2024

SANKALAN

NATIONAL HEALTH PROGRAMMES HANDBOOK

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DISCLAIMER

This “Sankalan – National Health Programmes Handbook” is intended for reference purposes only. While every effort has been made to ensure the accuracy and relevance of the information provided, it should not be considered a substitute for the official operational guidelines.

For comprehensive details, clarifications, and context, readers are encouraged to refer to the official operational guidelines or consult the relevant authorities. The author is not liable for any discrepancies or actions taken based on the information in this document.

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We dedicate this handbook to India's healthcare workforce—frontline workers, program managers, policymakers, and other changemakers—whose relentless efforts are the backbone of the nation's health programs. We hope that "*Sankalan–National Health Programmes handbook*" will serve as a valuable tool in your mission to create healthier communities.

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ACRONYMS

AAM	Ayushman Arogya Mandir
ABDM	Ayushman Bharat Digital Mission
AB-PMJAY	Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana
ACSM	Advocacy, Communication, and Social Mobilization
AMB	Anemia Mukt Bharat
ANC	Anti Natal Checkup
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Sowa Rigpa and Homoeopathy
BCG	Bacille Calmette-Guerin vaccine
CBO	Community-based Organization
CHO	Community Health Officer
CHC	Community Health Centre
CSR	Corporate Social Responsibility
DM	Diabetes mellitus
ECD	Early Childhood Development
FY	Fiscal Year
GoI	Government of India
HBNC	Home Based Neonatal Care
HBYC	Home Based Young Child Care
HSS	Health Systems Strengthening
IC	Infection Control
ICMR	Indian Council of Medical Research
ICT	Information and Communication Technologies
ICTC	Integrated Counseling and Testing Center
IMI	Intensified Mission Indradhanush
JAS	Jan Arogya Samiti
JMM	Joint Monitoring Mission
KPI	Key Performance Indicator
MAS	Mahila Arogya Samiti
MCH	Maternal and Child Health
MCHN Day	Maternal, Child Health Nutrition Day

MDG	Millennium Development Goal
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MPHW	Multipurpose Health Worker
MWCD	Ministry of Women & Child Development
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NCD	Non communicable Disease
NGO	Non-governmental Organization
NHA	National Health Authority
NHM	National Health Mission
NIKSHAY	Web-enabled electronic TB case notification/monitoring system
NP-NCD	National Programme for Prevention and Control of NCD
NRHM	National Rural Health Mission
NSP	National Strategic Plan
NSS	National Sample Survey
NTCP	National Tobacco Control Programme
NTEP	National Tuberculosis Elimination Program
NTSU	National Technical Support Unit
NUHM	National Urban Health Mission
NVHCP	National Viral Hepatitis Control Program
PHC	Primary Health Center
PHI	Peripheral Health Institution
PIP	Project Implementation Plan
PM-JAY	Pradhan Mantri Jan Arogya Yojna
PRI	Panchayati Raj Institution
PSM	Procurement and Supply Management
QA	Quality Assurance
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
SHWP	School Health and Wellness Programme
UHC	Universal Health Coverage
UIP	Universal Immunization Programme
UN	United Nations

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WCO	World Health Organization Country Office
WHO	World Health Organization
WHP	World Health Partners

Ayushman Bharat – Ayushman Arogya Mandir

About AB-AAM

The Ayushman Bharat – Ayushman Arogya Mandirs (AB-AAMs) were launched under the Ayushman Bharat Programme in a bid to move away from selective health care to a more comprehensive range of services spanning preventive, promotive, curative, rehabilitative and palliative care for all ages. The National Health Policy of 2017 envisioned these centres as the foundation of India's health system.

Expanded range of services

These centres deliver a range of comprehensive health care services like maternal and child health, services to address communicable and non-communicable diseases and services for elderly and palliative care. AB- AAMs provide free essential medicines and diagnostic services, teleconsultation, and health promotion including wellness activities like Yoga.

The expansion of services has been planned in incremental manner. As a first step, Screening, Prevention, Control and Management of Non-communicable Diseases and Chronic Communicable diseases like Tuberculosis and Leprosy has been introduced at AAMs.

1. Care in pregnancy and childbirth.
2. Neonatal and infant health care services
3. Childhood and adolescent health care services.
4. Family planning, Contraceptive services and Other Reproductive Health Care services
5. Management of Communicable diseases: National Health Programs
6. Management of Common Communicable Diseases and General Out-patient care for acute simple illnesses and minor ailments
7. Screening, Prevention, Control and Management of Non-Communicable diseases and chronic communicable disease like TB and Leprosy
8. Basic Oral health care
9. Care for Common Ophthalmic and ENT problems
10. Elderly and Palliative health care services
11. Emergency Medical Services
12. Screening and Basic management of Mental health ailment

Key Components

The delivery of CPHC through AAMs involve is complex task as it requires a paradigm shift at all levels of health systems. The operationalization of AAMs requires several inputs.

Source: https://aam.mohfw.gov.in/

MATERNAL HEALTH

MCHN Day (Maternal, Child Health & Nutrition Day)

MCHN day is to be organized in every village once a month at the Anganwadi Centre (It can also be held more than once if the local context warrants eg. high population villages). It may also be organized in urban areas. The session will be conducted for a minimum of four hours of this at least one hour should be devoted to group counselling sessions. Frontline service providers multi-purpose worker female (MPW-F/ANM), Accredited Social Health Activist (ASHA), Anganwadi Worker (AWW) and Anganwadi Helper (AWH) will be present during the entire session. MPW (M), where available will also attend MCHN Day. He should be responsible for Counselling for Communicable diseases, NCDs including mental health issues. Community-level representatives, members of Mothers' Groups and Self-Help Groups (SHGs), are to participate in the event.

Availability of all essential equipment such as weighing scale-adult & child, B.P. Instrument, examination table with stool, bed screen/curtains, Haemoglobin metres, kits for urine examination, fetoscope, measuring tape, Vaccine carrier with ice packs, Red/Black poly begs, etc.

Ensure sufficient availability of all supplies, such as vaccines, IFA tablets, Vitamin A, condoms, Centchroman (Chhaya), Emergency Contraceptives Pills (ECP), ORS, Zinc, Cotrimoxazole, Paracetamol, and AD syringes.

Conducting the MCHN Day

- ANM, AWW and ASHA will ensure that the Anganwadi Centre/MCHN site is opened at the stipulated time.
- Health area, Nutrition corner, ECD corner and group counselling area should be arranged with the requisite drugs, logistics, supplies, materials and IEC materials. The common due list for services should be available at the site.
- ASHA should check that the identified beneficiaries are attending the MCHN day.

- Services are delivered and documented by ANM and Anganwadi worker. Services listed in the MCP card are recorded on the card. Any additional services given should also be recorded.
- Lady supervisors, Lady Health visitors, ASHA facilitators and CHO are to provide supportive supervision and monitor MCHN day using the monitoring checklist.

Post MCHN Day

- ANM, Anganwadi worker and ASHA should make a tally of beneficiaries who attended MCHN day and the absentees. Households for follow up services should be listed. List of High Risk Pregnancies (HRPs), SAM children and any other beneficiaries requiring referral should be prepared and followed up. Any referral made should be documented by the three service providers.
- The report of services delivered during MCHN day is submitted by ANM, and Anganwadi worker through their regular channels to Block/PHC Medical Officer (BMO) and CDPO respectively.
- ASHA and AWW conduct follow-up visits to beneficiary homes such as for newborn care, to promote infant and young child feeding, counsel pregnant women etc. They also contact absentee beneficiaries to motivate them to attend the next MCHN day.
- District and Blocks/PHCs are to discuss on MCHN day held during the month in their monthly meetings. Findings from monitoring checklist are to be presented and discussed for necessary action.

Availability of Service Package on MCHN day

Services	Activities
Antenatal care	• All pregnant women are to be registered • Registered pregnant women to be given ANC services. • Dropout pregnant women eligible for ANC are to be tracked and given services.
Immunization	• All PW are to be given Td as per schedule • All eligible children are to be given vaccines as per National Immunization Schedule • All dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated.

	• Vitamin A solution is to be administered to under five-year children
Nutrition	• All under-six children are to be weighed every month and their height to be recorded every quarter, and data is to be plotted on MCP card. • Underweight and wasted children are to be identified and managed appropriately. • Identified SAM children with medical complications to be referred to the NRC or health facility with pediatric care facilities. • All under-six children to be provided supplementary nutrition.
Family Planning Services	• All eligible couples are to be given condoms, Combined Oral Contraceptives (COCs), Centchroman (Chhaya), Emergency contraceptive pills (ECP) as per their choice and referrals to be made for other contraceptive services.
HBV, Syphilis and HIV	• Screening using POC kits and referral where required, ensuring confidentiality.
Counselling	• Counseling on Care during pregnancy, Danger signs during pregnancy, Birth preparedness, Importance of nutrition, Institutional delivery, Identification of referral transport, post-natal care, Breastfeeding and complementary feeding, Care of a newborn, Contraception, etc.

Source: nhm.gov.in/ MoHFW /NHM/ 2024

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Ante Natal Checkup (ANC) and Post Natal Care (PNC)

During Ante Natal Care:

Early Registration

The first visit or registration of a pregnant women for ANC should take place as soon as the pregnancy is suspected. Ideally, the first visit should take place in the first trimester before or at the 12th week of pregnancy.

Number and timing of visits

Ensure that every pregnancy women makes at least 4 visits for ANC, including the first visit/registration and any home visits by the ANM. The first visit is recommended as soon as the pregnancy is suspected, the second visit should be schedules between the 4-6 months (around 26 weeks). The third one should be planned in the 8th month (around 32 weeks), and the fourth one in the 9th month (36-40 weeks)

ANC Schedule

At least 4 antenatal check-ups of every pregnant woman as per following schedule:

- 1st check-up: Within 12 weeks - preferably as soon as pregnancy is suspected & for registration of pregnancy and first antenatal check-up.
- 2nd check-up: Between 14 and 26 weeks
- 3rd check-up: Between 28 and 34 weeks
- 4th check-up: Between 36 weeks and term
- 100% Registration/Follow up of all HRP

Activities during ANC

Following activities should be done during ANC:

ANC visit	Weight	Height	Urine Test	Hemoglobin estimation	Blood Pressure	Blood Sugar	Td vaccine	HIV/ Syphilis
1st check-up	✓	✓	✓	✓	✓	✓	✓	✓
2nd check-up	✓		✓	✓	✓	✓	✓	
3rd check-up	✓		✓	✓	✓	✓		
4th check-up	✓		✓	✓	✓	✓		

Remember

- Availability of equipment such as functional adult weighing scale, functional B.P. Instrument, functional thermometer, inch tap, Uri sticks, fetoscope, Hemoglobinometer, HIV/syphilis test kit, etc.
- Availability of Iron Folic Acid tablets (IFA), Calcium tablets, Albendazole tablets, and Tetanus and adult diphtheria (Td) vaccine in adequate quantity.
- Iron sucrose (If Hb levels below 10gm/dl at PHC and above facilities)
- At least 4 doses of IV iron sucrose to pregnant women whose hemoglobin is <10 g/dl within 28 days of duration (stop IFA for these duration).
- Proper monitoring of all services being provided.

During Post Natal Care:

The first 42 days after birth is the postnatal period and is crucial for the mother and the newborn. First 48 hours, followed by the first one week are the most crucial period as most

of the fatal and near-fatal maternal and neonatal complications occur during this period. Evidence has shown that more than 60% of maternal deaths take place during the post-partum period.

Number and timing of post-partum visits:

Every pregnant woman and her newborn should be examined either by health service provider as per the following schedule. In case woman is unable to come to health facility, Health Service Provider should visit the mother for completing these examinations.

Visits	Visits After home delivery	After delivery at PHC/FRU
	Delivery at HWC-SC	(Woman discharged after 48 hours)
First visit	1st day (within 24 hours)	NA*
Second visit	3rd day after delivery	3rd day after delivery
Third visit	7th day after delivery	7th day after delivery
Fourth visit	6 weeks after delivery	6 weeks after delivery

*In case the mother and the newborn return home before 24 hours, then PNC visit should be planned on 1st day for institutional delivery.

Source: www.nhm.gov.in / MoHFW / 2023

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Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NHM). It promotes institutional delivery among pregnant women especially with weak socio-economic status i.e. women from Scheduled Castes, Scheduled Tribes and BPL households. The scheme is under implementation in all states and Union Territories (UTs), with a special focus on Low Performing States (LPS)

Background

About 56,000 women in India die every year due to pregnancy related complications. Similarly, every year more than 13 lakh infants die within 1 year of the birth and out of these approximately 2/3rd of the infant deaths take place within the first four weeks of life. Out of these, approximately 75% of the deaths take place within a week of the birth and a majority of these occur in the first two days after birth.

In order to reduce the maternal and infant mortality, Reproductive and Child Health Programme under the National Health Mission (NHM) is being implemented to promote institutional deliveries so that skilled attendance at birth is available and women and new born can be saved from pregnancy related deaths.

Objective

Reducing maternal and infant mortality by promoting institutional delivery among pregnant women, especially with weak socio-economic status i.e. women from Scheduled Castes, Scheduled Tribes and BPL households.

Target Group and benefits

The scheme focuses on poor pregnant woman with a special dispensation for states that have low institutional delivery rates, namely, the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha, and Jammu and Kashmir. While these states have been named Low Performing States (LPS), the remaining states have been named High Performing states (HPS). In LPS, the financial incentive is

available to all women regardless of age and number of children for delivery in government / private accredited health facilities.

The scheme also provides performance-based incentives to women health volunteers known as ASHA (Accredited Social Health Activist) for promoting institutional delivery among pregnant women. Under this initiative, eligible pregnant women are entitled to get JSY benefit directly into their bank accounts. Cash entitlement for different categories of mothers is as follows:

Cash Assistance for Institutional Delivery (in Rs.)

