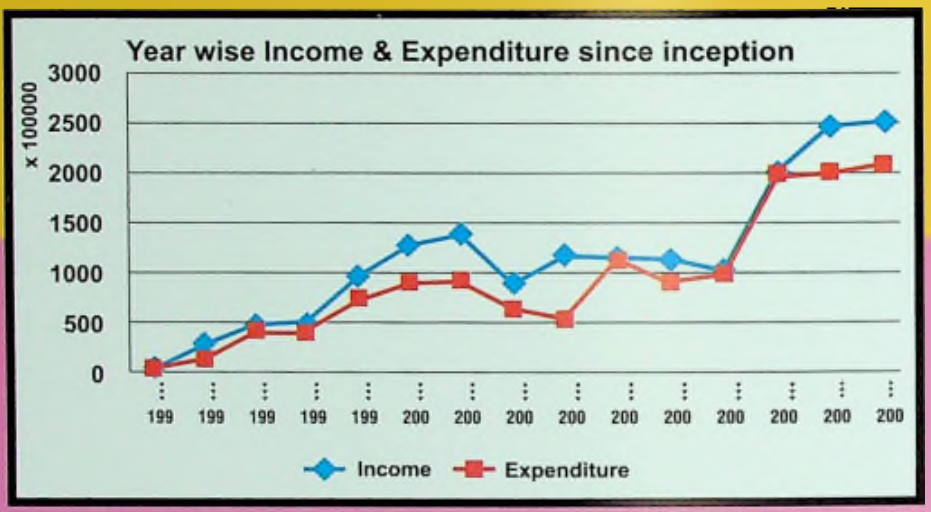
With a review of the system in 1998, the Government of Madhya Pradesh issued instructions that gave sweeping powers to the Samiti. The instructions expanded the objectives as well as the duties of the RKS. Rogi Kalyan Samiti got international recognition when it was awarded the Global network award of U.S. dollars 1,25,000/- at Japan on 13-2-2000.

GOI directed all states to follow Madhya Pradesh in RKS formation. In Madhya Pradesh RKS have been formed in all 50 District Hospitals, 53 Civil Hospitals and 228 Community Health Centres. RKS are also functioning in 870 of the total 1194 Primary Health Centres in the State.

Budget Details for RKS (2010-11) from RCH/NRHM	Amount (Rs. In lakhs)
District Hospital Rs. 5.00 lakhs per DH x 50 DHs	250.00
Civil Hospitals Rs. 1.00 lakh per Civil Hospital	54.00
Rs. 1.00 lakh per C.H.C	333.00
Rs. 1.00 lakh per PHC	882.00
Total	1519.00

[illegible] since inception in the year 1995-96 state level income is 176 crores & expenditure is 139 crores.

In the financial year 2010-11 the income of RKS up to 31-05-2010 is two crores thirty eight lakhs & expenditure is thirty one lakhs & eighty one thousands.

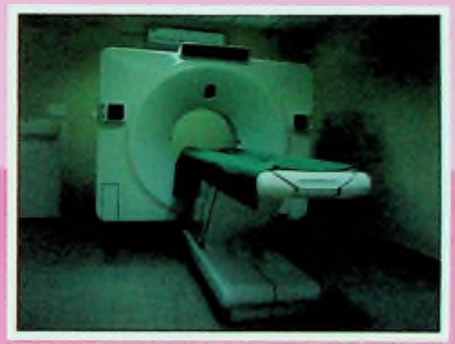


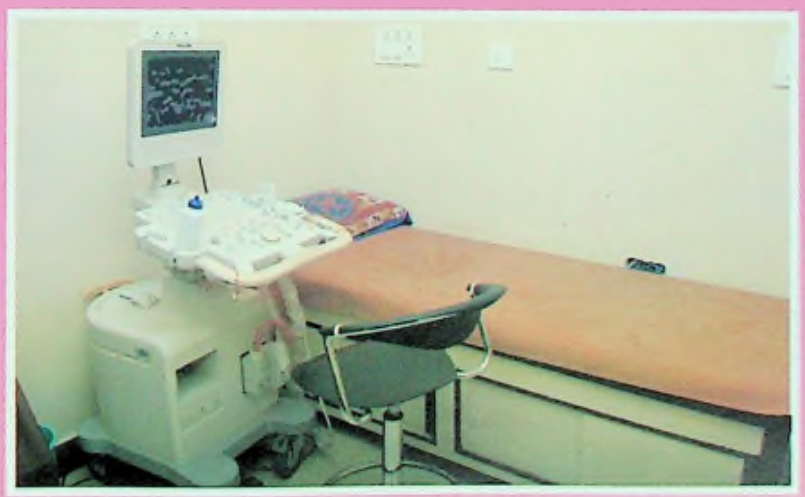
Success of RKS

The Rogi Kalyan Samitis are successful in up gradation of Hospitals. The society makes availability of life saving drugs like Anti Retro Virus (AIDS) drugs, Streptokinase (costly injectable medicine) etc. to the marginalised population of the society. At present Below Poverty Line (BPL) patients have access to high-tech investigations like Ultra-sonography, Computerised Tomography (CT) scan, Magnetic Resonance Imaging (MRI) & Colour Doppler free of cost.

The repair & maintenance of necessary equipments e.g. X-ray machine, Ultrasonography are done timely by RKS. Provision of X-ray films and Pathological reagent. Utilization of unused Govt. hospital land for commercial purposes as per the guidelines of the state Govt. ensures strengthening the financial condition of Rogi Kalyan Samiti. Special facilities like ambulance, Operation Theatre, Labour Room, Intensive Cardiac Care Unit (ICCU), NICCU are maintained by RKS funds. RKS Provides free treatment to patients below poverty line, handicapped, freedom-fighters, labourers & slums patients. Food, diet and stay arrangements for the relatives of the patients helps in better patient care. To ensure discipline and maintain accountability. Provide assured ambulance services in emergencies and during accidents. Maintenance and expansion of hospital building, cleanliness of Toilets, wards, corridors, ICCU, emergency units are taken care by the society. Drinking water facilities, shade to rest & chair, bench to seat make the ambience patient friendly in the hospital.

Patient on Dialysis machine at District Hospital Chhindwada.





Ultra Sonography Machine

STRENGTHENING OF SUB HEALTH CENTERS FOR 24 X 7 SAFE DELIVERIES

Background:

Financial incentives incorporated under Janani Suraksha Yojna provided the opportunity to bring clients to Health centre for Institutional delivery but it also raised challenges for institutions to keep pace with increasing delivery load. Then there were also villages which were remotely located with poor road connectivity making difficult for pregnant women to have timely access to BEmONCS for safe deliveries in spite of financial incentives provided by JSY. This was resulting in pockets of low institutional delivery with in the district leading to stagnation of institutional delivery gains after the initial rise.

In addition to this there was increasing load of normal deliveries coming to First referral units making it difficult for them to keep pace with increasing load resulting in deterioration in quality of Care.

Thus an urgent need was felt to improve access of women from remote areas to 24 x 7 safe delivery services as well as reduce congestion at First referral units. An attempt in this direction was first made in the year 2007-08 in Guna District where District health society Guna with support from UNICEF and Government of M.P piloted operationalization of Sub Centers for 24 x 7 delivery services in remote villages. Looking at the success of this need based innovation it was decided to scale it up State wide with necessary provisions made under NRHM plan for 2009-10 as well as 2010-11. As of date more than 450 Sub Centers have been accredited in the State for 24 x 7 safe delivery services.

Expected Outcome:

- Improvement in institutional delivery rate in remotely located and pocket areas/ villages.
- Improved access of excluded communities to institutional deliveries.
- Reduced travel time and delay in reaching safe delivery centers.
- Reduced congestion at District hospital and FRUs.

Operationalizing Sub Health Centres for safe delivery - Guna Experience:

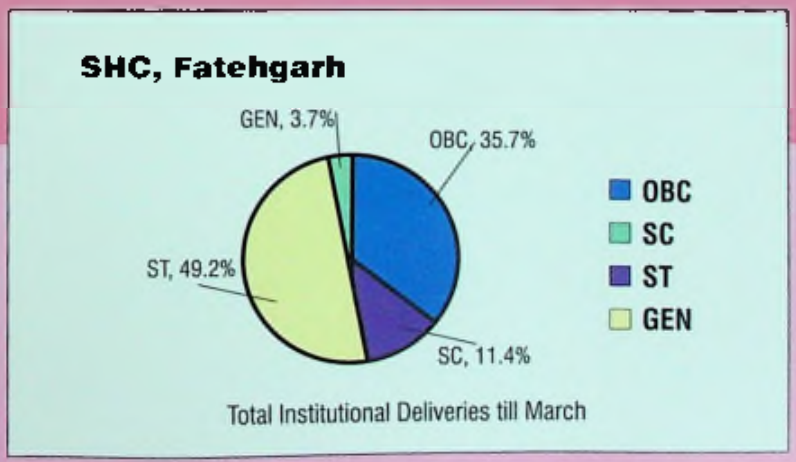
In Guna District till 2006 –07 delivery centers were concentrated along the main highway making it difficult for pregnant women from peripheral villages to access safe delivery centers in time as a result institutional delivery in the district was just 29.8 %. (DLHS-2). To improve access of these remote villages to 24 x7 safe delivery centers following steps were taken;