Category	*Rural Area*		*Urban Area*	
	Mother's package	***ASHA's package***	***Mother's package***	***ASHA's package***
Low Performing States - LPS	*₹1400* *All women regardless of age and number of children for delivery in government / private accredited health facilities*	*₹600*	*₹1000*	*₹400*
HPS	*₹700/-* *All BPL/Scheduled Caste/Scheduled Tribe (SC/ST) women delivering in a government/private accredited health facility*	*₹600*	*₹600*	*₹400*

Source: nhm.gov.in / National Health Mission / MoHFW

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Janani Shishu Suraksha Karyakaram (JSSK)

Introduction

Government of India has launched the Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011. The scheme is to benefit pregnant women who access Government health facilities for their delivery. Moreover it will motivate those who still choose to deliver at their homes to opt for institutional deliveries. All the States and UTs have initiated implementation of the scheme.

Situation

High out of pocket expenses being incurred by pregnant women and their families in the case of institutional deliveries in form of drugs, User charges, diagnostic tests, diet, for C – sections.

The New Initiative

In view of the difficulty being faced by the pregnant women and parents of sick new- born along-with high out of pocket expenses incurred by them on delivery and treatment of sick-new-born, Ministry of Health and Family Welfare (MoHFW) has taken a major initiative to evolve a consensus on the part of all States to provide completely free and cashless services to pregnant women including normal deliveries and caesarean operations and sick new born (up to 30 days after birth) in Government health institutions in both rural and urban areas.

The following are the Free Entitlements for pregnant women:

- Free and cashless delivery
- Free C-Section
- Free drugs and consumables
- Free diagnostics
- Free diet during stay in the health institutions
- Free provision of blood
- Exemption from user charges
- Free transport from home to health institutions

- Free transport between facilities in case of referral
- Free drop back from Institutions to home after 48hrs stay

The following are the Free Entitlements for Sick newborns till 30 days after birth. This has now been expanded to cover sick infants:

- Free treatment
- Free drugs and consumables
- Free diagnostics
- Free provision of blood
- Exemption from user charges
- Free Transport from Home to Health Institutions
- Free Transport between facilities in case of referral
- Free drop Back from Institutions to home

Key features of the scheme

The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section.

The entitlements include free drugs and consumables, free diet up to 3 days during normal delivery and up to 7 days for C-section, free diagnostics, and free blood wherever required. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. This has now been expanded to cover sick infants.

The scheme aims to eliminate out of pocket expenses incurred by the pregnant women and sick new borne while accessing services at Government health facilities.

The scheme is estimated to benefit more than 12 million pregnant women who access Government health facilities for their delivery. Moreover, it will motivate those who still choose to deliver at their homes to opt for institutional deliveries. All the States and UTs have initiated implementation of the scheme

Source: www.nhm.gov.in /*National Health Mission / MoHFW*

5

Pradhanmatri Surakshit Matritva Abhiyan (PMSMA)

Introduction:

- The Pradhan Mantri Surakshit Matritva Abhiyan has been launched by the Ministry of Health & Family Welfare (MoHFW), Government of India. The program aims to provide assured, comprehensive and quality antenatal care, free of cost, universally to all pregnant women on the 9th of every month.
- Hon'ble Prime Minister highlighted the aim and purpose of introduction of the Pradhan Mantri Surakshit Matritva Abhiyan in the 31st July 2016 episode of Mann Ki Baat.
- PMSMA guarantees a minimum package of antenatal care services to women in their 2nd / 3rd trimesters of pregnancy at designated government health facilities
- The programme follows a systematic approach for engagement with private sector which includes motivating private practitioners to volunteer for the campaign developing strategies for generating awareness and appealing to the private sector to participate in the Abhiyan at government health facilities.
- For Individual HRP tracking, MoHFW launched e-PMSMA (Extended -Pradhan Mantri Surakshit Matritva Abhiyan) on January 2022. Furthermore, for tracking Individual High-Risk Pregnancy (HRP), Ministry has developed additional feature in existing PMSMA portal.

Rationale for the program

- Data indicates that Maternal Mortality Ratio (MMR) in India was very high in the year 1990 with 556 women dying during child birth per hundred thousand live births as compared to the global MMR of 385/lakh live births
- Maternal Mortality Ratio (MMR) of India has declined by 459 points from 556 per one lakh live births in 1990 to 97 in 2018-2020 as per Sample Registration System (SRS). A decline of 83% has been achieved in MMR since 1990, which is higher than the global decline of 45%
- While India has made considerable progress in the reduction of maternal and infant mortality, every year approximately 24000 (MMEIG 2020 Report) women still die due to pregnancy-related causes and approximately 5.40 lakh infants die within the first 28 days of life (SRS 2020)

- Many of these deaths are preventable and many lives can be saved if quality care is provided to pregnant women during their antenatal period and high-risk factors such as severe anemia, pregnancy-induced hypertension etc are detected on time and managed well.

Goal of the PMSMA

Pradhan Mantri Surakshit Matritva Abhiyan envisages to improve the quality and coverage of Antenatal Care (ANC) including diagnostics and counselling services as part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) Strategy.

Objectives of the PMSMA

- Ensure at least one antenatal checkup for all pregnant women in their second or third trimester by a physician/specialist
- Improve the quality of care during ante-natal visits. This includes ensuring provision of the following services:
- All applicable diagnostic services
- Screening for the applicable clinical conditions
- Appropriate management of any existing clinical condition such as Anaemia, Pregnancy induced hypertension, Gestational Diabetes etc.
- Appropriate counselling services and proper documentation of services rendered
- Additional service opportunity to pregnant women who have missed ante-natal visits
- Identification and line-listing of high-risk pregnancies based on obstetric/ medical history and existing clinical conditions.
- Appropriate birth planning and complication readiness for each pregnant woman especially those identified with any risk factor or comorbid condition.
- Special emphasis on early diagnosis, adequate and appropriate management of women with malnutrition.
- Special focus on adolescent and early pregnancies as these pregnancies need extra and specialized care

Key Features of PMSMA

- PMSMA is based on the premise — that if every pregnant woman in India is examined by a physician and appropriately investigated at least once during the PMSMA and then appropriately followed up — the process can result in reduction in the number of maternal and neonatal deaths in our country.
- Antenatal checkup services would be provided by OBGY specialists / Radiologist/physicians with support from private sector doctors to supplement the efforts of the government sector.
- A minimum package of antenatal care services (including investigations and drugs) would be provided to the beneficiaries on the 9th day of every month at identified public health facilities (PHCs/ CHCs, DHs/ urban health facilities etc) in both urban and rural areas in addition to the routine ANC at the health facility/ outreach.
- Using the principles of a single window system, it is envisaged that a minimum package of investigations (including one ultrasound during the 2nd trimester of pregnancy) and medicines such as IFA supplements, calcium supplements etc would be provided to all pregnant women attending the PMSMA clinics.
- While the target would reach out to all pregnant women, special efforts would be made to reach out to women who have not registered for ANC (left out/missed ANC) and also those who have registered but not availed ANC services (dropout) as well as High Risk pregnant women.
- OBGY specialists/ Radiologist/physicians from private sector would be encouraged to provide voluntary services at public health facilities where government sector practitioners are not available or inadequate.
- Pregnant women would be given Mother and Child Protection Cards and safe motherhood booklets.
- One of the critical components of the Abhiyan is identification and follow up of high risk pregnancies. A sticker indicating the condition and risk factor of the pregnant women would be added onto MCP card for each visit:
- Green Sticker- for women with no risk factor detected
- Red Sticker – for women with high-risk pregnancy
- A National Portal for PMSMA and a Mobile application have been developed to facilitate the engagement of private/ voluntary sector.

- ‘IPledgeFor9’ Achievers Awards have been devised to celebrate individual and team achievements and acknowledge voluntary contributions for PMSMA in states and districts across India.
- For further details kindly refer to the detailed operational framework for the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA).

Key features of E-PMSMA

- Name- based line listing of HRPs
- Provision of additional PMSMA Session (Max 4 times in a month)
- Individual tracking of HRP up to healthy outcome (till 45th day after delivery)

Source: https://pmsma.mohfw.gov.in/about-scheme/#about **year 2024**

6

SUMAN (Surakshit Matritva Aashwasan)

INTRODUCTION

Improving the well-being of mothers, infants and children is an important public health goal for the Government of India (GoI). A healthy woman forms the cornerstone of a healthy, dynamic and progressive nation. Safe pregnancy, child birth and postpartum period are important milestones in the continuum of care for women to achieve optimal maternal and neonatal outcomes that have a significant impact on the future of mothers, children and families in the long run.

With that aim the Government of India has launched "SUMAN – Surakshit Matritva Aashwasan" a multipronged and coordinated policy approach that subsumes all existing initiatives under one umbrella in order to create a comprehensive initiative which goes beyond entitlements and provides a service guarantee for the entitlements. Simultaneously it also underlines the commitment of the government for addressing the existing inequities in maternal and newborn health care services and move towards zero preventable maternal and newborn deaths.

The SUMAN initiative was launched by the honourable Health Minister on 10th October 2019, at the 13th conclave of the Central Council of Ministers, wherein the GoI and the State Governments collectively committed to achieve zero preventable maternal and newborn deaths in the country and providing service assurance for maternal and newborn care services.

SUMAN promotes safe pregnancy, childbirth and immediate postpartum care with respect and dignity by translating the entitlements into a service guarantee which is more meaningful to the beneficiaries.

VISION

To create a responsive health care system which strives to achieve zero maternal and infant deaths through quality care provided with dignity and respect.

GOAL

To end all preventable maternal and newborn deaths.

OBJECTIVES

Assured, dignified, respectful and quality healthcare at no cost and zero tolerance for denial of services for every woman and newborn visiting the public health facility to end all preventable maternal and newborn deaths and morbidities and provide a positive birthing experience.

- Provide high quality medical and emergency services and referrals
- Create a responsive health care system
- Use institutional and other community-based platforms to spread awareness, mobilize community and facilitate 100% reporting & review of Maternal Deaths
- Develop and establish a system of continuous client feedback and redressal of grievances
- Provide an interdepartmental platform for convergent action plans.
- Effective governance including formulating strategies, supervision and review of the program for corrective actions.

BENEFICIARIES OF THE INITIATIVE:

- All Pregnant Women
- All mother up to 6 months post-delivery
- All Sick infants

ENTITLEMENTS UNDER THE INITIATIVE

- Provision of at-least 4 ANC checkups, one PMSMA checkup & six HBNC visits
- Free transport from home to health institution dial 102(108)
- Assured referral services with scope of reaching health facility within 1 hour of any critical case emergency.
- Deliveries by trained personnel (including Midwife/SBA)
- Elimination of Mother to Child Transmission (EMTCT) of HIV, HBV & Syphilis

- Choice for Delayed Cord Clamping up to delivery of placenta in uncomplicated deliveries
- Post partum FP counseling & IEC/BCC for safe motherhood
- Respectful Care with privacy and dignity
- Early Initiation and support for Breastfeeding
- Management of sick neonates
- Zero dose vaccination
- Birth registration certificates from healthcare facilities.
- Conditional cash transfers/direct benefit transfer under various schemes
- Drop back from institution to home after due discharge (minimum 48 hrs.)
- Free and zero expense delivery and C-section facility in case of complications at public health facilities
- Time bound redressal of grievances including through a responsive call center/helpline.

Broad Pillars of the Initiatives

SERVICE GUARANTEE:

JSSK, JSY, PMSMA, LaQshya, MAA, care for sick & small babies, Home based care for mothers & newborn

COMMUNITY AWARENESS:

Involving VHSNC and SHGs, Community Champions

HEALTH SYSTEM STRENGTHENING

Infrastructure- LDR, OT, Obstetric HDU/ICU, NBCC, NBSU, SNCU, Human resource, Drugs and diagnostics, Referral systems, Creating centres of excellence

MONITORING & REPORTING

Service Guarantee Charter, Grievance redressal including responsive call center for better redressal, ensured availability of MCP card and Safe motherhood booklet

Source: SUMAN standard operational guidelines, NHM / nhm.gov.in

7

Midwifery

Introduction to Midwifery:

The provision of midwifery is witnessing long awaited increase in global attention. Recognizing the significant contribution made by midwives worldwide, many countries are giving centre stage to midwives in order to improve quality of care, reduce "over-medicalization" during child birth and increase efficient use of resources.

What is midwifery?

"Skilled, knowledgeable and compassionate care for childbearing women, new-born infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women's individual circumstances and views; and working in partnership with women to strengthen women's own capabilities to care for themselves and their families." (Lancet Series on Midwifery, 2014)

Who is a midwife?

"A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the International Confederation of Midwives (ICM) Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife' and who demonstrates competency in the practice of midwifery." (International Confederation of Midwives, 2015)

Why does India need midwifery?

Global evidence has shown that the introduction of midwifery care has historically translated into the increased availability of quality maternal and newborn health services, and significantly aided the reduction of maternal and newborn mortality and morbidity.

Goal:

The 'Midwifery Services Initiative' aims to create a cadre of Nurse Practitioners in Midwifery who are skilled in accordance to ICM competencies, knowledgeable and capable of providing compassionate women-centre, reproductive, maternal and newborn health care services and also develop an enabling environment for integration of this cadre into the public health system, in order to achieve the SDGs for maternal and newborn health.

Objectives:

- To provide access to quality maternal and newborn health services and promote natural birthing by promoting positive child birthing experience.
- To promote respectful maternity care throughout pregnancy and child birth.
- To identify, manage, stabilize and/or refer as needed, women and their newborns experiencing complications.
- To decongest higher level of healthcare facilities.
- To expand access to quality maternal and neonatal services in remote areas including pockets of high home delivery rates and urban slums

Source: Guidelines on MIDWIFERY SERVICES IN INDIA 2018 / NHM/MoHFW

MDR Maternal Perinatal Death Surveillance Review

Introduction

The first and foremost step of the Maternal Death Review process is preparing a line list of all the maternal deaths in the area following which Facility and/or Community based maternal death reviews are to be undertaken. Currently approximately 50% of the estimated Maternal Deaths across the country are being reported by States/ UT s. Improving the surveillance and reporting of maternal deaths is thus critical. State level MDSR Committees (details described later) must take the following key steps to improve the same:

Monitor whether Maternal Deaths are being reported by all high delivery facilities (facilities conducting more than 1000 deliveries/ year).

Monitor the district-wise number of deaths reported against estimated - identify the number of districts that have zero/ poor reporting and focus on improving reporting from these districts.

Analysis of reported maternal death data indicates that approximately 20% of the maternal deaths occur at medical colleges and approximately 15% occur at private hospitals. This would obviously differ across States. However, data highlights an urgent need to conduct a mapping of the medical colleges and tertiary institutes in the State and monitor whether they are reporting and reviewing maternal deaths. States must also focus on improving reporting from private tertiary level institutions with the help of regulatory mechanisms such as the Clinical Establishment Act.

Analysis of available data also highlights that approximately 20% of the maternal deaths could happen during transit. States must thus monitor the number of deaths occurring during transit and the mechanism for reporting of deaths occurring during transits (both for private and government vehicles).

Identify areas of high home delivery and monitor whether maternal deaths are being reported from these areas.

All the maternal deaths reported will be investigated, irrespective of the place of death i.e. at home, in facility or in transit; area of death i.e. rural or urban. Maternal death review process will be undertaken at two levels:

1. Community level

2. Facility level

In addition, confidential review of cases of maternal deaths occurred at facility will be conducted at state level by the expert members of Committee for Confidential Review (CCR) to review the clinical line of management of cases.

Community Based MDSR (CBMDSR)

Community based MDSR is a method of identifying personal, family or community factors that may have contributed to the death by interviewing people such as family members or neighbours who are knowledgeable about the events leading to the death. Interview is done by using a verbal autopsy format.

Community based reviews must be taken up for all deaths that occur in the specified geographical area, irrespective of the place of death, be it at home, facility or in transit. District Nodal Officer (DN O) will ensure that all the maternal deaths reported by facilities will be investigated at community level also.

Steps for Community Based MDSR

A. Notification of maternal death

B. Investigation

C. Data transmission

D. Analysis

E. Review

Facility Based MDSR (FBMDSR)

Facility Based Maternal Deaths Reviews are undertaken with the objective of improving the quality of services and responsiveness of the facility in the emergency situations by assessing the details of services provided with the help of format filled from the case sheet

and by interviewing the close family members if needed. It is a process of learning lessons from the events happened in the past to prevent similar incidences in future.

FBMDSR will be taken up for all Government teaching hospitals, referral hospitals and secondary level hospitals under other departments like Corporation, Railway, ESI C etc., district hospital, sub-district and CHCs conducting more than 1000 deliveries/ year. If regulatory mechanisms exist, States would instruct private tertiary care institutions to undertake maternal death reviews. All maternal deaths should be reported within 24 hours to District and State officials.

Steps of Facility Based MDSR

A. Notification of maternal death

B. Investigation

C. Data transmission

D. Analysis

E. Review

Source: Guidelines for Maternal Death Surveillance and Response/NHM

9

Labour Room (LR)

Introduction

A labour room, also known as a delivery room or birthing room, is a specialized healthcare facility within a hospital or maternity center where pregnant women undergo labor and delivery. It is designed to ensure the safe and comfortable delivery of babies while maintaining high standards of hygiene and medical care to reduce risks to both the mother and the newborn. Key Features of a Labour Room:

- **Hygienic Environment:** Strict infection control measures are maintained to prevent infections to the mother and baby.
- **Medical Equipment:** Equipped with essential tools like delivery beds, foetal monitors, oxygen supplies, sterilized instruments, and resuscitation equipment.
- **Trained Staff:** Staffed by obstetricians, nurses, midwives, and anaesthesiologists who provide skilled care during childbirth.
- **Emergency Readiness:** Facilities to handle obstetric emergencies such as postpartum haemorrhage, obstructed labor, or foetal distress.
- **Comfort Measures:** Includes provisions for pain relief, privacy, and support for the mother during labor.
- **Neonatal Care:** Readily available neonatal equipment for immediate care of the newborn, such as incubators and radiant warmers.

Purpose:

- To provide a safe space for mothers to deliver their babies.
- To monitor and manage labor progression.
- To address any complications swiftly and effectively.
- To offer emotional and physical support to mothers.
- The design and operation of a labour room are critical in ensuring positive health outcomes and minimizing maternal and neonatal mortality.
- To avoid direct entry

Source: Labour room / NHM

CHILD HEALTH

1

Rashtriya Bal Swasthya Karyakram (RBSK)

Introduction

- Rashtriya Bal Swasthya Karyakram (RBSK) is a new initiative aiming at early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Deficiencies, Diseases, Development delays including disability.
- It is important to note that the 0-6 years age group will be specifically managed at District Early Intervention Center (DEIC) level while for 6 -18 years age group, management of conditions will be done through existing public health facilities. DEIC will act as referral linkages for both the age groups.
- First level of screening is to be done at all delivery points through existing Medical Officers, Staff Nurses and ANMs. After 48 hours till 6 weeks the screening of newborns will be done by ASHA at home as a part of HBNC package.
- Outreach screening will be done by dedicated mobile block level teams for 6 weeks to 6 years at Anganwadi centers and 6 - 18 years children at school.
- Once the child is screened and referred from any of these points of identification, it would be ensured that the necessary treatment/intervention is delivered at zero cost to the family.

Target age group

The services aim to cover children of 0 -6 years of age in rural areas and urban slums in addition to children enrolled in classes I to XII in Government and Government aided Schools. It is expected that these services will reach to about 27 crores children in a phased manner. The broad category of age group and estimated beneficiary is as shown below in the table. The children have been grouped in to three categories owing to the fact that different sets of tools would be used and also different set of conditions could be prioritized.

Target group under Child Health Screening and Intervention Service Categories		
Categories	Age Group	**Estimated Coverage**
Babies born at public health facilities and home	Birth to 6 weeks	**2 crores**
Preschool children in rural areas and urban slum	6weeks to 6 years	**8 crores**
School children enrolled in class 1st and 12th in government and government aided schools	**6yrs to 18 yrs**	**17 crores**

Health conditions to be screened

Child Health Screening and Early Intervention Services under RBSK envisages to cover 30 selected health conditions for Screening, early detection and free management. States and UTs may also include diseases namely hypothyroidism, Sickle cell anemia and Beta Thalassemia based on epidemiological situation and availability of testing and specialized support facilities within State and UTs.

Selected Health Conditions for Child Health Screening & Early Intervention Services	
Defects at Birth	**Deficiencies**
Neural tube defect **Down's Syndrome** **Cleft Lip & Palate / Cleft palate alone** **Talipes (club foot)** **Developmental dysplasia of the hip** **Congenital cataract** **Congenital deafness** **Congenital heart diseases** **Retinopathy of Prematurity**	**Anemia especially Severe anemia** **Vitamin A deficiency (Bitot spot)** **Vitamin D Deficiency, (Rickets)** **Severe Acute Malnutrition** **Goiter**
Diseases of Childhood	**Developmental delays and Disabilities**

Skin conditions (Scabies, fungal infection and Eczema) **Otitis Media** **Rheumatic heart disease** **Reactive airway disease** **Dental conditions** **Convulsive disorders**	**Vision Impairment** **Hearing Impairment** **Neuro-motor Impairment** **Motor delay** **Cognitive delay** **Language delay** **Behavior disorder (Autism)** **Learning disorder** **Attention deficit hyperactivity disorder**
30. Congenital Hypothyroidism, Sickle cell anemia, Beta thalassemia (Optional)	

Mechanisms for screening at Community & Facility level:

Child screening under RBSK is at two levels community level and facility level. While facility based new born screening at public health facilities like PHCs / CHCs/ DH, will be by existing health manpower like Medical Officers, Staff Nurses & ANMs, the community level screening will be conducted by the Mobile health teams at Anganwadi Centres and Government and Government aided Schools.

Screening at Anganwadi Centre

All pre-school children below 6 years of age would be screened by Mobile Block Health teams for deficiencies, diseases, developmental delays including disability at the Anganwadi centre at least twice a year. Tool for screening for 0-6 years is supported by pictorial, job aids specifically for developmental delays. For developmental delays children would be screened using age specific tools specific and those suspected would be referred to DEIC for further management.

Screening at Schools - Government and Government aided

School children age 6 to 18 years would be screened by Mobile Health teams for deficiencies, diseases, developmental delays including disability, adolescent health at the local schools at least once a year. The too used is questionnaire (preferably translated to local or regional language) and clinical examination.

Composition of mobile health team

The mobile health team will consist of four members- two Doctors (AYUSH) one male and one female, at least with a bachelor degree from an approved institution, one ANM/Staff Nurse and one Pharmacist with proficiency in computer for data management

Suggested Composition of Mobile Health Team.		
S.No	Member	**Number**
1	Medical officers (AYUSH) -1male and 1 female at least with a bachelor degree from an approved institution	**2**
2	ANM/Staff Nurse	**1**
3	Pharmacist with proficiency in computer for data management	**1**
***In case a Pharmacist is not available, other paramedics –Lab Technician or Ophthalmic Assistant**		

Source: Operational guidelines of RBSK / *National Health Mission*

2

District Early Intervention Centre (DEIC)

Introduction

The purpose of a District Early Intervention Centre (DEIC) is to provide early identification and intervention services for children with developmental delays, disabilities, and other health conditions. DEICs are typically established as part of a larger healthcare system, to promote early detection, diagnosis, and treatment of developmental issues in children.

Developmental impairment is a common problem in children health that occurs in approximately 10% of the childhood population and even more among “at risk” children discharged from the sick newborn care unit. Children, disabled or non-disabled, under 6 years of age, represent a rapidly growing segment in India. Children with disabilities are often denied access to appropriate services. According to the National Sample Survey Organization (NSSO 2002), the total number of disabled populations in India is approximately 1.85 crores (1.8% of the population), however the actual estimates may be higher. The idea behind early intervention is to intervene early and minimize disability. Once the disability is already established then the intervention would include enhancement of child development for the child to reach the highest potential for the child possible and prevent progression to handicap that may arise from activity limitation.

Developmental intervention requires an interdisciplinary approach of a multidisciplinary team placed under one roof. However, there are very few centers in India which provide such services but even most of these centers do not have all the components required for evaluation and intervention in a holistic way.

Goals and Services of A DEIC

DEIC should be aiming at early detection and early intervention so as to minimize disabilities among growing children. WHO has stated that defect or developmental delay leads to functional disability and these functional disability in turn lead to handicap if not addressed adequately. The burden of this handicap is borne by the family and also by society. DEIC should aim at detection of defect and minimize disability through intervention.

The broad goals and services for DEIC include:

Screening of children from birth-18 years for 4d's

Early identification of selected Health Conditions

- Holistic assessment
- Investigations
- Diagnosis
- Intervention
- Referral
- Prevention
- Psycho-social interventions

Services to be Provided by a DEIC

A. **CORE SERVICES:**

Medical services – for diagnostic or evaluation purposes. Medical treatment of children suffering from diseases and deficiencies. (Doctor: Pediatrician/ Medical officer)

Dental services – for problems of teeth, gums and oral hygiene in children from birth to 6 years esp. "Early Childhood Caries" (Dentist) Goals and Services of a DEIC

Occupational therapy & Physical therapy – services that relate to self-help skills, adaptive behavior and play, sensory, motor, and postural development i.e. services to prevent or lessen movement's difficulties and related functional problems. Sensory Integration, oro-motor and feeding difficulties. (Physiotherapist/Occupational therapist)

Psychological services – administering and interpreting psychological tests and evaluation of a child's behavior related to development, learning and mental health as well as planning services including counseling, consultation, parent training, behavior modification and knowledge of appropriate education programs. (Rehabilitation Psychologist/Clinical Psychologist)

Cognition services – identifying cognitive delays and providing intervention to enhance cognitive development, adaptive and learning behaviors. (Clinical Psychologist and Early Interventionist)

Audiology – identifying and providing services for children with hearing loss among children from birth to 6 years for both congenital deafness and also acquired deafness. (Audiologist cum speech and language pathologist)

Speech-language pathology – services for children with delay in communication skills or with motor skills such as weakness of muscles around the mouth or swallowing. (Audiologist cum speech and language pathologist)

Vision services – identification of children with visual disorders or delays and providing services and training to those children. (Optometrist).

Retinopathy of Prematurity (RoP) – for premature or preterm children. (Optometrist and ophthalmologist)

Health services – health-related services necessary to enable a child to benefit from other early intervention services.(Doctor)

Lab services – for routine blood investigations among children to begin with but slowly would develop services for confirming congenital hypothyroidism, Thalassemia and Sickle cell anemia or other inborn error of metabolism depending on the prevalence of such diseases. (Lab technician)

Nutrition services – services that help address the nutritional needs of children that include identifying feeding skills, feeding problems, food habits, and food preferences. (Nutritionist/ Dietician or Nursing staff)

Social support services – preparing an assessment of the social and emotional strengths and needs of a child and family, and providing individual or group services such as counseling. Socio economic evaluation of the family and linkages with the need based social services. (Social Worker /Psychologist)

Psycho-social services – includes designing learning environments and activities that promote the child's development, providing families with information, skills, and support to enhance the child's development. (Special Educator)

Transportation and related costs – providing or reimbursing the cost of travel necessary to enable a child and family to receive any tertiary level services. (DEIC Manager)

Service coordination – (DEIC Manager)

Referral services following referral guidelines – children who are diagnosed for any of the selected health conditions would receive follow-up referral support and treatment including surgical interventions at tertiary level. (DEIC Manager)
Documentation and maintenance of case records, data storage for service delivery, follow up and research. (Data entry operator)

Training and enhancing capability of multi-skilled community personnel in the district and helping in operationalizing of early intervention services at blocks and in the community and provide supportive supervision and domain specific referral services in the community. (DEIC core Intervention team)

B. **SUPPLEMENTARY SERVICES**

Disability certificates: with other members of the disability board (DEIC Manager)
Liaison with other departments under various ministries: (DEIC Manager) e.g.