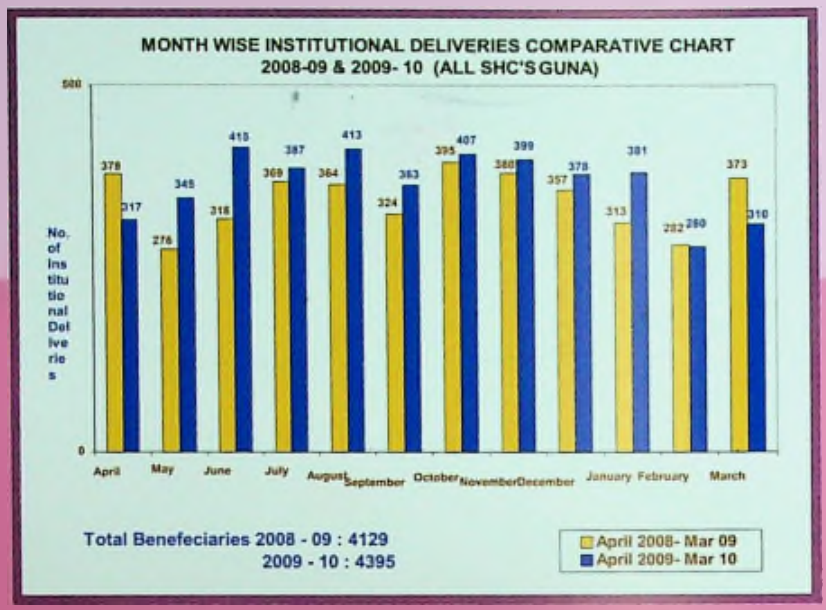
1) Establishment of Emergency Transport system connected to 24 x7 Call centre
2) Operationalizing 24 X 7 delivery centers at PHC and Sub centre level.
3) Training of Staff at Health centers. (SBA and essential Newborn care)

Mapping of the health facilities in the district was done and 12 new centers were identified and operationalized as 24 x7 safe delivery centers. Out of these eight were sub centers which were upgraded to provide the above services. The aim was to provide 24x7 safe delivery centers at every 20 Km distance thus improving accessibility and reduction in travel time leading to increased service utilization. Solar power back up, running water supply, SBA trained staff, essential equipments and Emergency transport vehicle have been provided to these revitalized Health centers.

Mapping of Delivery Centres in Guna District

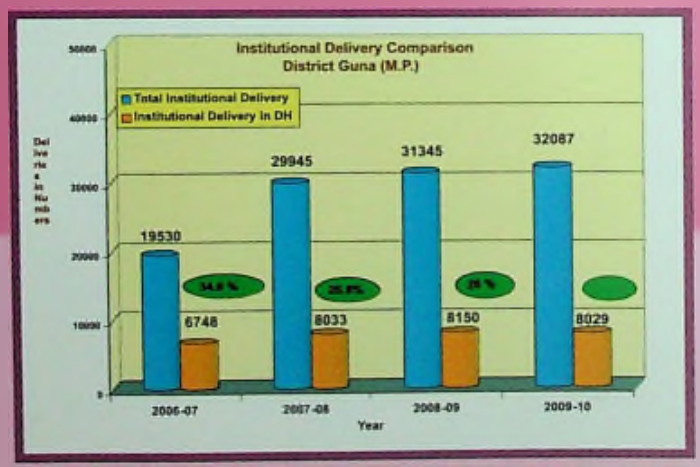
First such centre was started in Fatehgarh village which is a remote village in Guna district of Madhya Pradesh located at Rajasthan border. The nearest safe delivery point was nearly 40 Km away with very poor connectivity resulting in 10 % institutional delivery rate till 2006. To address this it was decided to start delivery services at Fatehgarh Sub centre in 2007 by providing SBA training to the staff and upgrading infrastructure to provide delivery services and essential new born care. A total of 2963 deliveries have been conducted till date safely at Fatehgarh Sub Health Centre by SBA trained ANMs with nearly 50% beneficiaries from tribal community. This data send loud innovation has helped transform a remotely located poorly maintained Sub Health Centre to be evaluated as a 24 X 7 safe delivery centre providing state-of-art support not only to Fatehgarh village but also to neighboring 30 villages. Learning from Fatehgarh experience District health society has operationalized eight such remotely located Sub centers for 24 hrs safe delivery services and more than 4000 deliveries per year are being conducted successfully at these 8 Sub centers.



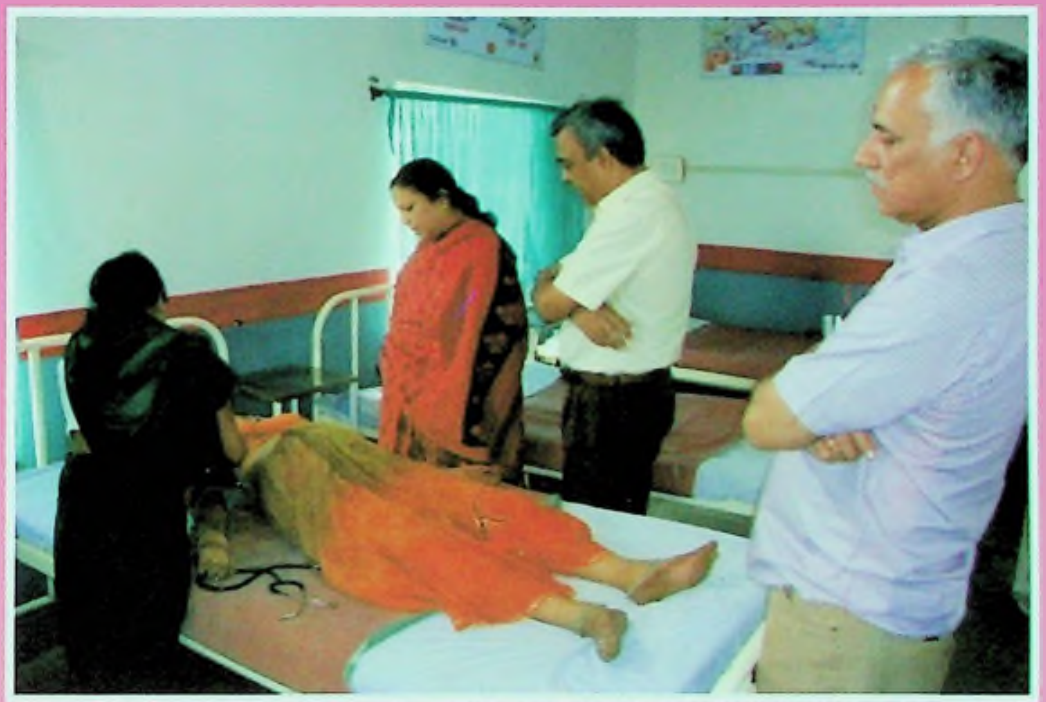


Total Deliveries at all SHC in Guna in 2008-09 and 09-10

This need based innovation to operationalize delivery services in remotely located poorly connected sub centers has gone a long way in promoting ANC and skilled birth attendance for the rural women of Madhya Pradesh. In addition with nearly 13 % of the institutional deliveries in the district being conducted at SHC and another 20 % at PHC there has been a 10 % reduction in cumulative load of Deliveries at District hospital leading to decongestion.



Decongestion at Guna District Hospital



Secretary Health GOI at Jhagar SHC, Guna

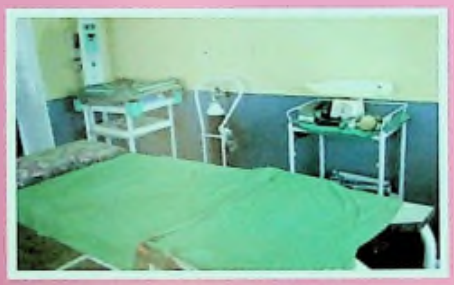
Scaling up

Learning from the success of this it was decided to operationalise five to ten remotely located sub-centers in each district for 24 x 7 safe delivery services with technical support of UNICEF. A State level committee was constituted to develop accreditation criteria for sub health centers based on which the district level committee accredit sub health center full filling the below mentioned criteria. The accredited sub health centers are providing cash incentive to women and motivator under Janani Suraksha Yojana.

- Unavailability of delivery point within 20 km radius
- Labour room and delivery ward with attached toilet
- 24 hrs running water supply and power back up
- Telephone connectivity and Availability of referral transport (Janani Express)
- Two residential ANMs trained in skilled birth attendance & ENBC
- Monitoring of Labor through Partographs.
- Essential drugs like Misoprostol and Magnesium sulphate.

Infrastructure upgradation was done using maintenance grant and untied funds and additional Rs. 25,000 per sub centre was provided under NRHM plan since 2008-09.

24 x 7 SHC, Shivpuri



Labour Room SHC, Shivpuri

24 x 7, SHC Mandsaur

Labour Room 24 x 7 SHC Anuppur

At present 450 Sub Health Centers have been upgraded in the State to provide 24 x7 delivery services. By the end of 2010 total of 500 Sub centers would be made functional for the same. Such need based initiatives to reach the unreached have resulted in maximizing benefits of opportunity provided by JSY scheme to bring women from remote villages and excluded community to health facilities and as a result Madhya Pradesh is showing rapid gains in institutional delivery

(DLHS-3: 47 %,JSY Concurrent Evaluation Report 2009: 72.8%)

SAVING LIFE ON WHEELS – JANANI EXPRESS

24 x 7 Call Centre for Referral Transport of Pregnant Women & Sick Children

Background: High Maternal and infant mortality rate is the challenging issue for the state. Considering the WHO concept of all pregnancies to be considered at risk the state is moving forward with the approach of making EmONC facilities easily available and accessible along with referral transport facilities. Lack of availability of transport has been identified as one of the major bottlenecks in timely access of women from rural area in institutional delivery centers. Thus to improve access of rural community to safe institutional delivery centers, Government of MP decided to establish referral transport system linked to 24 x 7 Call Centre for coordinated contact. The vision is to have a Comprehensive, functional, adequately funded health system, able to respond quickly to the emergency needs of women in the throes of pregnancy and childbirth complications. Three Continuum of Care from Community to Facility and from Labor room to New Born Care units within the facility has been envisioned as the key focus of work for the coming years in the State. Safe abortion services and successful contraception are the two reproductive health services not designed to treat complications but to avert them before they can even emerge are also in focus.

Concept and Operationalization of the scheme

- Janani Express Yojna is offering 24 hrs free referral transport facility to urban and rural beneficiaries APL and BPL. It is operational in 298 block of the state and nearly 40% of the beneficiaries of JSY are availing benefit of the scheme.
- Janani Express Yojana is a scheme to ensure availability of transport facility round the clock for pregnant mothers to carry them up to the nearest health facility. Vehicles used under this scheme are hired from private sector. Tenders are invited at district level and further agreements are made on prefixed criteria. 1500 kms per month has been calculated as the average distance which a vehicle will cover during a month for mobilizing pregnant women for institutional deliveries. Rs. 5/- per km has been fixed Charges of this service are paid by the transport cost (Rs. 250/) under Janani Suraksha Yojana (JSY).