A) Disability division of Ministry of Social Justice and Empowerment (MoSJE):

- Assistive technology devices and services – equipment and services that are used to improve or maintain the abilities of a child to participate in such activities as Hearing, seeing (Vision), Moving, Communication and learning to compensate with a specific biological limitation.

- Special Education services for School age groups from six to sixteen, pre-vocational training for age 16-18 years and Vocational training for the age of 18

- Aids and appliances: Assistance to Disabled Persons for Purchase / Fitting of Aids and Appliances under the "Assistance to Disabled Persons for Purchase/ Fitting of Aids/Appliances (ADIP)" Scheme, with the objective of assisting needy persons with disabilities in procuring durable, sophisticated and scientifically manufactured standard aids and appliances that can promote their physical, social and psychological rehabilitation.
- Rehabilitation of the differently abled child above 6 years of age at the Rehabilitation centers in that state e.g. District Disability Rehabilitation Centers (DDRCs) for the districts where they are functional or Composite Regional Centers (CRCs) or National Institutes/Regional Centers etc.
- Family support services esp. for children having Autism, Cerebral palsy, Mental retardation, multiple disabilities. These Services would be to support those children who would require long term support and would focus on supporting the child in their natural environments and in their everyday experiences and activities. All services would be provided using a family-centered approach, recognizing the importance of working in partnership with the family. However, whenever a detailed domain specific management would be required, they would be referred to the DEIC.
- Guardianship
- Parent Associations
- Promoting advocacy for right-based society
- Social security's such as disability scholarship and disability pension
- Linkages with Ministry of Human Resource Development (MoHRD), Department of School Education & Literacy under "Education of Children with Special Needs in "Sarva Shiksha Abhiyan"
- Provide inclusive education and support to children from age of 6 -14 years
- Provide Aids and appliances to school going children with special needs and support of trained special educators to these children.
- To provide home based educational services to children with special needs on need basis.

Source: Setting Up District Early Intervention Centres Operational guidelines /NHM / MoHFW

3

Home Based Newborn Care (HBNC)

Introduction:

Home Based New Born Care (HBNC) programme was launched in 2011 for accelerated reduction of Neonatal mortality and morbidity rates especially in rural, remote areas where access to care is largely unavailable or located faraway. The guidelines were revised in 2014. Under this programme, ASHA to make visits to all newborns according to specified schedule up to first 42 days of life. This includes six visits in case of institutional deliveries on 3rd, 7th, 14th, 21st, 28th& 42nd days after birth and one additional visit within 24 hours of delivery in case of home deliveries. Additional visits for babies who are pre-term, low birth weight or ill and SNCU discharged babies will be conducted.

Key objectives of HBNC:

The objectives of **Home-Based Neonatal Care (HBNC)** are aimed at reducing neonatal morbidity and mortality by addressing the health needs of newborns through community-based interventions. Key objectives include:

1. **Early Identification and Management of Health Issues**:
   Detect and manage common neonatal problems such as infections, jaundice, hypothermia, low birth weight, and feeding difficulties.
2. **Reducing Neonatal Mortality**:
   Prevent avoidable neonatal deaths through timely care, appropriate referrals, and education of caregivers.
3. **Promoting Essential Newborn Care**:
   Ensure implementation of essential practices like breastfeeding within the first hour, exclusive breastfeeding, thermal protection, cord care, and hygiene.
4. **Empowering Families and Caregivers**:
   Educate families about newborn care, danger signs, immunization, and the importance of seeking healthcare when needed.

5. **Timely Referrals**:
   Facilitate early referral of sick newborns to healthcare facilities for specialized care.
6. **Capacity Building of Frontline Workers**:
   Train community health workers like ASHAs and ANMs in providing essential neonatal care and managing common complications.
7. **Enhancing Postnatal Care Coverage**:
   Increase the reach and effectiveness of postnatal care visits, especially in underserved and rural areas.
8. **Strengthening Health Systems**:
   Link home-based care to existing health systems for continuity of care and long-term improvement in neonatal health.

Activities in HBNC

The major activities in **Home-Based Neonatal Care (HBNC)** focus on delivering essential care, monitoring newborn health, and supporting families through trained frontline workers like ASHAs. These activities include:

1. Essential Newborn Care

- Promoting **early initiation of breastfeeding** within the first hour of birth and ensuring **exclusive breastfeeding**.
- Maintaining **thermal protection** (e.g., skin-to-skin contact and preventing hypothermia).
- Providing clean **cord care** and emphasizing hygienic practices.

2. Postnatal Home Visits

- Conducting home visits as per the HBNC schedule (e.g., 6 visits for institutional births and additional visits for home births).
- Monitoring newborn health for signs of infections, feeding difficulties, or other complications.
- Recording and tracking weight, feeding patterns, and overall health.

3. Detection of Danger Signs

- Identifying danger signs such as:
    - Poor feeding or refusal to breastfeed.
    - Hypothermia or fever.
    - Rapid or difficulty breathing.
    - Signs of infection (pus around the cord, lethargy).
- Educating families about recognizing these signs.

4. Timely Referral

- Facilitating referral to health facilities for newborns with complications or danger signs.
- Supporting families in accessing emergency care when needed.

5. Care for Low Birth Weight and Preterm Newborns

- Promoting **Kangaroo Mother Care (KMC)** for warmth, feeding, and bonding.
- Regular weight monitoring to assess growth.

6. Family Counselling

- Educating families on:
    - Importance of immunization and adherence to schedules.
    - Maintaining hygiene to prevent infections.
    - Nutrition for both the newborn and lactating mothers.
- Addressing myths and misconceptions about neonatal care.

7. Documentation and Reporting

- Maintaining a **home visit register** to record observations and actions taken.
- Reporting health data to supervisors and linking it with health systems.

8. Capacity Building of Frontline Workers

- Regular training and refresher sessions for ASHAs and ANMs on HBNC protocols, danger signs, and counselling techniques.

9. Linkage with Health Programs

- Ensuring integration with programs like Routine Immunization, Integrated Child Development Services (ICDS), and Rashtriya Bal Swasthya Karyakram (RBSK).

Activities during home visit by ASHA

- Information and skills to the mother and family on how to do better care of newborn, on special care for low weight babies, on how to identify danger signs and promote exclusive breastfeeding and immunization
- Examining every newborn for prematurity and low birth weight, identification of illness, anything unusual in baby, provision of appropriate care at home, refer to ANM or nearest health facilities as defined in the protocols
- Follow up for sick newborns after they are discharged from facilities.
- Counselling the mother on postpartum care, recognition of postpartum complications and enabling referral
- Counseling the mother for adoption of an appropriate family planning method.

Activities to be ensured during HBNC visits

Temperature	Weight	Respiratory Count of newborn	Identification of danger sign in		Counselling to mother and care givers
			Newborn	Mother	
✓	✓	✓	✓	✓	✓

Source: HBNC Guidelines 2014 / NHM

4

Home Based Care of Young Child (HBYC)

Introduction

Home-Based Care for Young Child Programme (HBYC) was launched in 2018 as part of National Health Mission and POSHAN Abhiyan for promotion of health and nutrition of young children (3-15 months), for reducing child morbidity and mortality and for promotion of growth and Early Childhood Development. Under HBYC, ASHA provides incentivized five home visits on 3rd, 6th, 9th, 12th and 15th months. ASHAs are being paid incentive of Rs.250/- per HBYC category child for five scheduled home visits.

Objectives

The objective of Home-Based Care for Young Child is to reduce child mortality and morbidity and improve nutrition status, growth and early childhood development of young children through structured, focused and effective home visits by ASHAs.

Purpose of Home Visits

The purpose of the additional home visits by ASHAs are promotion of evidence-based interventions delivered in four key domains namely nutrition, health, child development and WASH (water, sanitation & hygiene).

Specific Action during HBYC

Nutrition

- Exclusive breastfeeding for six months
- Adequate complementary feeding from six months and continued
- breast feeding up to two years of age
- Iron and folic acid (IFA) supplementation
- Promote use of fortified food

Health

- Full immunization for children
- Regular growth monitoring
- Appropriate use of Oral Rehydration Solution (ORS) during diarrhoea episodes

- Early care seeking during sickness

Child Development

- Age-appropriate play and communication for children

WASH

- Appropriate Handwashing practices

Strategies

Under Home Based Care of Young Child (HBYC) programme, the additional five home visits will be carried out by ASHA with support from Anganwadi workers. From 2–3-month onward ASHAs will provide quarterly home visits (3rd, 6th, 9th, 12th and 15th months) and ensure exclusive and continued breastfeeding, adequate complementary feeding, age-appropriate immunization and early childhood development. The quarterly home visits schedule for low-birth-weight babies, SNCU & NRC discharges will now be harmonized with the new HBYC schedule.

Anganwadi workers will continue to provide **'Take Home Ration'** and nutrition-specific counselling to mothers. In addition, she will record weight of the young children and monitor growth and development using MCP card as per guidelines. Based on the growth chart, underweight children will be identified and taken up for further management.

Task of ASHAs and AWWs under HBYC

Home Visits	ASHAs	AWWs
At 3rd Month	• Support for exclusive breastfeeding • Counsel on hand washing practices • Appropriate play and communication • Check immunization status • Check weight recording in MCP card; identify growth faltering	• Monthly weighing of infants • Weight recording and plotting on growth chart • Detect underweight children & take further action • Counsel mother for exclusive • breast feeding

At 6th, 9th, 12th and 15th Months	• All above activities PLUS • Counsel on initiation of complementary feeding & continued breastfeeding • Age appropriate & adequate complementary feeding for children • Age-appropriate play and communication • Ensure full immunization • Distribution of prophylactic IFA and ORS and counselling for their appropriate usage • Depot holder for ORS & Zinc	• Take Home Ration' and nutrition specific counselling to mothers • Monthly weighing and supplementary food from AWC • Counselling regarding complementary feeding • Weight recording on growth chart; • detect underweight children & take further action • Record length/height • Counsel for deworming of children • above 1 year of age

5 days HBYC training of ASHA. After completion of training, ASHA should be capable for HBYC and home visits with an HBYC kit (ECD kit) containing toys, torch, mirror, bell, bangle (to assess child for developmental delay), ARI timer, functional Thermometer, ORS and IFA Syrup with ASHA.

Source: Home Based Care for Young Child (HBYC) Strengthening of Health & Nutrition through Home Visits OPERATIONAL GUIDELINES April 2018 / NHM

5

Child Death Surveillance & Response (CDSR)

Background

Reducing infant mortality is one of the key goals under NHM. The infant and under five child mortality has shown a steady decline over the last few years. This operational guideline is designed for use by Health Care Service Providers, Programme Managers and Administrators at different levels of public health system to assist them in undertaking systematic Child Death Review (CDR) and use this information to improve the on-going child health interventions and accordingly plan for the future.

Objectives

- To specify the steps for CDSR at the health facility and community levels.
- To specify the roles and responsibilities of community health workers, service providers, programme managers and data entry operators at different levels in the conduct of CDSR.
- To provide relevant tools for the conduct of CDSR.
- To provide clear guidance on the process of data collection, data flow, data analysis, review and feedback.

Working definitions to conduct CDSR:

Neonatal Deaths: Neonatal deaths are deaths occurring during the neonatal period, commencing at birth and ending 28 completed days after birth.

Post-Neonatal Deaths: Deaths occurring from 29 days of life to less than one year are called post-neonatal deaths.

Infant Deaths: Deaths of children less than 1 year of age.

Child Deaths: Deaths of children less than 5 years of age.

Still Birth: Still birth is the birth of a new born after 20th completed week of gestation, weighing 500gm or more, when the baby does not breathe or show any sign of life after delivery.

Child Death Surveillance & Review – operational plan

Children in the age group 0-5 years will be included in the review. **All deaths in this age group will be reported** irrespective of the place it takes place: at home, in health facility or in transit; area of death i.e. rural or urban.

The review processes will remain the same for all children; however, the details to be investigated will vary in neonates (0-28 days) and children (29 days-5 years).

Child Death Review will be of two types:
1. Community Based Child Death Surveillance & Review **(CBCDSR)**
2. Facility Based Child Death Surveillance & Review **(FBCDSR)**

Online Portal of Maternal, Perinatal, Child Death Surveillance and Review (MPCDSR) was released by Hon'ble Union Minister of Health and Family Welfare, Government of India on 17th September 2021. This portal will enable real time recording of all neonatal and child deaths, review causes and need based action can be taken based on the report on timely manner.

Community-Based Child Death Surveillance & Review (CBCDSR)

Community-Based CDSR is a method of identifying personal, family, or community factors that may have contributed to the death by interviewing people such as family members or neighbours who are knowledgeable about the events leading to the death.

Initially, Community-based reviews would be undertaken for child deaths occurring at home or in transit.

Steps for CBCDSR:

Involves Notification, Investigation, Data transmission, Analysis of Child death followed by formulating and implementing remedial actions as deemed necessary to avert such incidence in future.

Responsible person for CBCDSR

- For information regarding death- ANM/ASHA
- Fill first investigation report- ANM
- Detail verbal autopsy/Social autopsy – MO assign task to team
- Report of Death to Block level- MO/DEO
- Report of detail review death and social autopsy to RCHO- BCMO/BNO
- Collect all death review and social autopsy report at state- RCHO/DNO
- Conduct social review in DHS meeting- DPM (NUHM)

Facility-Based Child Death Review

Facility based reviews will be taken up in all MCHs, Teaching Hospitals, DHs, SDHs, SGHs, Decentralised Hospitals, RHs, BPHCs.

FBCDSR committee will consist of the following members:

- MSVP/ Hospital Superintendent / BMOH / other administrative head of the institution.
- HOD, Dept. of Paediatrics
- FNO-CDSR (Paediatrician) and FNO-MDSR (Obstetrician)
- Paediatrician / Medical Officer posted in the Paediatrics
- One Anaesthesiologist
- MOIC of SNCU
- Nodal Asst. Superintendent (NM) looking after Maternal & Child Health.
- Nurse Staff of Paediatrics ward / SNCU

TOR of FBCDSR Committee:

- The committee will conduct child death review **every week**. FNO will fix the meeting in discussion with the Hospital Superintendent / MSVP.

- The main focus of the review is to check the clinical protocols and the line of treatment followed.
- FBCDSR formats and case summary will be discussed in the review meeting.
- The Committee will suggest corrective measures and steps to be taken to improve quality of care at the hospital.
- The Committee will suggest steps to be taken at the Community level, District level and State level.
- The FNO will send minutes of the meeting to the DNO along with the case summary prepared.
- The Committee will review actionable points of the last meeting.

Steps for FBCDSR are as follows:

- Step 1: Notification of child death
- Step 2: Investigation of child death
- Step 3: Data transmission
- Step 4: Analysis of the data followed by making suitable action plans from it.

Responsible Person for FBCDSR

- For information regarding death- Nursing staff to in charge
- Detail verbal autopsy– MO / In charge assign task to team/health manager
- Report of Death to Block level- MO / In charge /DEO
- Report of detail review death and social autopsy to RCHO- BCMO/BNO/Health manager
- Collect all death review and social autopsy report from MCH/DH/SDH/Block and sent to state- RCHO/DNO
- Conduct social review in DHS meeting- DPM (NUHM)

Source: CDSR guidelines / NHM

6

Social Awareness and Action to Neutralize Pneumonia Successfully (SAANS)

Background

Childhood pneumonia continues to be the topmost infectious killer among under-five children, contributing to 17.51 percent of under-five deaths in India.

Pneumonia morbidity & mortality in India Number of episodes of ARI/Pneumonia every year2	30 million
Incidence rate (per child per year)	0.22
Severe pneumonia cases out of total cases	3 million (10%)
Mortality rate per 1000 live births4	5.1

According to SRS 2020 Statistical report, the under-5 mortality is 32 per 1000 live births and the goal of National Health Policy 2017 is to reduce U5MR to 23 per 1000 live births by 2025. In order to achieve the National Health Policy goals, the Pneumonia mortality in children needs to reduce to less than 3 per 1000 live births. This is also in tune with the goal of India Integrated Action Plan for Pneumonia & Diarrhoea (IAPPD) in the State like Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh.

- Pneumonia being the number one of the leading causes of death of Under-five children in India. It demands prioritization & more investment of resources.
- Early preparedness, roll out and monitoring of the SAANS 2023-24 campaign by States/UTs and districts would be key to the success of control of childhood pneumonia.
- Additional emphasis and focus for early identification and appropriate management of childhood pneumonia cases through home visits by ASHAs and other front-line workers during the campaign period.
- SAANS campaign should also focus on strengthening of health facilities for paediatric care.
- Ensure that all eligible children receive 3 doses of Pneumococcal Conjugate Vaccine (two primary doses at 6 weeks and 14 weeks and a booster dose at 9 months) as per

the national immunization schedule under the universal immunization programme (UIP).

- Create Awareness about Indoor and Outdoor Air Pollution and its effects on Under 5 Children.

Goal

To intensify action for reducing mortality due to childhood Pneumonia in India to less than 3 per thousand live births by 2025.

It is expected that the SAANS (Social Awareness & Action to Neutralize Pneumonia Successfully) campaign will ensure health system strengthening and community awareness towards childhood pneumonia. The SAANS campaign will carry the tagline "***Pneumonia Nahi, Toh Bachpan sahi***" which clearly establishes the positive impact of a Pneumonia Free Childhood.

Objectives

- Adoption and adherence to National Childhood Pneumonia Management guidelines 2019
- Create awareness & mobilize community for Pneumonia Protection, Prevention & Treatment
- Early identification and management of under-five children to detect suspected pneumonia cases
- Strengthen facility-level management for cases of severe-pneumonia

SAANS Initiatives

Following is a suggested roadmap for implementation of SAANS campaign at the state/UT & district level.

1. Organise state and district orientation cum planning meeting
2. Prepare implementation plans for State / District & Block as per annual PIPs
3. Paediatric care strengthening in health facilities including access to medical oxygen
4. Capacity building of heath staff
5. Use digital & mass media for community awareness generation and mobilization
6. Awareness & Promotion of Pneumococcal Vaccine (PCV) & its administration
7. Screen under-five children at household level

8. Management of suspected Pneumonia cases at Facilities
9. Supportive supervision and monitoring
10. Reporting and feedback mechanism

The campaign organizes from 12 November (Worlds Pneumonia Day) to 28 February every year.

- Trained all frontline workers and MOs/SNs in 2 days SAANS program training.
- Orientation and training of all medical officers, Nursing staffs, CHOs, ANMs and ASHAs regarding identification of pneumonia cases and management as per guidelines.
- Timely identification of sign & symptoms of pneumonia and prompt referral of baby by giving prereferral dose of amoxicillin syrup.
- Availability of indoor treatment of a pneumonia suffer child at every PHC/CHC.
- Regular and Timely data recording and reporting in prescribed formats.

Source: Childhood Pneumonia Management Guidelines" available on https://nhm.gov.in/

6

STOP Diarrhea Campaign

Introduction

Reduction of childhood mortality to 23 per 1,000 live births by 2025 is one of the prime goals of National Health Policy. Childhood diarrheal diseases continue to be a major killer among under-five children in many states, contributing to 5.8 percent of under five deaths in the country (Cause of Death Statistics 2017-19, Sample Registration System of Registrar General of India). Around 50,000 children die due to diarrhea annually in the country. Diarrheal deaths are usually clustered in summer and monsoon months and the worst affected are children from poor socio-economic situations. Diarrhea is defined as the passage of three or more loose or liquid stools per day (or more frequent passage than is normal for the individual). Almost all the deaths due to diarrhea can be averted by preventing and treating dehydration by using ORS (Oral Rehydration Solution) and administration of Zinc tablets along with adequate nutritional intake by the child during diarrhea. Diarrhea can be prevented by exclusive and continued breastfeeding, timely introduction of appropriate and safe complementary feeding, use of safe drinking water, handwashing, sanitation and immunization.

In continuation of the efforts of Diarrhea Management till 2023, this year Ministry of Health and Family Welfare has renamed Diarrhea Campaign as “STOP Diarrhea Campaign” with the slogan for the year 2024:

“Diarrhoea ki Roktham, Safai aur ORS se rakhen apna dhyaan”

STOP Diarrhea Campaign consists of a set of activities to be implemented in an intensified manner during campaign period for prevention and control of deaths due to dehydration from diarrhea across all States/UTs. These activities mainly include - intensification of advocacy & awareness generation activities for diarrhea management utilizing inter-convergence of various departments, strengthening service provision for diarrhea case management, establishment of ORS-Zinc corners, prepositioning of ORS and Zinc by ASHA in households with under-five children, awareness generation activities for hygiene and sanitation.

Goal of STOP Diarrhoea Campaign

The ultimate goal is to reach zero child deaths due to diarrhea.

Objectives

"STOP Diarrhea Campaign is a preparedness activity to address potentially high incidence of diarrhea during the summer/monsoon season and floods / natural calamity. The objectives are:

- To ensure high coverage of ORS and Zinc usage in children with diarrhea throughout the country
- Inculcating appropriate behavior in care givers for diarrhea prevention & management of under-five children, Special focus needs to be accorded to the high priority areas (slums, drought/flood prone areas) and vulnerable communities.

Strategy

The focus is on delivery of simple proven interventions that have large impact towards control of childhood diarrheal morbidity and mortality. The strategy is four folds, as below:

- Improved availability and use of ORS and Zinc at household level
- Facility level strengthening to manage cases of dehydration Enhanced advocacy and communication on prevention and control diarrhea through Information, Education and Communication (IEC)/Social Behaviors Change Communication (SBCC) campaign
- Intersectoral convergence of relevant ministries and stakeholders for preventive measures

Source: Guidance note on STOP Diarrhoea Campaign / NHM

7

Facility Based Newborn Care (FBNC)

Facility Based Newborn Care (FBNC) along with Home Based Newborn Care (HBNC) and Home-Based Care for Young Child (HBYC) establishes a continuum of care to ensure that every newborn receives essential services right from the time of birth and first 48 hours at the health facility and then at home up to 15 months.

Facility Based Newborn Care Program:

Newborn Care Corners (NBCC)

Newborn Stabilization Units (NBSU)

Special Newborn Care Unit (SNCU)

Newborn Care Corner (NBCC)

New-born Care Corner (NBCC) is a designated space in the labor room & Obstetric OT which is situated in draught free area, with equipment's like radiant warmers, suction machines, self-inflating bag/AMBU bag including masks of size 0 &1, Oxygen availability etc. NBCC is established to provide support to newborns required resuscitation services and/or assistance at the time of birth by Navjat Sishu Suraksha Karyakaram (NSSK) trained staff.

New-born Care Corners provide services during care at birth i.e. Prevention of Infection, Provision of warmth, Resuscitation, Early initiation of breastfeeding, weighting of new-born, immunization services, identification and prompt referral at risk or sick new-burns.

New-born Stabilization Unit (NBSU)

New-born Stabilization Units (NBSU) is 4-6 bedded unit established at the sub district level for managing sick and small new-born that are not so seriously sick and can be managed at first level of new-born care facility. Pre-referral stabilizing of sick & small new-born at NBSUs before transfer to SNCU/NICU essentially improves the outcome of these babies.

Special New-born Care Unit (SNCU)

SNCU is a 12 bedded or larger unit located at district/Sub district hospitals and medical colleges with dedicated and adequately trained doctors, staff nurses and support staff to

provide 24*7 comprehensive secondary level of new-born care to small and sick neonates. The SNCU should have Patient Care area, Ancillary area and step down or MNCU area within or in close proximity. The minimum recommended number of beds for and SNCU at all the district hospital is 12. However, if the district hospital conducts more than 3000 deliveries per year, 4 beds should be added for each 1000 additional deliveries.

SNCUs are providing the care for sick and small new-born i.e. Management of Low-birth-weight infants < 1800 g, Management of all sick new-borns except those requiring mechanical ventilation and major surgical interventions, follow-up services of all babies discharged from the unit and high – risk new-borns, immunization services and referral services. Operational cost budget is being provided to SNCUs for ensuring day to day services and management as per FBNC operational guideline.

Mother Newborn Care unit:

The aim of this initiative is 'no separation' of mother and baby including small and sick babies who require newborn care. The mother and newborn dyad are to be cared for together while mother is empowered to participate in developmentally supportive care to her own newborn.

Services at different levels of facility based newborn care:

	Newborn care corner (at all Delivery Points)	Newborn Stabilization units (FRUs/CHCs)	Special Newborn Care Unit (Sub District/District)
Care at birth	Resuscitation, provision of warmth, prevention of infection Early initiation of breastfeeding, weighing the newborn	Resuscitation, provision of warmth Prevention of infection, early initiation of breastfeeding Weighing the newborn	Resuscitation, provision of warmth, prevention of infection, early initiation of breastfeeding and weighing the newborn
Care of normal newborn	Breastfeeding/ feeding support	Breastfeeding/ feeding support	Breastfeeding/ feeding support

Care of sick newborn	Identification and prompt referral of 'at risk' and 'sick' newborn	Management of low-birth-weight infants ≥1800 grams with no other complication Phototherapy for newborns with hyper-bilirubinemia Management of newborn sepsis Stabilization and referral of sick newborns and those with very low birth weight (rooming in) Referral services	Managing of low-birth-weight infants <1800grams Managing all sick newborns (except those requiring mechanical ventilation and major surgical interventions) Follow-up of all babies discharged from the unit and high-risk newborns Referral services

Kangaroo Mother Care:

Kangaroo Mother Care (KMC) is a simple method of care for low-birth-weight infants that includes early and prolonged skin-to-skin contact with the mother (or a substitute caregiver) and exclusive and frequent breastfeeding. This natural form of human care stabilizes body temperature, promotes breast feeding, prevents infection and other morbidities. This also leads to early discharge, better neurodevelopment and encourages bonding between mother and infant.

KMC is initiated in the hospital and continued at home until the infant needs it and for optimum care a regular follow-up should be ensured.

Kangaroo mother care has following components

Skin to skin contact

Exclusive breast feeding

KMC satisfies all five senses of the infant. The infant feels the mother's warmth through skin-to-skin contact (touch), listens to her voice and heartbeat (hearing), sucks breast milk (taste) has eye contact with her (vision) and smells her odor (olfaction).

Though all LBW infants should be provided KMC but considering the huge burden at facilities, priority must be given to infants with birth weight less than 2000 grams.

Minimum duration of a KMC session should be one hour because frequent handling may be stressful for the infant. The duration of each KMC session should be gradually increased for as long as the mother can comfortably provide KMC. GoI has implemented Family Participatory Care and KMC can be practiced inside the SNCU/MNCU.