- Rs. 250 will be deducted from ASHA package of rural beneficiary under JSY when adequate pool of vehicles will be available in all blocks. On an average two vehicles are available in each block @Rs. 15000/- to Rs. 20000/- per month. The range varies depending upon number of deliveries in a block and its geographical location. The vehicle is also utilized to transport referral of sick and malnourished children.

To optimize utilization of the vehicles contracted under Janani Express and ensuring better monitoring of service fleet of Janani Express has been linked to 24 x7 Call centre situated at district level. First two Call Centres were established at Guna

and Shivpuri with UNICEF technical support. To ensure timely availability of vehicle to all pregnant women and also monitoring of Janani Express Vehicle the concept of call centre has been adopted at each district head quarter.

1. Call Centre Model

Components of Model: The model has two key components

1) **Fleet of Vehicles**: Existing network of Janani Express vehicles are used. Preferably 2 vehicles in each block are contracted. Vehicles of health department can also be added in this fleet to meet the gaps. All the vehicles are available 24 x 7 and drivers to carry functional mobile phones. These vehicles are strategically placed in the blocks so that no village is more than 30 minutes in access.

2) **Centrally located 24 x 7 Call Centre:** This is required to control the fleet of vehicles and ensure Coordinated Contact. The call centre is located in district hospital campus in a room of roughly 80-150 sq. feet size. It has minimum 3 dedicated operators on 8 hourly duty shift (One in each shift) Additional 4th operator can also be kept to adjust weekly off and field coordination with drivers and ASHA workers.

   The call centre are provided with 2 dedicated telephone lines with both incoming and outgoing facility. Both the numbers are being publicized in community through radio, TV scrolls, posters, banners and ASHA workers. The Call centre is equipped with a computer in which all information about the caller is entered and contact details of drivers are kept. On receiving the call the operator directs the nearest vehicle in the village and also informs the nearby delivery centre about incoming patient. The software (provided by UNICEF) uses the information stored to generate monthly report which is being used by District Health Society to address the gaps.

Cost Analysis:

1) **Cost of Establishment of Call Centre is undertaken in RCH**

- **Cost of Setting up of Call Centre: Approx. Rs. 200,000**

  Computer with Printer and UPS: Approx. Rs. 35,000.
  Air Conditionner 1.5 ton split : Approx. Rs. 25,000
  Furniture: 2 computer table and 4 visitor chairs : Approx. Rs. 10,000
  Two telephone connections with out going facility: Approx. Rs. 5,000
  Civil work: Approx. 125,000 (allocate room of about 100 sq. feet for call centre)

2) **Operational Cost**

- **Fleet of Vehicles :**

  On an average vehicles are being hired @ Rs. 15-20 thousand per month which is inclusive of fuel cost, hiring of drivers, maintenance of vehicles from JSY transport cost.

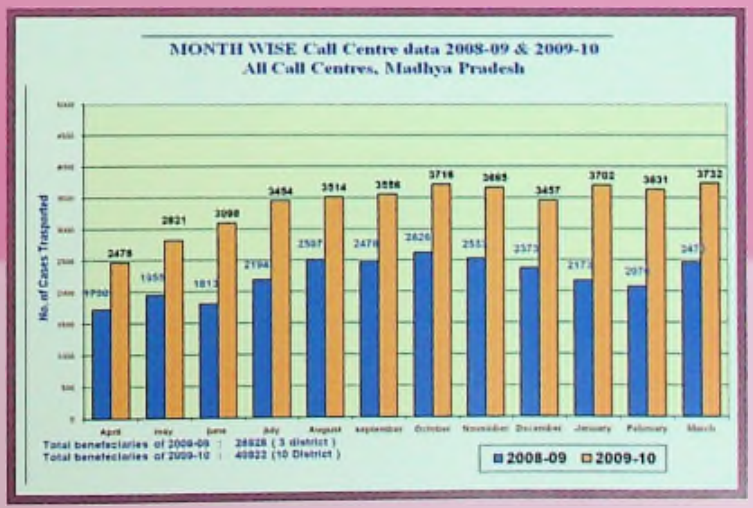
Call Centre

Running Cost: Rs. 24,000 per month. Met under RCH
Salary of 4 Computer operators: Rs. 4000 per month x 4 = Rs. 16,000 per month
Electricity and telephone bills: Rs. 4,000 per month.
Contingency. Rs.4,000 per month.

Output of referral transport system and Call Center:

Example Guna: In the year 2007-08 total 5026 pregnant women were transported free of charge from villages of Guna to [illegible] In the year 2008-09 total 9421 pregnant women were transported free of charge which accounts for nearly 40 % of institutional delivery taking place in rural area. In addition majority of beneficiaries were from [illegible]

Combined data of all Call centers in Madhya Pradesh



Scaling Up of Call Centre and Referral transport:

The Call Centre Model has been scaled up in twenty one districts of Madhya Pradesh till June 2010 using NRHM funds. In the year 2010-11 it would be scaled up in all 44 districts out of total 50 districts in the State with technical support of UNICEF. The fleet of vehicles in scale up version is not owned by district but contracted to private operator through open tender process and minimum two vehicles per block are ensured

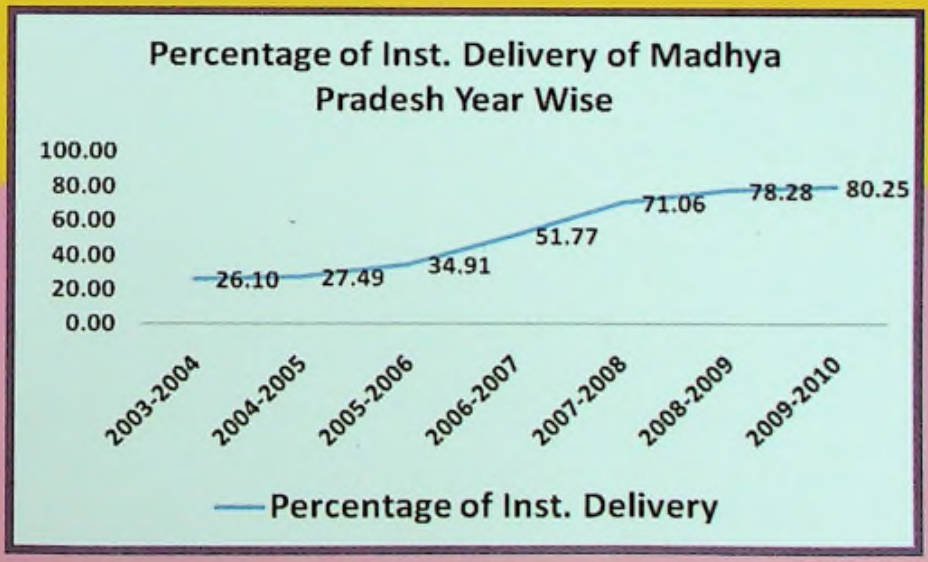
Referral transport services in the remaining four districts having Medical college hospitals and well developed private sector network is being provided through EMRI model which in context of Madhya Pradesh is more apt for bigger cities. This will be further upscaled in two more districts. The rural areas of these districts will also have Janani Express exclusively for pregnant women and sick children but no separate call centre will be there in these districts.

Future Plans:

- Establish specialized Neonatal transport system linked with Special Care New Born Unit.
- Strengthening birth preparedness and pregnancy tracking through call centre.
- Monitoring Routine Immunization using Call Centre.

MODEL MATERNITY WING: ADDRESSING QUALITY AMIDST QUANTITY

Madhya Pradesh has shown significant gains in terms of Institutional deliveries with DLHS-3 showing institutional delivery figures of 47.1 % and concurrent assessment of JSY 2009 reflecting : 72.8% in 2009. The main catalyst for this spurt in institutional deliveries has been success of Janani Suraksha and Janani Express scheme. This rapid rise has also put a challenge before our health institutions to keep pace with increasing delivery load and provide quality care to the beneficiaries. The main bottlenecks currently are inadequate infrastructure especially number of Labour beds, Small size of labour rooms, equipments inadequate, number of beds in maternity wards and shortage of trained Human resources in the labour room. To overcome these constraints and ensure quality maternity services, model maternity wings are planned in all the district hospitals of the state. The fund allocation has been done through 13th Finance Commission grant of Rs 75 crore. The construction of model maternity wings is being taken in a phased manner and by the year 2013, the state envision to establish model maternity wings across all the 50 districts.



Source: DHS Bulletin

Model maternity wing will have following section:

1- Labour room
2- OT
3- Maternity ward (ANC, PNC for ND)
4- Separate Post Operative ward
5- Obstetric ICU
6- Receiving Room
7- Observation Room
8- LSCS Room
9- Laboratory facilities

MATERNITY WING TO BE ESTABLISHED IN CLOSE PROXIMITY TO SNCU.

Design of maternity wing will be district specific depending upon delivery load, available space and existing infrastructure.

In year 2010-11 upgradation/ establishment of maternity wing will be done in 10 District Hospitals based on Guna Model. Focus will be on upgradation of existing labour rooms/ establishment of new labour rooms.

Efforts have been made to address and establish a model maternity wing under NRHM with the technical support of UNICEF. The focus is on following areas:

1) Civil modification and renovation
2) Human resource rationalization
3) Equipment's provision/upgradation
4) Infection control

1) Civil modification and renovation:

District Hospital at Guna has nearly 8,000 deliveries per year. Labour room size was increased to handle 8-10 deliveries at a time. The current size was increased to around 500 square feet for the delivery area including two toilets and New born corner. Nearly same area has been provided for changing room, utility services, nursing and doctor's station. Another 200 square feet area has been marked as patient waiting area for the attendants of women in labour. 8 Labour tables have been provided along with two neonatal warmers.