Source: Operational Guidelines for FBNC,
https://nhm.gov.in/index4.php?lang=1&level=0&linkid=484&lid=754

IMMUNIZATION

1

Universal Immunization Programme

Introduction

Immunization is one of the most cost-effective health investments and a success story for global health and development. It is a well-established fact that, vaccination has reduced morbidity and mortality due to many infections, cancers and other chronic diseases, globally. Vaccination has played a major role in the battle on infectious diseases way back from 496 B.C, when the Greek historian Thucydides observed that those who survived smallpox would never get re-infected. Edward Jenner, pioneered the concept of vaccines and developed the smallpox vaccine, the world's first vaccine that was introduced. The terms vaccine and vaccination are derived from Variolae vaccine (‹smallpox of cow›), these terms were coined by Jenner to denote cowpox. In 1798, he demonstrated, that inoculation of humans with live vaccinia virus (cowpox) could protect against smallpox. This brought the first hope that the disease could be controlled by vaccination.1

The Aim of UIP:

The aim of UIP is that eligible beneficiaries should get all UIP vaccines in India, so that they may be protected from life threatening vaccine preventable diseases against which vaccines are provided under UIP in India.

Objectives:

- To attain more than 90% full immunization coverage on a year-to-year basis and sustain the gains
- To achieve MR elimination
- To maintain and sustain Polio free status and Maternal & Neonatal Tetanus elimination
- To sustain robust VPD and AEFI surveillance
- To ensure efficient supply chain, cold chain and logistic system for UIP
- To provide regular supportive supervision to UIP
- To ensure accountability framework through regular task force meetings
- To expand digitization in UIP
- To introduce need based new vaccines

Immunization programme milestones – India

1977	India declared Smallpox free
1978	Expanded Programme of immunization (EPI) launched with BCG, DPT, OPV, Typhoid (urban areas)
1983	TT vaccine for pregnant women
1985	EPI expanded nationwide as Universal Immunization Programme (UIP) with addition of measles and removal of Typhoid vaccines; Focus on children less than 1year of age
1986	Technology mission for expansion of UIP – Monitoring under PMO's 20-point programme
1990	Vitamin-A supplementation
1992	UIP became a part of Child survival and safe motherhood (CSSM) included both UIP and Safe motherhood programme
1995	Polio National Immunization Days
1997	Vaccine Vial Monitor introduced in Polio vaccine for campaign. Later expanded to all UIP vaccines in 2006 UIP became a part of RCH-1 programme
2001	National Technical Advisory Group on Immunization (NTAGI) in India was formed
2002	Hepatitis B vaccine introduced as pilot in 33 districts & 16 cities of 10 states
2005	Auto Disable (AD) Syringes introduced into UIP
2006	Immunization week strategy was introduced to strengthen immunization Japanese Encephalitis (JE) vaccine introduced after campaigns in endemic districts
2007-2008	Hepatitis B vaccine expanded to all districts in 10 states
2010	Measles 2nd dose introduced in RI (21 states) and after Measles vaccine catch up campaign (MCUP) (14 states) covering 9 months-10 years over a period of 3 years Hepatitis B vaccine scaled up nationwide
2011	Pentavalent vaccine (DPT, Hepatitis B, Hib) introduction in phased manner. However, the birth dose of Hepatitis B and booster dose of DPT vaccines continued
2013	Second dose of JE vaccine introduced

	Open Vial Policy for vaccines in UIP e-VIN introduced
2014	India and Southeast Asia Region certified POLIO- FREE Launch of Mission Indradhanush for low immunization coverage pockets
2015	Pentavalent vaccine expanded to all states Inactivated Polio Vaccine Introduced in 5 states India validated for Maternal and Neonatal Tetanus elimination
2016	Rotavirus vaccine introduced in 4 states in Phased manner tOPV to bOPV Switch (25 April) Switch to fractional IPV nationwide
2017	MR vaccine introduced through campaign in 9months- 15 years replacing measles vaccine, followed by its inclusion in NIS PCV introduced (Phased manner) Use of adrenaline (intramuscular) at immunization session site by ANM Intensified Mission Indradhanush (IMI) campaign
2019	Td vaccine introduced replacing TT vaccine
2019	Rotavirus vaccine expanded nationwide
2021	Pneumococcal Conjugate Vaccine nationwide expansion COVID-19 vaccine introduced using CoWIN platform
2022	Rota virus vaccine formulation with VVM on Label introduced, which becomes eligible for Open Vial Policy
2023	Introduction of 3rd dose of fractional IPV at 9-11 months (fIPV 3) U-WIN introduced, as a pilot in 65 districts and rollout across the country during Intensified Mission Indradhanush 5.0

Vaccine Preventable Diseases:

Under the UIP, presently vaccines are provided to prevent the following VPDs:

Six Viral diseases:

1. Poliomyelitis
2. Hepatitis B
3. Measles

4. Rubella
5. Diarrhoea due to Rota virus
6. Japanese Encephalitis

Six bacterial diseases

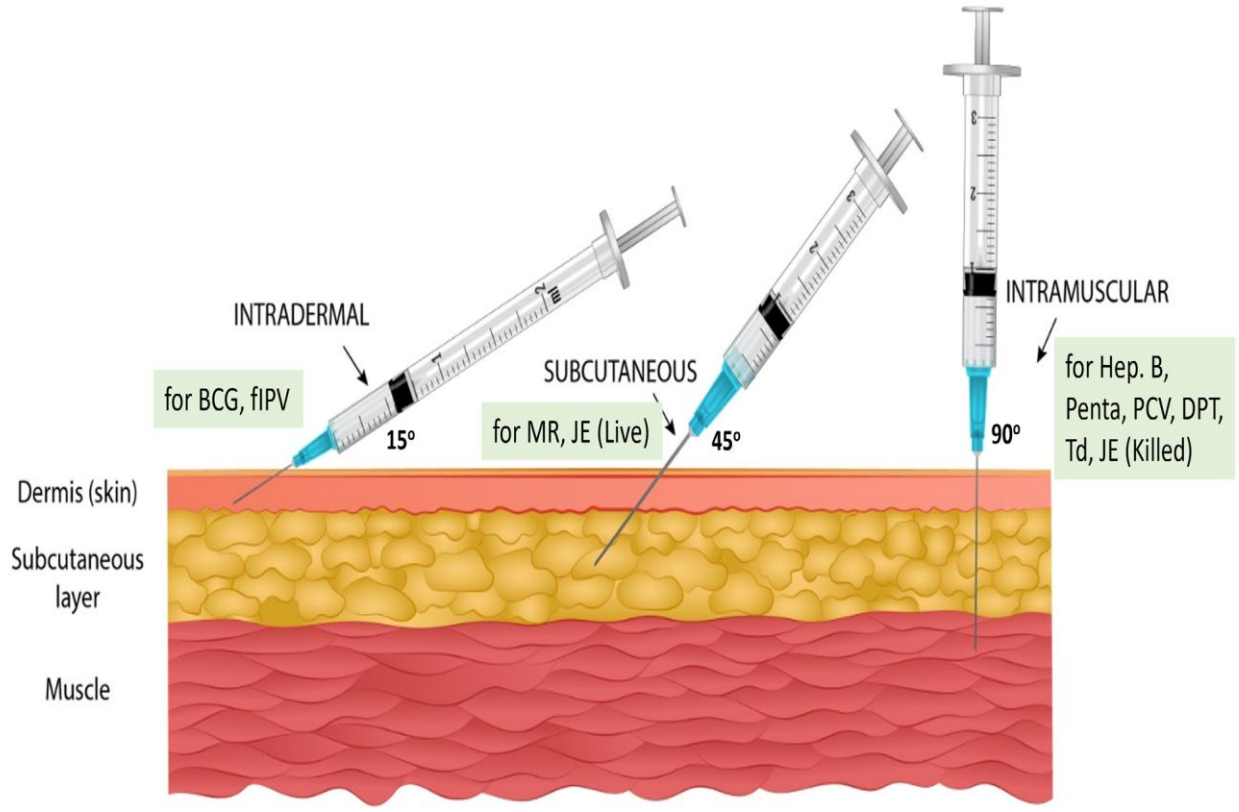
1. Severe form of childhood Tuberculosis
2. Diphtheria
3. Pertussis
4. Tetanus
5. Haemophilus influenzae Type b related diseases
6. Pneumococcus related diseases

National Immunization Schedule:

Vaccine	Age of administration	Maximum age	Dose	Route	Site
For Pregnant Women					
Td-1	As early as possible during First Antenatal visit	4 wks before EDD* If not received, any time before delivery	0.5 ml	Intra-muscular	Upper Arm in Deltoid region
Td-2*	4 weeks after Td-1	Any time after 4 wks from Td-1	0.5 ml	Intra-muscular	Upper Arm in Deltoid region
Td- Booster	If received 2 Td doses during pregnancy within the last 3 years	4 wks before EDD* If not received, any time before delivery	0.5 ml	Intra-muscular	Upper Arm in Deltoid region
For Infants					
BCG $	At birth	one year of age, before 1st birthday	0.05 ml (up to 1 month of age) 0.1ml (1 month to 1 year)	Intra-dermal	**LEFT-** Upper Arm in Deltoid region
Hepatitis B - Birth dose	At birth	within 24 hours of birth	0.5 ml	Intra-muscular	**LEFT-**Antero-lateral side of mid-thigh
bOPV-0	At birth	within the first 15 days of age	2 drops	Oral	Mouth
bOPV 1, 2 and 3	At 6, 10 and 14 weeks of age	till 5 years of age	2 drops	Oral	Mouth
Rotavirus vaccine 1, 2 and 3®	At 6, 10 and 14 weeks of age	1 year of age	5 drops or 2ml as per vaccine formulations	Oral	Mouth
f-IPV 1, 2 and 3	At 6, 14 weeks and at 9 -11 months of age	1 year of age	0.1 ml	Intra-dermal	Upper Arm in Deltoid region -

					RIGHT for fIPV-1 & fIPV-2 -**LEFT** for fIPV-3
Pneumococcal Conjugate Vaccine (PCV) (2 Primary +1 booster)	At 6, 14 weeks for primary doses, and 9-11 months for booster dose	1 year of age	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Pentavalent 1, 2 and 3	At 6, 10 and 14 weeks of age	1 year of age	0.5 ml	Intra-muscular	Antero- lateral side of mid-thigh-LEFT
Measles Rubella vaccine (MR) 1st dose#	9 to 11 months of age	5 years of age	0.5 ml	Sub-cutaneous	Upper arm in Deltoid region - RIGHT
Japanese Encephalitis¥ (in selected districts)	9 to 11 months of age	2 years of age (Killed & live vaccine)	0.5 ml	Killed Vaccine: Intra-muscular Or Live attenuated Vaccine: Subcutaneous	Killed vaccine: Antero-lateral side of mid-thigh – LEFT Or Live attenuated vaccine: Upper arm in Deltoid region – LEFT
Vitamin A (1st dose)	9 months with MR 1st dose	5 years of age	1 ml (1 lakh IU)	Oral	Mouth
For Children					
bOPV Booster	16 to 23 months	5 years of age	2 drops	Oral	Mouth
MR 2nd dose#	16 to 23 months of age	5 years of age	0.5 ml	Sub-cutaneous	Upper Arm-RIGHT
DPT Booster-1	16 to 23 months of age	7 years of age	0.5 ml	Intra-muscular	Antero- lateral side of mid-thigh–LEFT
JE vaccine 2nd dose ¥ (in selected districts)	16 to 23 months of age	2 years of age	0.5 ml	Killed Vaccine: Intra-muscular or Live attenuated Vaccine: Subcutaneous	Killed vaccine: Antero-lateral side of mid-thigh – RIGHT or Live attenuated vaccine: Upper arm – LEFT

Vitamin A (2nd to 9th dose)	16 to 23 months with MR 2nd dose, subsequent doses at an interval of 6 months, up to 5 years of age	5 years of age	2 ml (2 lakh IU)	Oral	Mouth
DPT Booster-2	5 to 6 years of age	7 years of age	0.5 ml	Intra-muscular	Upper Arm -LEFT



*EDD=Expected Date of delivery

$ BCG vaccine requires reconstitution with diluent which is supplied by the manufacturer

® Rota virus vaccine – Open vial policy is applicable to RVV with VVM on the label; Not applicable to RVV with VVM on the cap

MR vaccine requires reconstitution with diluent which is supplied by the manufacturer

¥ JE Vaccine is provided in select districts in India. Live JE vaccine requires reconstitution with diluent which is supplied by the manufacturer.

Important Definitions related to Immunization

Full Immunization: *Child who has received BCG, 3 doses of OPV, 3 doses of pentavalent and 1 dose of MR by first year of age. This is the historical definition used for survey and evaluation purposes and hence has been continued. - Full Immunization coverage (FIC)*

FIC plus: *Child who has received all the vaccines given in the Universal Immunization Programme (UIP) by one year of age.*

Complete Immunization: *Child who has received all the vaccines given in the Universal Immunization Programme (UIP) by two years of age.*

Left-out: *Child who has not received any vaccine under UIP (unimmunized).*

Drop-out: *Child who has received one or more UIP vaccine/s but did not complete the schedule as per the age (partially immunized).*

Zero-dose (operational & reporting purpose): *Child who has not received first dose of pentavalent vaccine by one year of age.*

2

Immunization Cold-Chain Supply System

Network and different levels of Immunization Supply Chain (ISC) in India

The immunization supply chain encompasses all the people, activities, infrastructure, resources and planning necessary to ensure that vaccines stay safe and effective when they reach the children who need them.1 It is a system of storing and transporting vaccines at the recommended temperature starting from point of manufacture to the point of use. Strong supply chains is an essential prerequisite to an effective immunization program. ISC ensures that the right vaccine is always available in the right quantity at the right place and is stored, distributed in the right conditions.

India has a four-tiered Immunization Supply Chain:

a. Primary (PR) Stores: Includes cold-chain stores which receive vaccines directly from manufacturer. In India, the primary stores include 4 Government Medical Store Depot (GMSD) and 37 State Vaccine Stores. Few regional vaccine stores of bigger states also receive vaccines directly from the manufacturers.

b. Sub-National (SN) Stores: These stores include regional vaccine stores which receive vaccines from primary stores, and further supply vaccines to the lowest distribution stores. There are 118 regional vaccine stores in India.

c. Lowest Distribution (LD) Stores: Lowest distribution stores are the District Vaccine Stores (DVS) which supply vaccines to the last cold-chain points. There are 745* functional DVS in India.

d. Service Delivery Points (SP) Stores: These are 30,231* last cold-chain points also known as SP stores which supply vaccines to the fixed and outreach session sites. Service delivery points or last cold-chain points are located in PHC/CHC/UPHC/District hospital and Medical College, etc.

*Data as on 20 March 2024

Journey of vaccine from point of manufacture to the beneficiary

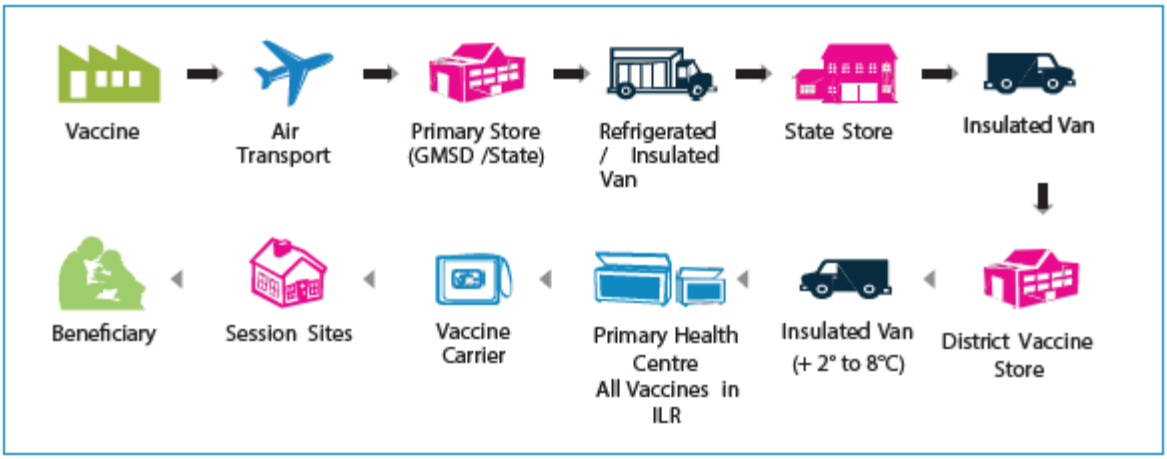
Cold Chain is a system of storing and transporting vaccines at recommended temperatures from the point of manufacture to the point of use. A vaccine once manufactured is supplied to the beneficiary within the recommended temperature range to maintain its potency. The vaccines are supplied in tertiary boxes (usually a thermocol box) which usually contain secondary packaging (cardboard box/plastic packing) of vaccines. The vaccines are supplied

to the primary stores (GMSD, state or regional vaccine stores) by the manufacturer usually by air or road route. In India, usually 80% of the annual supply is made directly to the primary stores. Approximately twenty percent of the annual supply is stored at the GMSD as buffer.

From the primary store, the vaccines are transported to the lower stores through insulated trucks/vans or refrigerated vaccine van or trucks.

Last cold-chain (ILR) points, store vaccines and supply them to the session sites in vaccine carrier through Alternate Vaccine Delivery (AVD) systems.

Immunization cold-chain supply system



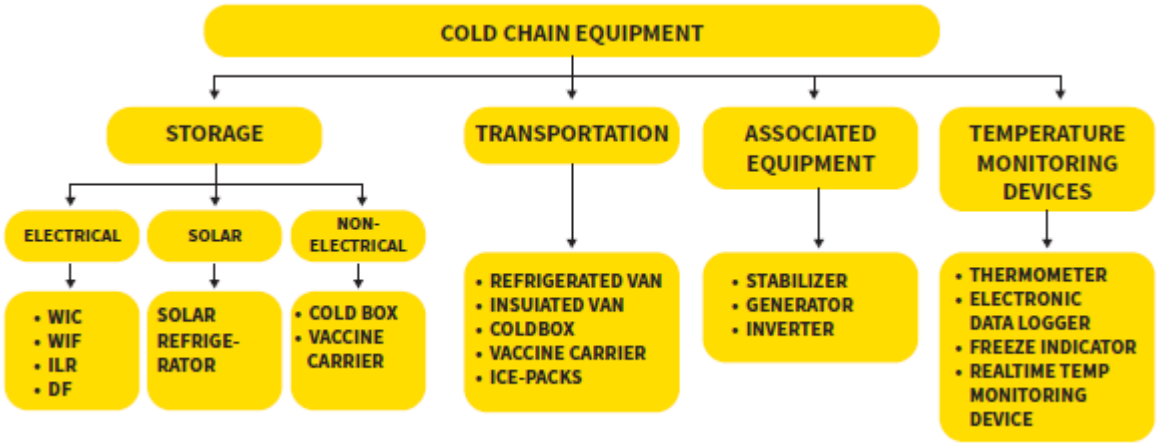
Key elements of cold chain

The key elements of the cold-chain are:

- **Personnel:** to manage vaccine storage and distribution at each level
- **Equipment:** to store and transport vaccine and monitor their storage temperature

• **Procedures:** to ensure correct utilization of equipment and ensure vaccines are stored and transported safely.

Overview of cold-chain equipment



Technical specifications of cold-chain equipment

Equipment	Temperature	Storage Capacity	Holdover time
Electrical			
Deep Freezer (Large)	-15°C to -25°C	Ice pack preparation At DVS & above levels for OPV/Freeze dried vaccine storage (180 to 250 litres)	At 43°C for 2 hrs 30 mins (minimum)
Deep Freezer (Small)	-15°C to -25°C	Ice packs preparation & storage (105 to 125 litres)	At 43°C for 2 hrs 30 mins (minimum)
ILR (Large)	+2°C to +8°C	All Vaccine storage (180 to 250 litres)	At 43°C for 24 hrs (minimum)
ILR (Small)	+2°C to +8°C	All vaccines storage (80-130 litres)	At 43°C for 20 hrs (minimum)
Non-electrical			
Cold Box (Large)	+2°C to +8°C	All vaccines stored for transport, during defrosting of ILR or in case of power failure (20 to 25 litres)	At 43°C for 96 hrs*
Cold Box (Small)	+2°C to +8°C	All vaccines stored for transport, during defrosting of ILR or in case of power failure (5 to 8 litres)	At 43°C for 48 hrs*

Vaccine carrier (1.7 litres)	+2°C to +8°C	All vaccines carried to immunization session/ local transport of vaccines (max for 12 hours)(4 conditioned Ice packs & 16-20 vials)	At 43°C for 36 Hrs *

Source: RI Module for Medical Officer / Health workers – 2024 NHM/MoHFW

3

Mission Indhradhanush

Mission Indradhanush (MI) was launched by the Ministry of Health and Family Welfare (MoHFW) on 25th December 2014.

It is a special catch-up campaign under the Universal Immunization Program (UIP), conducted in the areas of low immunization coverage to vaccinate all the children and pregnant women left out or dropped out from Routine Immunization. The initiative's mammoth task is being fulfilled with the support of an integrated and committed task-force, ensuring full immunization coverage.

Objective

The Mission Indradhanush aims to cover all those children who are either unvaccinated, or are partially vaccinated against vaccine preventable diseases. India's Universal Immunization Programme (UIP) provide free vaccines against 12 life threatening diseases, to 26 million children annually. The Universal Immunization Programme provides life-saving vaccines to all children across the country free of cost to protect them against Tuberculosis, Diphtheria, Pertussis, Tetanus, Polio, Hepatitis B, Pneumonia and Meningitis due to Hemophilus Influenzae type B (Hib), Measles, Rubella, Japanese Encephalitis (JE) and Rotavirus diarrhea. (Rubella, JE and Rotavirus vaccine in select states and districts).

Implementation

Focused and systematic immunization drive will be through a "catch-up" campaign mode where the aim is to cover all the children who have been left out or missed out for immunization. Also, the pregnant women are administered the tetanus vaccine, ORS packets and zinc tablets are distributed for use in the event of severe diarrhea or dehydration and vitamin A doses are administered to boost child immunity.

Mission Indradhanush Phase I was started as a weeklong special intensified immunization drive from 7th April 2015 in 201 high focus districts for four consecutive months. During this phase, more than 75 lakh children were vaccinated of which 20 lakh children were fully vaccinated and more than 20 lakh pregnant women received tetanus toxoid vaccine.

The Phase II of Mission Indradhanush covered 352 districts in the country of which 279 are medium focus districts and remaining 73 are high focus districts of Phase-I. During Phase II of Mission Indradhanush, four special drives of weeklong duration were conducted starting from October 2015.

Phases I and II of the special drive had 1.48 crore children and 38 lakh pregnant women additionally immunized. Of these nearly 39 lakh children and more than 20 lakh pregnant women have been additionally fully immunized. Across 21.3 lakh sessions held through the country in high and mid-priority districts, more than 3.66 crore antigens have been administered.

Phase III of Mission Indradhanush was launched from 7 April 2016 covering 216 districts. Four intensified immunization rounds were conducted for seven days in each between April and July 2016, in these districts. These 216 districts have been identified on the basis of estimates where full immunization coverage is less than 60 per cent and have high dropout rates. Apart from the standard of children under 2, it also focused on 5-year-olds and on increasing DPT booster coverage, and giving tetanus toxoid injections to pregnant women.

Overall, in the first three phases, 28.7 lakh immunization sessions were conducted, covering 2.1 crore children, of which 55 lakhs were fully immunized. Also, 55.9 lakh pregnant women were given the tetanus toxoid vaccine across 497 high-focus districts. Since the launch of Mission Indhradhanush, full immunization coverage has increased by 5 per cent to 7 per cent. Mission Indradhanush has resulted in a 6.7 % annual expansion in the immunization cover.

Phase IV of Mission Indradhanush was launched from 7 February 2017 covering the North-eastern states of Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura. It has been rolled out in rest of the country during April 2017.

The four phases of Mission Indradhanush have reached to more than 2.53 crore children and 68 lakh pregnant women with life-saving vaccines.

The fifth phase of Mission Indradhanush was carried out in 190 lowest performing districts. At the end of six phases of Mission Indradhanush, 554 districts across the country were covered. A survey (IMI- CES) carried out in 190 districts covered in Intensified Mission Indradhanush (5th phase of Mission Indradhanush) shows 18.5% points increase in full immunization coverage as compared to NFHS-4.

On completion of seven phases (from April 2015 to March 2020), 690 districts wherein 3.76 crore children were reached and 94.6 lakh pregnant females were immunized. As of April 2021, during the various phases of Mission Indradhanush, a total of 3.86 crore children and 96.8 lakh pregnant women have been vaccinated. As of January 2022, ten phases of Mission Indradhanush have been completed covering 701 districts across the country. As of October 2023, 12 phases have been completed and a total of 5.06 crore children and 1.25 crore pregnant women have been cumulatively vaccinated under the campaign.

The Ministry is being technically supported by WHO, UNICEF, Rotary International and other donor partners. Mass media, interpersonal communication, and sturdy mechanisms of monitoring and evaluating the scheme are crucial components of Mission Indradhanush.

Areas Under Focus

The following areas are targeted through special immunization campaigns:

- High risk areas identified by the polio eradication programme. These include populations living in areas such as:
- Urban slums with migration
- Nomads
- Brick kilns
- Construction sites
- Other migrants (fisherman villages, riverine areas with shifting populations etc.) and
- Underserved and hard to reach populations (forested and tribal populations etc.)
- Areas with low routine immunization (RI) coverage (pockets with Measles/vaccine preventable disease (VPD) outbreaks).
- Areas with vacant sub-centers: No ANM posted for more than three months.
- Areas with missed Routine Immunization (RI) sessions: ANMs on long leave and similar reasons
- Small villages, hamlets, dhanis or purbas clubbed with another village for RI sessions and not having independent RI sessions.

Mission Indhradhanush - Districts covered

Phase V - All districts across the country

Phase V - 190 low performing districts

Phase IV - The fourth phase of Mission Indradhanush covered North-eastern states - Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura from 7th February 2017. It was rolled out in rest of the country in April 2017.

Phase III - 216 districts

Phase II - 352 districts

Phase I - 201 districts

Strategy for Mission Indradhanush

Mission Indradhanush will be a national immunization drive to strengthen the key functional areas of immunization for ensuring high coverage throughout the country with special attention to districts with low immunization coverage.

The broad strategy, based on evidence and best practices, will include four basic elements-

Meticulous planning of campaigns/sessions at all levels: Ensure revision of micro plans in all blocks and urban areas in each district to ensure availability of sufficient vaccinators and all vaccines during routine immunization sessions. Develop special plans to reach the unreached children in more than 400,000 high risk settlements such as urban slums, construction sites, brick kilns, nomadic sites and hard-to-reach areas.

Effective communication and social mobilization efforts: Generate awareness and demand for immunization services through need-based communication strategies and social mobilization activities to enhance participation of the community in the routine immunization programme through mass media, mid media, interpersonal communication (IPC), school and youth networks and corporates.

Intensive training of the health officials and frontline workers: Build the capacity of health officials and workers in routine immunization activities for quality immunization services.

Establish accountability framework through task forces: Enhance involvement and accountability/ownership of the district administrative and health machinery by strengthening the district task forces for immunization in all districts of India and ensuring the use of concurrent session monitoring data to plug the gaps in implementation on a real time basis.

The Ministry of Health and Family Welfare will establish collaboration with other Ministries, ongoing programmes and international partners to promote a coordinated and synergistic approach to improve routine immunization coverage in the country.

Intensified Mission Indradhanush (IMI)

The Intensified Mission Indradhanush (IMI) has been launched by the Government of India to reach each and every child under two years of age and all those pregnant women who have been left uncovered under the routine immunization programme. The special drive focuses on improving immunization coverage in select districts and cities to ensure full immunization to more than 90% by December 2018.