In addition following modifications have been made:

- Air conditioning: To improve air circulation, temperature regulation and microbial reduction.
- Central Oxygen points for all labour beds and Neonatal warmers
- Flooring with Vitrified Tiles of 1 sq mtr by 1 sq. mtr to reduce joints.
- Wall tiles till 6 feet to maintain hygiene and facilitate cleaning.
- False ceiling with Central Music and concealed lights.
- Wall mounted focus lights with each delivery bed for better visibility.
- Provision of uninterrupted hot water supply 24 x 7.
- 2 Attached toilets
- Receiving room, changing room, Nursing station, Duty Doctors room in vicinity.

Present : Model labour Room Guna District Hospital

2) Human Resource Rationalization :

To provide adequate quality Care in maternity wing, provision of 6 additional staff nurses and three lady medical officers have been done to provide round the clock services in maternity wing.

Nurses: Total 6 nurses posted in labour room (2 for each shift and 2 for leave and weekly off) These nurses are trained for handling different range of obstetric problems and proper obstretic protocols. In addition 4 student nurses in Morning and evening shift have been planned.

Medical Officers: Total 3 female medical officers deputed for labour room with one doctor for round the clock duty.

Aaya Bai : One female cleaning staff round the clock exclusively for labour room provided with necessary cleaning material and training (Total 4).

Security : One security personal round the clock to control crowds at entry of Maternity has been deployed. Only one relative per patient is allowed.

3) Equipments : As per standard requirement.

4) Infection Control

- No shoes allowed inside, separate clean slippers provided.
- Sterile Gowns for patient and Staff.
- Hand washing
- Regular Floor and wall mopping with disinfectant
- Restricted entry
- Use of sterile gloves
- Safe Waste Disposal and other universal precautions.

The above concept is being replicated in all the other districts keeping in view the requirement and space availability. The model maternity wings are being standardized for services as per the IPHS.

JANANI SURAKSHA YOJANA

Janani Suraksha Yojana is safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery. With the implementation of JSY there is substantial rise in institutional delivery but ANC coverage still needs focused efforts.

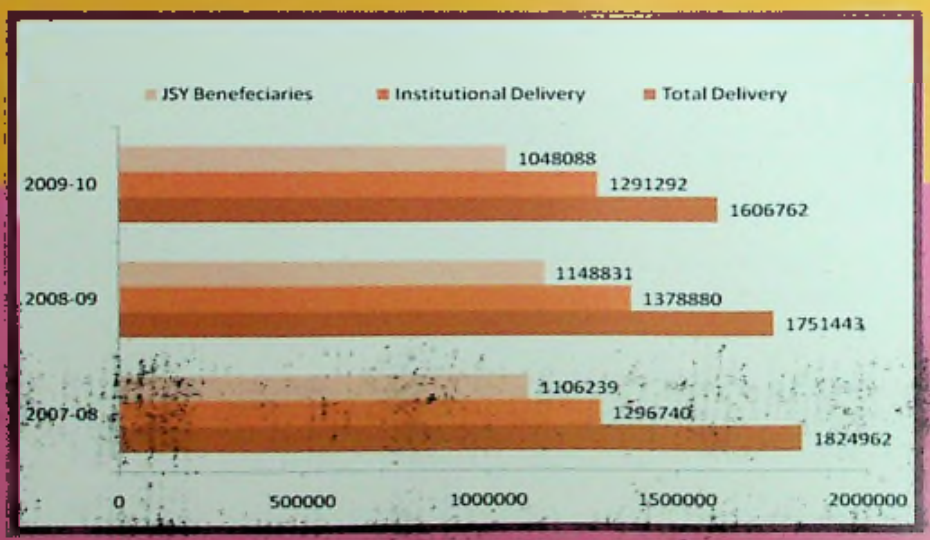
Progress

With the inception of JSY in 2005-06 the number of beneficiaries was limited to only BPL population until in year 2006-07 the benefit under the scheme was extended to all pregnant women in Madhya Pradesh which is evident by threefold rise in institutional delivery.

Evaluation of JSY

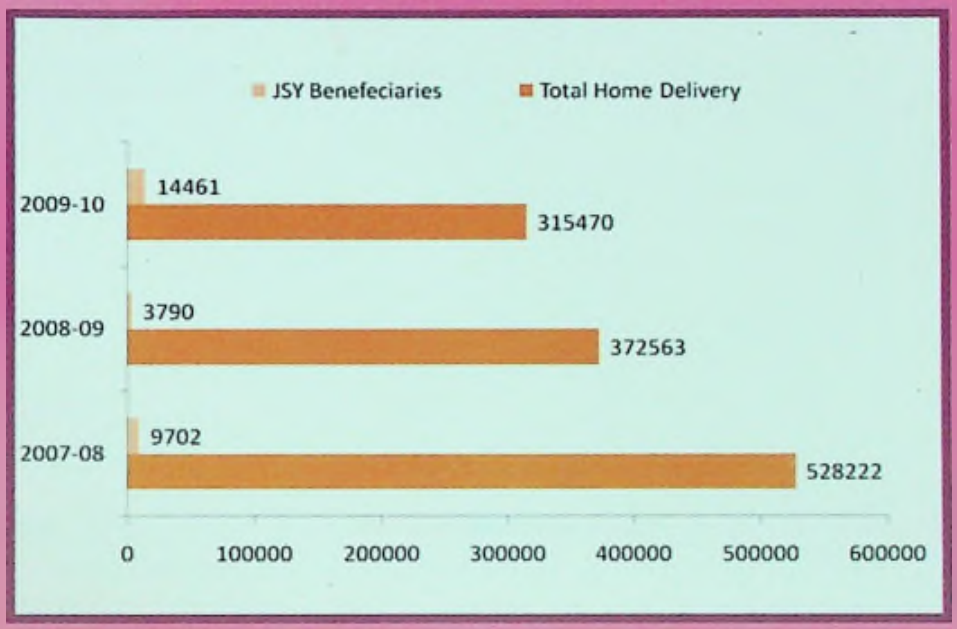
DLHS-3 has shown improvement in various maternal health indicators including institutional deliveries. The improvement in institutional delivery is remarkable as compared to other maternal health indicators. The total number institutional deliveries have increased from 28.7% to 47.1% DLHS-III. In rural sector this rise is appreciable but due to lack of micro birth planning there has not been much improvement in ANC coverage which has shown rise in just one percent between DLHS-2 and DLHS-3.

Increasing trends in Institutional Deliveries with JSY Beneficiaries



Source: DHS & D&E Bulletin

Institutional Deliveries Vs Home Deliveries in JSY



Source: DHIS & D&E Bulletin

Focus on Equity

Nearly 70% of the MP is rural .The number of women from rural areas benefited under the scheme is proportionately high as compared to urban beneficiaries, which means that benefit is extended to remote rural women.

The women belonging to Scheduled Caste, Scheduled Tribe and below poverty line families have shown remarkable acceptance of the scheme.

Concurrent assessment of Janani Suraksha Yojana (JSY) scheme in selected states of India. 2008

The assessment study conducted in rural areas with a selected sample of 1200 mothers in the State has shown encouraging results-

- 86.7 % women are aware about JSY scheme
- 80.3 % women are aware about 24x7 Govt. facilities
- 72.8 % institutional deliveries.

- 67.8 % deliveries in Govt. facilities.
- 68% JSY beneficiaries.
- 46.3% women had three days stay in hospital after delivery.
- 82.7% of JSY beneficiaries received any money after delivery.
- 91.3% women registered for ANC.
- 64.5% of received at least 3 ANC checkups.
- 37.1% of women consumed 100 IFA tablets.
- 67.9% of institutional deliveries received PNC care.

Lancet 2010; 375:2009-23 – Janani Suraksha Yojana, a conditional cash transfer programme to increase **births in health facilities: an impact evaluation**

Institute for Health Metrics and Evaluation, University of Washington, Seattle, WA, USA

- Madhya Pradesh has achieved highest level of participation and uptake of JSY.
- About 44% of women (95% of 42-46) reported of receiving JSY payment, which is highest in the country.
- Madhya Pradesh acclaimed of making special efforts to accredit remote health facilities.

Steps taken to keep pace with increased delivery load in terms of quality of services -

Up-gradation of infrastructure in Public Health Institutions:

Institutional Delivery has increased tremendously. It is proposed to strengthen maternity wings of all districts hospitals for which Rs 75 Cr has been sanctioned under 13 finance commission. Upgradation of labour room and extension of maternity ward in below district institutions is undertaken from State and NRHM funds.

Accreditation of Private Institutions– Accreditation of private health institutions to provide the benefit of JSY to BPL women coming for institutional delivery has been taken up under the "Janani Suraksha Yojana". Sub district hospitals have been encouraged to join hands with govt. for increasing the accessibility of the scheme.

Accreditation of Sub Health Centers - criteria for sub health centers have been developed and circulated to the districts. Process of accreditation of sub health centers has been is under processed. 450 Sub Health Centres are accredited out of which around 270 are providing essential obstetric care and have been accredited under JSY.

Home Deliveries – Benefit of Rs. 500/- is provided to BPL women opting for home delivery. The proportion of such women benefitted under the scheme has been consistently around 1% of the total deliveries from 2005-06 to 2008-09. The payments are monitored for home delivery beneficiaries, revised guideline of Janani Suraksha Yojana has been circulated, in accordance to Hon'ble Supreme Court order, regarding cash incentive to all BPL home deliveries within two days of delivery through VHSC account by ANM. This fund is reimbursed by fund earmarked for JSY under RCH flexipool. ANM to conduct all home deliveries is being made mandatory.

Microbirth planning:

To address the issue of low ANC coverage due to inadequate microbirth planning as per the recommendations of GoI following steps are being taken.

Registration:

1. For ensuring registration during first trimester of pregnancy Nishchay pregnancy test kits are being procured from state budget and is made available in AESA kit. ASHA is being trained on pregnancy test at village level.

2. Pregnancy tracking of each pregnant woman by UID number will be ensured from July 2010. Training to field level staff is being imparted.

3. The existing Janani Shishu Suraksha Card has been modified to capture the details at VHND and Matru Evam Bal Suraksha Card will be in use shortly.

ANC

Quality ANC has been ensured by regular organizations and monitoring of VHND, refresher core competency training of ANM and LHV with focus on nutritional counseling.

Facility Identification and referral transport:

The state has a vision to address second stage delay leading to maternal death by comprehensive referral transport mechanism. Presently the state has 21 functional call centre linked to Janani express vehicles. Directives have been issued to establish call centre in all districts with technical support from UNICEF. Nearly 40% of the rural beneficiaries have availed the services of Janani Express Vehicles. 6 districts have DHH to mobilize women for institutional delivery. Decision has been taken to mobilize all rural beneficiaries to health institution through Janani express vehicles. All blocks to have atleast two vehicle under Janani Express to mobilize all rural women for institutional delivery in each block.

Improving the Quality of Service:

Intra-natal care

1. Quality intra-natal care with focus on evidence based practices in all CEmoNC and BEmoNC is being ensured through skill based training of service providers.

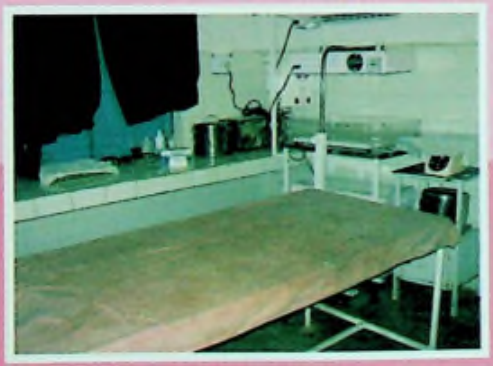
2. Quality of EmOC and BEmONC training of MOs and SBA training of SN,LHV and ANM are being strictly monitored from pre-test protocols during and after training. Training coordinators are being positioned with technical support from UNFPA at State & Divisional Head Quarter

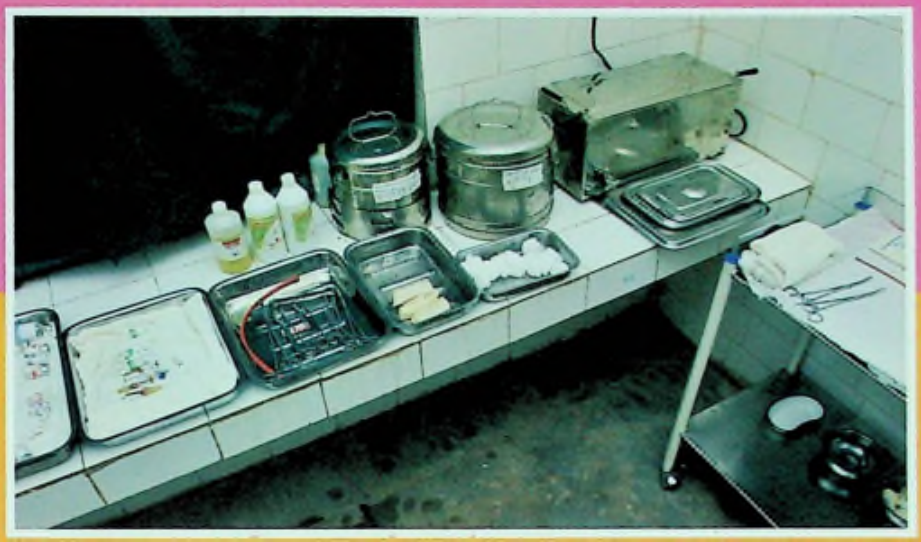
3. Instructions regarding all deliveries to be conducted at health facilities and in case home delivery if required ANM should immediately assist in delivery has been issued.

4. Rs. 75 crores has been sanctioned from 13th Finance Commission for maternity wing in all district hospitals. Sanctioned to the district will be given as per the need based proposal submitted by the district. Maternity wing will include labour room, maternity ward as per delivery load in the hospital. The essential equipments and furniture will be taken care with this fund. Additional manpower will be managed through RCH.

5. Every BEmONC and CEmOC institutions has a functional new born care corner with a radiant warmer, ambu bag for neonate, oxygen and suction facilities, all in working conditions. Essential training to health providers has been reflected under Child health component.

6. Doctor and staff conducting deliveries are being trained on BEmONC services, so that every labour should be monitored through a Partograph. The protocols of Active Management of Third Stage of Labour (AMTSL), for management of Post Partum Hemorrhage (PPH), Early Newborn Care (ENBC) and resuscitation are followed as per protocols.





Post Partum Care:

JSY assessment assessment report reflects that nearly 47% of the women stay 3 days after delivery in institution which ensures atleast 2 checkups during post natal period.

Steps taken to Increase PNC checkup as per protocol

1. Directives have been issued to ensure post-delivery mandatory stay of 48 hours after delivery and extension of maternity ward has been taken care of in this regard. Following protocols have been ensured for mothers:
   a. Looking the signs and symptoms for hemorrhage
   b. Nutritional and family planning counseling.
   c. Advice on IFA Supplementation and Birth Registration
2. In NIPI supported 3 districts Yashodas are hired in district hospitals to provide support to women during labour and after delivery and proper counseling also care to new born and mother. ASHA has been given incentive for ensuring 5 postnatal checkups as per protocols, in 3 districts supported by NIPI.
3. State specific module for ASHA is being developed which encompasses home based new born care, nutrition and PNC of women.

Monitoring

Monitoring mechanism has been developed as per the guidelines of the Govt.

Physical Verification – Physical verification of JSY beneficiaries is done by the district nodal officer. the institutions providing delivery facility are also inspected. 5% of the total women benefited at district and 2% at divisional level during the previous month are physically verified by concerned district and divisional authorities.

Beneficiary List – List of previous month's beneficiaries is sent to every displayed at each facility and sub-health centre.

MIS – Records of JSY are maintained in standard formats in all facilities. Data Entry Operators have been provided in all district hospitals and civil hospitals with bed strength of 100 or more. Monthly reports on physical and financial progress are sent from the delivery institution to the block, district and state level.

1. Grievance Redressal

Grievance Redressal Cell – Grievance redressal cells have been set up in the offices of Block Medical Officers, Civil Surgeons, Chief Medical and Health Officers and Directorate of Health Services.

Vigilance Teams – Special vigilance units have been constituted at the divisional level to monitor the implementation of JSY and address the grievances on the spot.

Help Desk –All hospital with high delivery load have help desk for assisting the target beneficiaries of JSY and Deendayal Antyoday Yojana and also to maintain records and display of list of beneficiaries .3% administrative cost is being utilized for this purpose.

CONTINUUM OF CARE OF SEVERE ACUTE MALNUTRITION IN M.P. 2006 – 2010

Evidence based interventions to address under nutrition in the State

1. Due care of Adolescent girls and maternal nutrition to help shape the baby's tomorrow
2. Early Initiation of Breast feeding & Promotion of Exclusive breast feeding up to first 6 months of life
3. Improved access to locally available low cost nutritive foods
4. Enhanced Knowledge, Attitude and Practices regarding complementary feeding in under priviledged populations.
5. Ensuring availability of micronutrients – Zinc, Vitamin A, IFA, Iodine
6. Emphasis on early identification & treatment of severe acute malnutrition (SAM)

The First Step – 2006

- NRC conceptualized and set up in Shivpuri district in January 2006
- IAP guidelines adapted
- Admission criteria - W/A (Grade III & IV)
- Locally made F-75 & F-100, and mixed Diets
- Mothers counseled
- Discharged from NRC after 14 days
- Regular follow up ensured

NRC Strengthened – 2007

- 47 NRCs established till mid 2007 across the State
- IAP 2006 guidelines followed
- Appropriate infrastructure and Staff recruitment
- Revised administrative guidelines implemented
  - Treatment cost – Rs. 3375/Child
  - AWWs to refer SAM children to NRC
- Residential Trainings of NRC Support Staff started
  - Standardized preparations as per IAP of F-75 & F-100 taught
  - MUAC & W/H measurement introduced but admission criteria remained W/A
  - Support ensured by UNICEF - W/H wall charts, MUAC tapes
  - Recording system streamlined

Scaling up NRCs – 2008

- More than 100 NRCs functional by 2008

- Looking at the magnitude of the problem, NRCs planned in every high risk block
- Diet charts formulated based on weight range

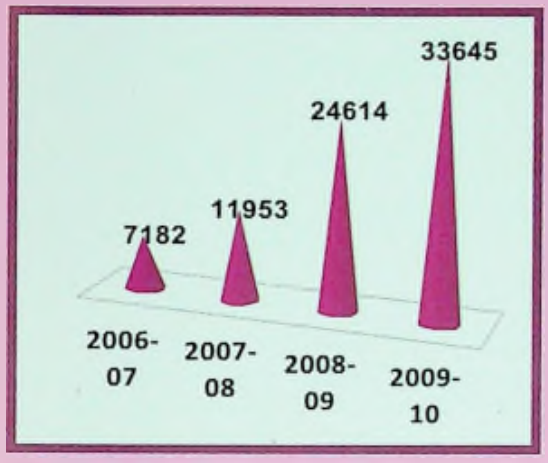
Way Forward in – 2009

- 196 NRCs functional
- Appetite test formulated and standardized with local available food
- Feeding protocol
  - Locally made F-75 and F-100 as per IAP/WHO protocol along with
- Admission criteria
  - MUAC < 11.5cm &/or
  - Bilateral pitting Oedema
- Follow-up after discharge
  - 4 Follow ups at 15 days intervals for 2 months
- Appropriate MIS system

Present NRC Scenario – 2010

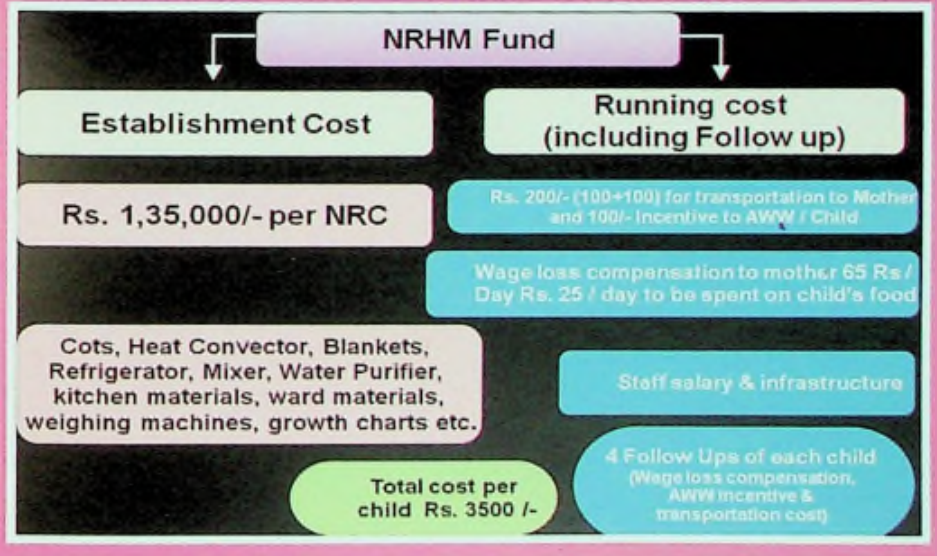
- 210 NRCs functional
- Feeding protocol
  - Locally made Therapeutic Feed introduced across the State
- Discharge criteria from Program
  - 15% weight gain over the Admission weight
- Introduction of Multi-charts for recording feeding and treatment of SAM child
- Supplementary suckling technique (SST) unit in NRC for management of <6m SAM child

To MP is in process of scaling up NRCs all over the State in a phased manner, and in year 2010-11, 45 NRCs are proposed to be established to cover the high risk blocks.



In the year 2009-10, 33645 children were treated in NRCs and 65% children were followed. All the functional NRCs have one Feeding Demonstrator to manage the feeding and treatment protocol of the admitted children and counseling their mothers, at least one Nurse for administering medicines, two caretakers to maintain NRC atmosphere, at least one cook for preparing the feeds and sweeper for cleaning

Financial Guidelines for Bal Shakti Yojna

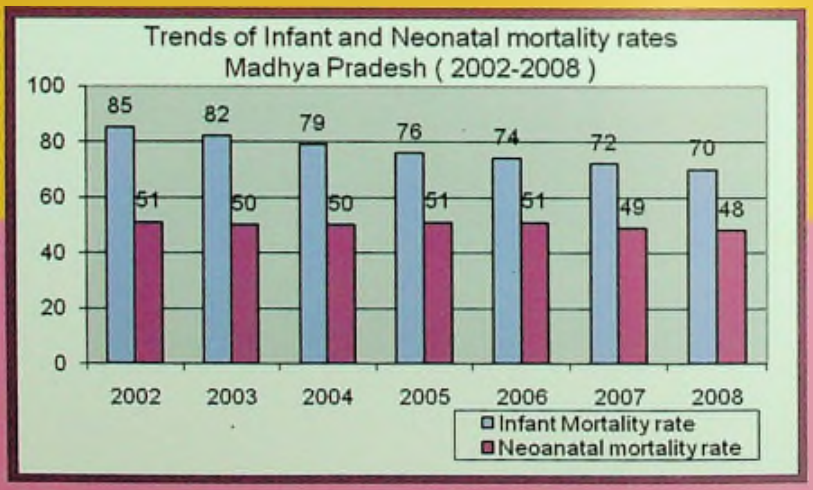


Certain evidence based studies have showed that majority (>75%) of the SAM cases who are not medically complicated can be treated in the community itself with an outpatient program, while only 15-20% cases who are diagnosed with medical complications, require treatment in facility based care (NRC). Hence, both DoPH&FW and DoWCD in convergence have reached to a consensus to devise and start with a state specific strategy for the integrated management of severe acute malnutrition. It has been recommended by AIIMS, New Delhi, and IAP that therapeutic feed is required for optimum treatment of SAM both at Facility level as well as Community level.

URGENCY OF IMPROVING NEW BORN SURVIVAL IN MADHYA PRADESH

STRENGTHENING FACILITY BASED NEW BORN CARE THROUGH SCNU

Background: The Millennium Development Goal (MDG) 4 of the United Nations Millennium Declaration calls for a two thirds reduction of the under five mortality rate between 1990 and 2015. The National Population Policy of India has set a goal of achieving an IMR of 30 and NMR < 20 by 2010. In Madhya Pradesh, as per SRS 2008 Infant Mortality rate at 70 per 1000 live births is highest in the country with a high Neonatal mortality rate of 48 per 1000 accounting for 69% of Infant deaths and 52% of under five deaths. Not only is the Neonatal mortality in the State high but has only reduced by three points during 2002 to 2008 as against the fall of 15 points in the IMR during the same period. As a result proportion of neonatal deaths of all infant deaths has increased from 60% in 2002 to 69% in 2008. (Data Source: SRS)

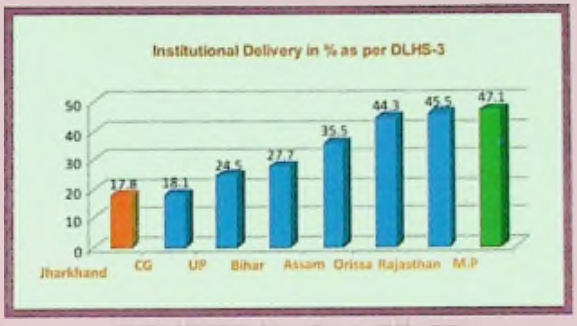


Data Source : SRS 2002 - 2008

Thus if reduction in IMR has to be expedited and MDG for child survival is to be met, priority must be given to prevent Neonatal deaths.

In addition to stagnant Neonatal mortality rate in the State as a result of success of JSY scheme there is a huge increase in institutional delivery rate leading to increased load of new born at delivery centers, 10% of which require specialized care at birth which was non-existent till 2007.

Lack of specialized care for new born at birth in Government hospitals was the biggest challenge to maximize benefits of increased institutional delivery for New Born survival.



DLHS-3 (SRS Bulletin Report - 2009) = 73%

Program Strategies to Improve New Born Survival:

To address high Infant and Neonatal mortality in the State, Continuum of Care from Community to Health facility has been adopted as the core theme.

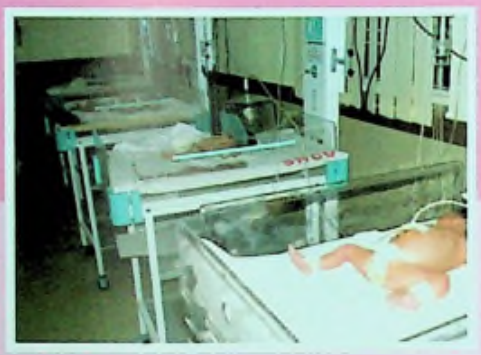
Key interventions in community and health facility were identified and access of Community to Facility was ensured through emergency transport system connected to 24 x 7 Call centre. This approach was first piloted with UNICEF support in Guna in the year 2007 and is now being scaled up State wide under NRHM.

Community:	Call Centre for Emergency Transport	Facility:
IMNCI /HBNC sub-block level		-24 x 7 delivery centers till
IYCF practices feeding		Early initiation of Breast
Immunization & VHND New born care		- Staff trained in SBA &
ASHA for Social Mobilization Premature Labour		- Antenatal Steroids in
LLIN (Bed Nets)		- *Sick New Born Units
Zinc and ORS in Diarrhea Centers		- Nutrition Rehabilitation
Maternal Death Audit		- Pediatric ICUs

*Sick New Born Units: Giving Hope to Life:

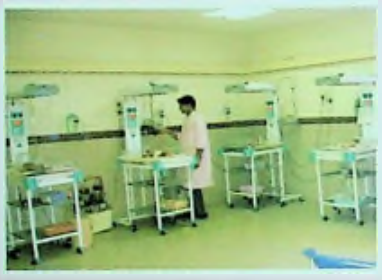
To meet the need of providing specialized care to increasing load of new born in line with rise of institutional delivery and referrals under IMNCI, Sick New Born Units are being set up at District and Block level. First two such units were set up by Government of M.P with support from UNICEF in Guna and Shivpuri districts.

These units are helping to reduce the mortality of sick newborns particularly among the low birth weight and very low birth weight babies.



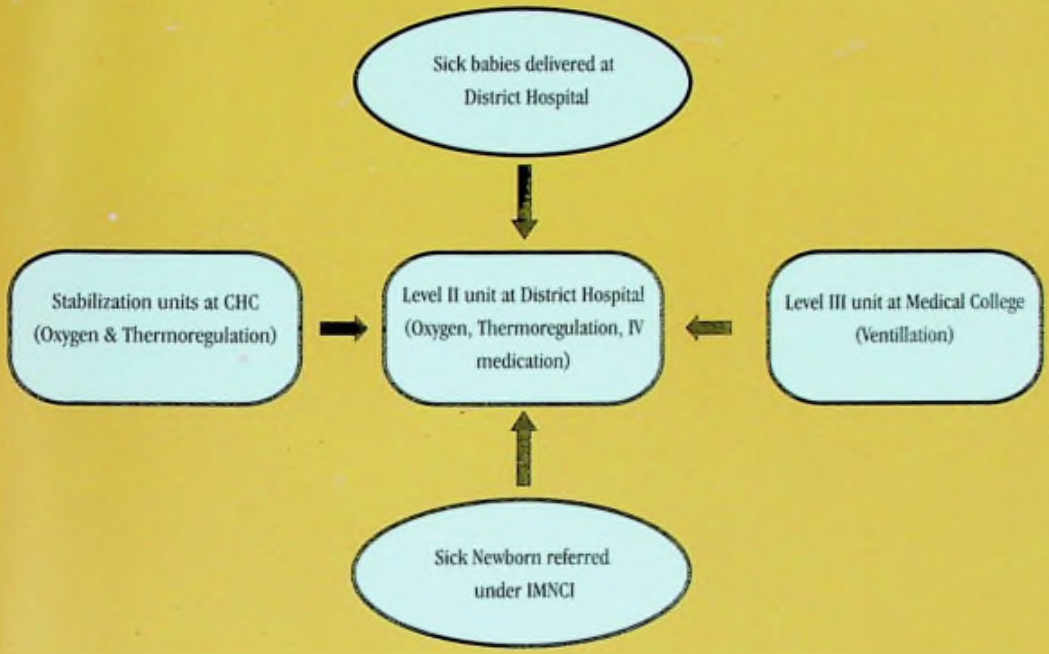
Salient Features of Each Unit:

- 20 bedded unit with nearly 2000 sq feet area
- Four Pediatrician, Twelve staff nurses and Two lab technicians
- Separate section for inborn and Out born babies
- Breast feeding room in each unit
- Central oxygen supply with Power back up
- Establishment cost of each unit Rs. 45 Lakhs. (Civil work Rs.25 lakh, Equipments 20 lakh)
- Running cost of pilot units and scale up entirely through NRHM
- Each unit has a potential to save 1200 New born every year.

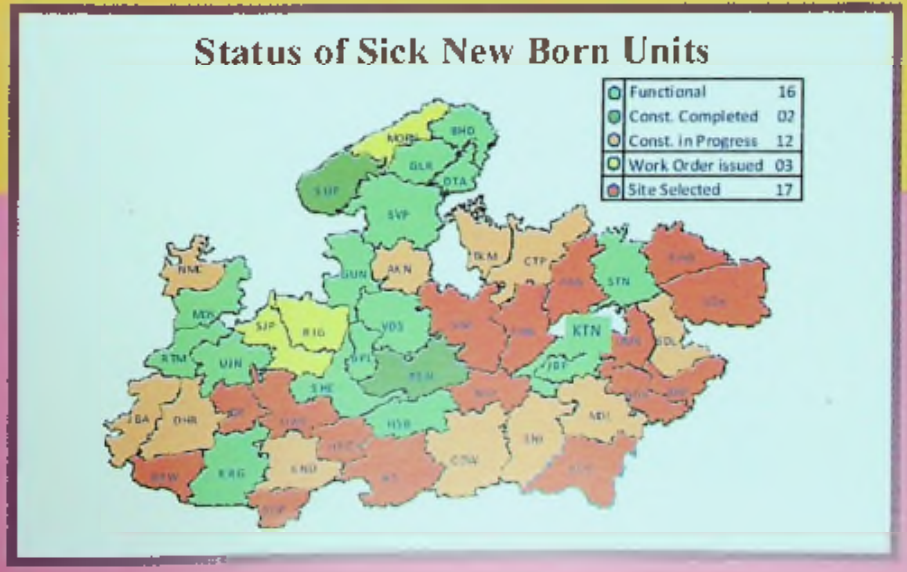


[illegible] units functional as of date with more than [illegible] new born saved in last two years. Scale up to all 50 districts by December 2010.

These units in addition to inborn deliveries also cater to sick babies born at peripheral health centers as well as serve as a referral unit for Sick Newborns identified through home visits and referred under IMNCI. The District hospital units are level-II unit and are linked to smaller stabilization units at block level and level III unit at medical college.



Scale up Plan: Government of Madhya Pradesh is committed to scale up these units in all 50 districts of the State in the year 2010-11. **As of now 16 district level units are functional and another 20 are in final stages of construction.** Necessary budgetary provisions have been provided under NRHM plan for 2010-11 to support scale up. In addition, the State has made necessary HR policy changes to meet the human resource demand to operate these units



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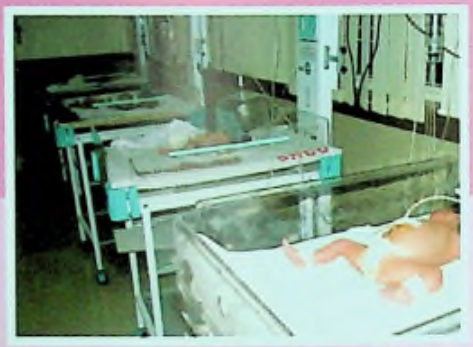

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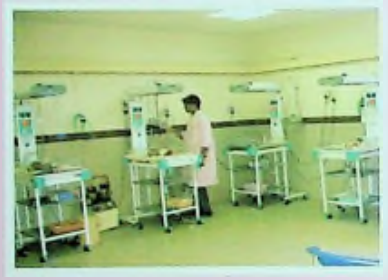

16 such units functional as of date with more than 16,000 new born saved in last two years. Scale up to all 50 districts by December 2010.

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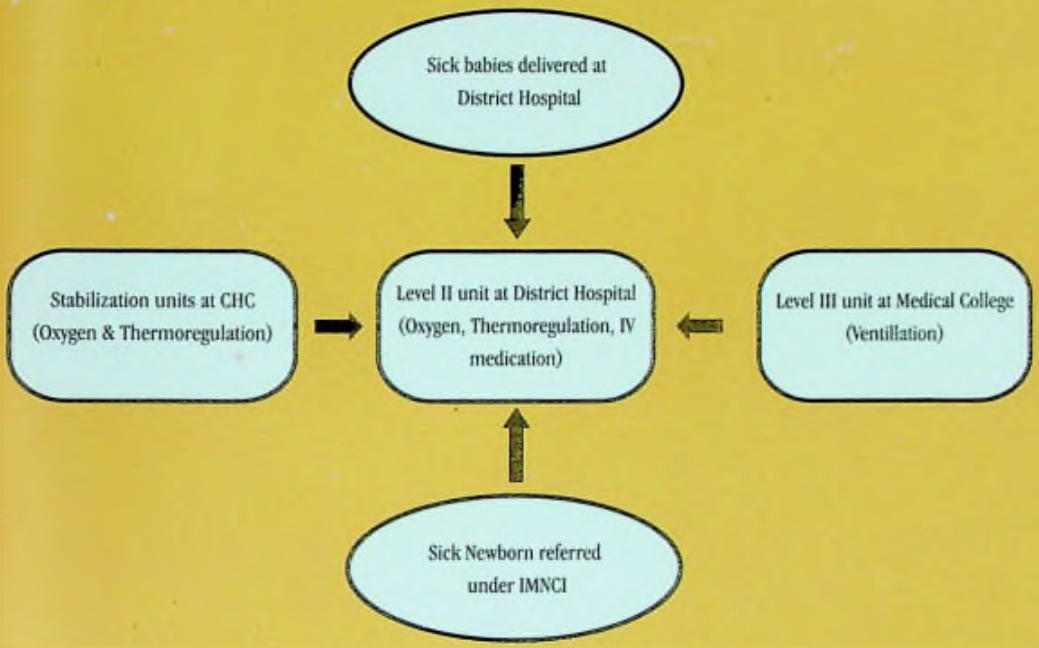

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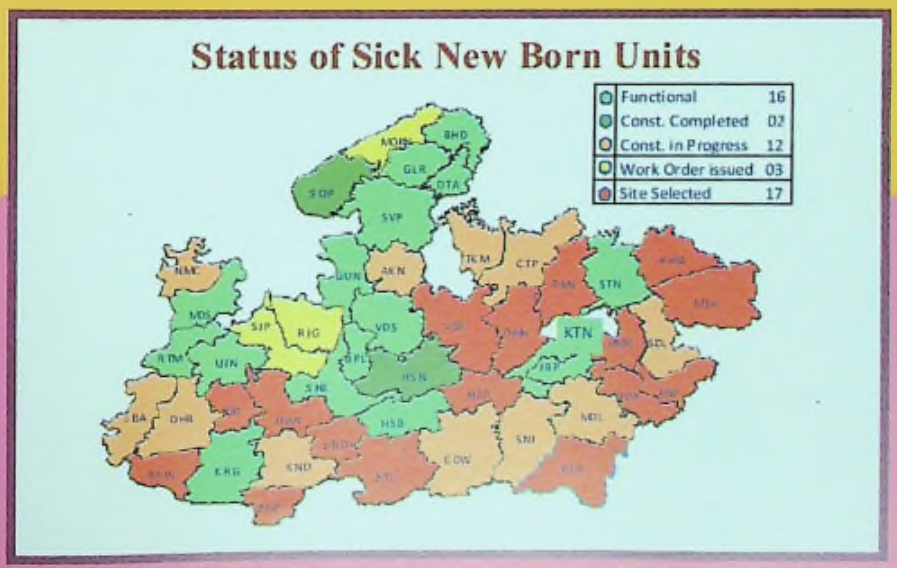
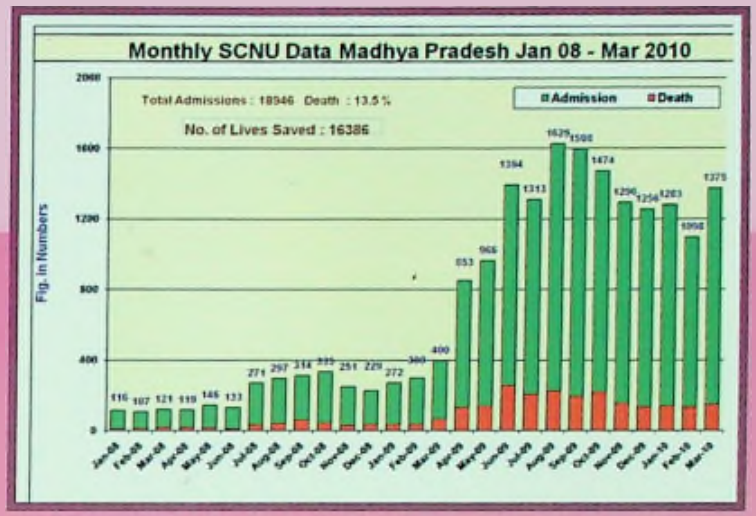
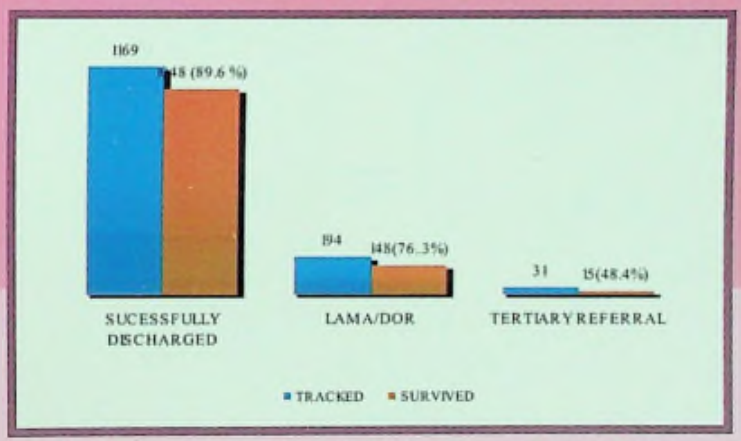


Scaling Up : What Helped

Strong Political Commitment at the highest level backed up by prompt facilitation from bureaucrats & hand holding by UNICEF has led to rapid scale up.

Health Minister at SCNU with 800 gm baby who was saved in SCNU
More than 16,000 New Born saved in last two years





90 % Newborn discharged after successful treatment survived at One year of age.

Survival at One Year of Age: Guna SCNU Data

Future Plans:

- [illegible] (Currently in two blocks to be scaled up to six districts this year).
- Extending Continuum of Care Back to Community to ensure survival of New born after discharge from SCNUs **(Piloted in Guna and Shivpuri).**
- [illegible] data monitoring system for prompt corrective action

EMERGENCY AMBULANCE SERVICE

Emergency is a sudden unplanned occurrence of an event that poses immediate risk to life, health, property, daily life and demands immediate action. Most emergencies require urgent intervention to prevent a worsening of the situation or at least offer palliative care for the aftermath. Medical services and Medical care are one of the essential services that would be required at this stage to reduce the levels of risk on Life and Health. The Department of Public Health and Family Welfare, Government of Madhya Pradesh, has labeled this issue as a top priority of concern and invited Emergency Management & Research Institute (EMRI), Hyderabad a 'Not for profit' organization to develop and operationalise emergency response units in the entire state and signed a Memorandum of Understanding (MoU), with EMRI on 25th November 2007. The objective of this project is to develop an integrated emergency management setup to cater to all kinds of emergencies in the state and coordinate responses with multiple agencies like Police, Fire and Medical to ensure timely, reliable, quality and comprehensive emergency management services to the residents of State.

Bhopal Launch

Indore Launch

In this context, an Emergency Management Service (EMS) system is being developed to provide pre-hospital acute care and transport to definitive care, to patients with illnesses and injuries which constitute a medical emergency. The aim of EMS is to provide treatment to those in need of urgent medical care, with the goal of either satisfactorily treating the malady, or arranging for timely removal of the patient to the next point of definitive care. The framework is being developed including a call center and supported activities of emergency handling as medical assistance to critical patients, ambulance management and equipment management. The major institutions and infrastructure setups like hospitals, police stations, and fire brigades are being identified and a system of networking is also being established between these institutions and the Emergency Management Service system. Well equipped vehicles, with GPS, GIS maps, Automatic Vehicle Location Tracking and Mobile Communication systems and adequately equipped with manpower & other resources to tackle with a various possible medical emergencies along with providing appropriate support for other forms of emergencies occurring simultaneously are being developed.

At present the status of the project is that 55 ambulances are running in four districts- Bhopal, Indore, Gwalior & Jabalpur and it is expected that by March/April 2010, another 45 ambulances will be added to the project. These ambulances are equipped with medical equipments and supplies to handle the emergencies at the site primarily and transfer the person to the Health Facility for necessary medical care.

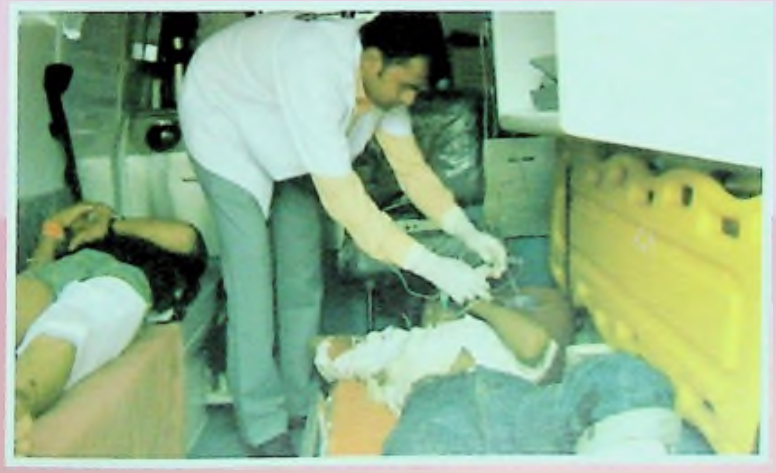
A State level call centre has been established at Bhopal to receive and segregate/ dispatch the calls received for any emergencies. The uniform number is "**108**" (Toll free) which can be accessed from landline as well as mobile telephone.

Advantages

- Emergency Medical Service system provides pre-hospital acute care and transport which covers definitive care to patients with illness and injuries which constitutes Medical Emergencies.
- System networking of major institutions and infrastructure set up in the State of Madhya Pradesh like Hospitals, Police stations & Fire brigades and a system networking of these with Emergency Response Centre. This is the first such system in the State linking and providing the complete Sense, Reach and Care.
- These would be first ambulances in the state with GPS, GIS Maps, Automatic Vehicle Location Tracking and Mobile Communication System. These Ambulances are adequately equipped with trained manpower and supplies to meet medical emergencies.
- The framework includes a call Centre supporting

  a) Emergency handling medical Assistance
  b) Ambulance Management
  c) Equipment Management

Pre-Hospital Care of Injured



The rural and semi urban areas population is being benefitted by the 24 hours Emergency Ambulance Service in the four districts presently. This would also help reduce the IMR and MMR along with road side accident death cases in the State. This would also be of immediate response in case of epidemic and natural disasters which is on long term perspective and well implemented in the States of Gujarat, Uttarakhand, Andhra Pradesh and few other states.

The operations in all 4 districts are going on smoothly with achieving the vision of saving lives. We have been receiving good number of emergency calls since the day one of launch in each district. Currently, we are running total of 55 ambulances in these 4 districts with 15 ambulances in Indore, 14 ambulances in Bhopal & Jabalpur and 12 ambulances in Gwalior which are based in urban as well as rural locations.

Following table shows the total number of emergencies transported till 20th January, 2010 and breakup also:

Emergency Type	Bhopal	Indore	Gwalior	Jabalpur	Total
Acute Abdomen	618	210	419	1345	2592
Animal Bite	64	26	109	179	378
Cardiac	442	162	146	508	1258
Diabetes	61	20	28	44	153
Others** Poisoning/	2475	883	1784	3088	8230
Drug Overdose	84	84	106	230	504
Pregnancy Related	3214	1075	2685	4007	10981
Respiratory	355	114	209	384	1062
Suicide	6	6	10	7	29
Trauma (Non Vehicular)	404	184	353	301	1242
Trauma (Vehicular)	2684	1375	1774	1490	7323
Total	10407	4139	7623	11583	33752

Note: 456 deliveries conducted in ambulance

This year it is requested to fund for

(a) Cost of new 45 vehicles @ Rs. 10.50 lakhs per unit
(b) Operational cost of old 55 vehicles @ Rs. 12.00 lakhs per unit per year.
(c) Operational cost of new 45 vehicles @ Rs. 12.00 lakhs per unit per year.

Operational cost for old 55 vehicles is proposed 60% of the total requirement and for new 45 vehicles is proposed 80% of the total requirement as per guidelines issued by Ministry of Health and Family Welfare, Government of India.

owards population stabilisation: CM

HT

tion in the state.

Speaking at his official residence after awarding 22 couples under a promotion scheme on population stabilisation initiatives here, the Chief Minister said overpopulation was one of the factors triggering poverty.

"Overpopulation is a drain on our resources. A small family concept ensures better health and nutrition for the children," he said. Chouhan said overpopulation leads to not just poverty but also the problem of child labour. "Overpopulation is

y Our Staff Reporter

hopal, Mar 30

Madhya Pradesh Chief Minister Shivraj Singh Chouhan

नसंख्या नियंत्रण से होगा विकास

web www.bhaskar.com दैनिक भास्

केंद्रीय स्वास्थ्य सचिव ने किया मंदसौर जिला अस्पताल का निरीक्ष

प्रदेश में स्वास्थ्य सुविधाएं अच्छ

e for sick newborns

Govt Sets Up Special Units To Battle Infant Mortality

03.06.2010 web www.bhaskar.com दैनिक भास्

सोनाग्राफी सेंटरों की जांच शु

मामला सोनोग्राफी सेंटर के रजिस्ट्रेशन निरस्त होने का

भास्कर संवाददाता | उज्जैन

कलेक्टर एम.गीता द्वारा एक सोनोग्राफी सेंटर का रजिस्ट्रेशन रद्द करने के बाद अब भोपाल टीम ने भी उज्जैन जिले के अन्य सेंटरों की जांच शुरू कर दी है। कलेक्टर ने सीएमओ कार्यालय से भेजी गई रिपोर्ट के बाद कार्रवाई करते हुए सहज सोनोग्राफी

बुधवार को टीम उज्जैन पहुंची और जिले के सोनोग्राफी सेंटरों की जांच शुरू की है।

डॉ. अनिल पालोड़ [illegible] स्वास्थ्य केंद्र में बीएमओ [illegible] होने के बावजूद भी [illegible] सोनोग्राफी मशीन [illegible] सेंटर के [illegible]

दिए थे। शासकीय कर्मचारी द्वारा सो सेंटर के संचालन का मामला प्रकाश के बाद बुधवार को जांची गई उपा अतिरिक्त भोपाल के [illegible]

Department of
Public Health & Family Welfare
Madhya Pradesh