With a sharpened focus on high priority districts and urban areas, under IMI, four consecutive immunization rounds were conducted for 7 days in 173 districts - 121 districts and 17 cities in 16 states and 52 districts in 8 north eastern states - every month between October 2017 and January 2018. Intensified Mission Indradhanush covers low performing areas in the selected districts and urban areas. These areas have been selected through triangulation of data available under national surveys, Health Management Information System data and World Health Organization concurrent monitoring data. Special attention will be given to unserved/low coverage pockets in sub-center and urban slums with migratory population. The focus is also on the urban settlements and cities identified under National Urban Health Mission (NUHM).

Intensified Mission Indradhanush will have inter-ministerial and inter-departmental coordination, action- based review mechanism and intensified monitoring and accountability framework for effective implementation of targeted rapid interventions to improve the routine immunization coverage. IMI is supported by 11 other ministries and departments, such as Ministry of Women and Child Development, Panchayati Raj, Ministry of Urban Development, Ministry of Youth Affairs among others. The convergence of ground level workers of various departments like ASHA, ANMs, Anganwadi workers, Zila preraks under National Urban Livelihood Mission (NULM), self-help groups will be ensured for better coordination and effective implementation of the programme.

Intensified Mission Indradhanush would be closely monitored at the district, state and central level at regular intervals. Further, it would be reviewed by the Cabinet Secretary at the

National level and will continue to be monitored at the highest level under a special initiative 'Proactive Governance and Timely Implementation (PRAGATI)'.

This Intensified Mission is driven based on the information received from gap assessment, supervision through government, concurrent monitoring by partners, and end-line surveys. Under IMI, special strategies are devised for rigorous monitoring of the programme. States and districts have developed coverage improvement plans based on gap self-assessment. These plans are reviewed from state to central level with an aim to reach 90% coverage by December 2018.

An appreciation and awards mechanism are also conceived to recognize the districts reaching more than 90% coverage. The criteria include best practices and media management during crisis. To acknowledge the contribution of the partners/Civil Society Organization (CSOs) and others, Certificate of Appreciation will be given.

Source: Operational Guidelines of Mission Indradhanush / Ministry of Health and Family Welfare/NHM

4

Pulse Polio Programme

With the global initiative of eradication of polio in 1988 following World Health Assembly resolution in 1988, Pulse Polio Immunization programme was launched in India in 1995.

Children in the age group of 0-5 years administered polio drops during National and Sub-national immunization rounds (in high-risk areas) every year. Around 17.4 crore children of less than five years across the country are given polio drops as part of the drive of Government of India to sustain polio eradication from the country.

The last polio case in the country was reported from Howrah district of West Bengal with date of onset 13th January 2011. Thereafter no polio case has been reported in the country. WHO on 24th February 2012 removed India from the list of countries with active endemic wild polio virus transmission.

Objective

The Pulse Polio Initiative was started with an objective of achieving hundred per cent coverage under Oral Polio Vaccine. It aimed to immunize children through improved social mobilization, plan mop-up operations in areas where poliovirus has almost disappeared and maintain high level of morale among the public.

Steps taken by the Government to maintain polio free status in India

Maintaining community immunity through high quality National and Sub National polio rounds each year.

An extremely high level of vigilance through surveillance across the country for any importation or circulation of poliovirus and VDPV is being maintained. Environmental surveillance (sewage sampling) has been established to detect poliovirus transmission and as a surrogate indicator of the progress as well for any programmatic interventions strategically in Mumbai, Delhi, Patna, Kolkata Punjab and Gujarat.

All States and Union Territories in the country have developed a Rapid Response Team (RRT) to respond to any polio outbreak in the country. An Emergency Preparedness and Response Plan (EPRP) has also been developed by all States indicating steps to be undertaken in case of detection of a polio case.

To reduce risk of importation from neighboring countries, international border vaccination is being provided through continuous vaccination teams (CVT) to all eligible children round the clock. These are provided through special booths set up at the international borders that India shares with Pakistan, Bangladesh, Bhutan Nepal and Myanmar.

Source: Pulse Polio Programme / Ministry of Health and Family Welfare / NHM

5

eVIN

The Electronic Vaccine Intelligence Network (eVIN) is a smartphone and cloud-based app that helps the Government of India's Universal Immunization Programme by providing real-time information on vaccine stocks, temperatures, and flows:

Purpose

eVIN's goal is to ensure that safe and potent vaccines are available to the right people in a timely manner.

Features

eVIN includes a mobile app that allows cold chain handlers to report data on vaccine stocks, consumption, and movement. It also has a SIM-enabled temperature logger for remotely monitoring vaccine storage temperatures.

Benefits

eVIN has helped to:

- Increase vaccine availability rates to over 99% at all cold chain points
- Reduce vaccine stock-outs by over 80%
- Streamline cold chain points and vaccine flow
- Standardize and digitize vaccine registers

Development

The United Nations Development Programme (UNDP) supported the development and implementation of eVIN.

Source: eVIN guidelines

6

UWIN

About U-WIN

- India's Universal Immunization Programme (UIP) is a part of the Reproductive and Child Health (RCH) Program under National Health Mission (NHM).

- It is one of the largest public health programs in the world under which vaccination is being provided free of cost to all pregnant women & children.

- Vaccination can be availed against 12 vaccine preventable diseases: nationally against 11 diseases- Diphtheria, Pertussis, Tetanus, Polio, Measles, Rubella, severe form of childhood Tuberculosis, Rotavirus Diarrhoea, Hepatitis B, Meningitis & Pneumonia caused by Hemophilus Influenza Type B and Pneumococcal Pneumonia and sub-nationally against 1 Disease - Japanese Encephalitis (JE vaccine is provided only in endemic districts).

- U-WIN platform captures each & every vaccination event of all pregnant women & children under Universal Immunization Programme (UIP).

Get Vaccinated in 3 Easy Steps

1. Scheduled Appointment
2. Get Vaccination
3. Immunization details.

Source: https://uwin.mohfw.gov.in/home

ADOLESCENT HEALTH

1

Rashtriya Kishor Swasthya Karyakram (RKSK)

The Ministry of Health & Family Welfare has launched a health programme for adolescents, in the age group of 10-19 years, which would target their nutrition, reproductive health and substance abuse, among other issues.

The *Rashtriya Kishor Swasthya Karyakram* was launched on 7th January, 2014. The key principle of this programme is adolescent participation and leadership, Equity and inclusion, Gender Equity and strategic partnerships with other sectors and stakeholders. The programme envisions enabling all adolescents in India to realize their full potential by making informed and responsible decisions related to their health and well- being and by accessing the services and support they need to do so.

To guide the implementation of this programme, MOHFW in collaboration with UNFPA has developed a National Adolescent Health Strategy. It realigns the existing clinic-based curative approach to focus on a more holistic model based on a continuum of care for adolescent health and developmental needs.

The Rashtriya Kishor Swasthya Karyakram (National Adolescent Health Programme), will comprehensively address the health needs of the 243 million adolescents. It introduces community-based interventions through peer educators, and is underpinned by collaborations with other ministries and state governments.

The Vision

The strategy envisions that all adolescents in India are able to realise their full potential by making informed and responsible decisions related to their health and well-being, and by accessing the services and support they need to do so. The implementation of this vision requires support from the government and other institutions, including the health, education and labour sectors as well as adolescents' own families and communities.

Building an agenda for adolescent health requires an escalation in the visibility of young people and an understanding of the challenges to their health and development. It needs implementation of approaches that will ensure a successful transition to adulthood. This

requires that the multi-dimensional health needs and special concerns of adolescents are understood and addressed in national policies and a range of programmes at different levels.

Objectives

- Improve nutrition
- Reduce the prevalence of malnutrition among adolescent girls and boys
- Reduce the prevalence of iron-deficiency anaemia (IDA) among adolescent girls and boys
- Improve sexual and reproductive health
- Improve knowledge, attitudes and behaviour, in relation to SRH
- Reduce teenage pregnancies
- Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents
- Enhance mental health
- Address mental health concerns of adolescents
- Prevent injuries and violence
- Promote favourable attitudes for preventing injuries and violence (including GBV) among adolescents
- Prevent substance misuse
- Increase adolescents' awareness of the adverse effects and consequences of substance misuse
- Address NCDs
- Promote behaviour change in adolescents to prevent NCDs such as hypertension, stroke, cardio- vascular diseases and diabetes

Target Groups

The new adolescent health (AH) strategy focuses on age groups 10-14 years and 15-19 years with universal coverage, i.e. males and females; urban and rural; in school and out of school; married and unmarried; and vulnerable and under-served.

Strategies

- Strategies/interventions to achieve objectives can be broadly grouped as:
- Community based interventions

- Peer Education (PE)
- Quarterly Adolescent Health Day (AHD)
- Weekly Iron and Folic Acid Supplementation Programme (WIFS)
- Menstrual Hygiene Scheme (MHS)
- Facility based interventions
- Strengthening of Adolescent Friendly Health Clinics (AFHC)
- Convergence
- Within Health & Family Welfare - FP, MH (incl VHND), RBSK, NACP, National Tobacco Control Programme, National Mental Health Programme, NCDs and IEC
- With other departments/schemes - WCD (ICDS, KSY, BSY, SABLA), HRD (AEP, MDM), Youth Affairs and Sports (Adolescent Empowerment Scheme, National Service Scheme, NYKS, NPYAD)
- Social and Behaviour Change Communication with focus on Inter Personal Communication

Source: Operational Guidelines of RKSK / *National Health Mission*

2

Adolescent Friendly Health Clinics (AFHCs)

Rashtriya Kishor Swasthya Karyakram (RKSK) highlights the need for strengthening Adolescent Friendly Health Clinics (AFHC) under its facility based approach. This approach was initiated in 2006 under RCH II in the form of Adolescent Reproductive Sexual Health (ARSH) Clinic to provide counselling on sexual & reproductive health issues.

Now under RKSK, AFHC entails a whole gamut of clinical and counselling services on diverse adolescent health issues ranging from Sexual and Reproductive Health (SRH) to Nutrition, Substance abuse, Injuries and Violence (including Gender based violence, Non Communicable Diseases and Mental Health. Adolescent Friendly Health Services are delivered through trained service providers- MO, ANM and Counsellors at AFHCs located at Primary Health Centers (PHCs), Community Health Centers (CHCs) and District Hospitals (DHs) and Medical Colleges

The key 'friendly' component of AFHC mandates facility-based clinical and counselling services for adolescents, which are:

- **Equitable**—services are provided to all adolescents who need them.
- **Accessible**—ready accessibility to AFHCs by adolescents i.e. AFHC should be established where adolescents can go without hesitation for example: it should not be placed near labour rooms, integrated counselling and treatment centres, Sexual and Reproductive Transmitted Infections (STI/RTI) centre etc.
- **Acceptable**—health providers meet the expectation of adolescents who use the services.
- **Appropriate**—the required care is provided and any unnecessary and harmful practices are avoided.
- **Effective**—healthcare produces positive change in the status of the adolescents; services are efficient and have high quality. The right health services are provided in the right way, and make a positive contribution to their health.
- **Comprehensive**—care provision covers promotive, preventive and curative aspects.

Benchmark for AFHC

- Infrastructure- clean, bright and colorful
- Can be easily accessed by the adolescents (distance and convenient working hours)
- Awareness about the clinic and range of service it provides (IEC, Proper Sinages)
- Non judgmental and competent health service providers
- Maintains privacy and confidentiality
- Community members are aware of the services provided and understand the need of the same.
- Referral from the periphery/community and further referral linkages with the higher facilities and specialty clinics.

Adolescent Friendly Health Clinics (AFHCs) at District level will be designated as Adolescent Health Resource Centre (A-HRC). These centres apart from providing the full complement of services envisioned for AFHC will also act as resource centre for capacity building of health care providers and repository for Information, Education and Communication materials on Adolescent Health such as posters, banners, pamphlets, audio-video materials.

Counselors play a crucial role in operationalizing Adolescent Friendly Health Clinics (AFHCs). They Inform, educate and counsel clients on Adolescent Health issues and refer clients to health facilities, or other service delivery points such as Integrated Counselling Testing Centre (ICTC), de-addiction centre, Non-Communicable Diseases clinics etc. Besides this, outreach services by counsellors are carried out at schools, colleges, youth clubs and in the community at least twice a week to sensitize the adolescents, caregivers and influencers on various adolescent health issues and apprise them of various available adolescent-friendly health services.

It is important to recognise that AFHCs are part of a wider package of adolescent health services. Adolescent-friendly health Clinics will have strong linkages with the Peer Education Programme. Adolescent Health Day and Adolescent Friendly Clubs will work as a platform for referring clients to the Adolescent-friendly health Clinics.

Source: Adolescent Friendly Health Clinics (AFHCs) / NHM

3

Weekly Iron Folic Acid Supplementation

The Ministry of Health and Family Welfare has launched the Weekly Iron and Folic Acid Supplementation (WIFS) Programme to meet the challenge of high prevalence and incidence of anaemia amongst adolescent girls and boys. WIFS is evidence based programmatic response to the prevailing anaemia situation amongst adolescent girls and boys through supervised weekly ingestion of IFA supplementation and biannual helminthic control. The long term goal is to break the intergenerational cycle of anaemia, the short term benefits is of a nutritionally improved human capital. The programme, implemented across the country both in rural and urban areas.

Salient features of WIFS

Objective of Weekly Iron Folic acid Supplementation (WIFS) To reduce the prevalence and severity of anaemia in adolescent population (10-19 years).

Target groups

- School going adolescent girls and boys in 6th to 12th class enrolled in government/government aided/municipal schools.
- Out of school adolescent girls.

Intervention

- Administration of supervised Weekly Iron-folic Acid Supplements of 100mg elemental iron and 500ug Folic acid using a fixed day approach.
- Screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.
- Biannual de-worming (Albendazole 400mg), six months apart, for control of helminthic infestation.
- Information and counselling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.

Convergence

Convergence with key stakeholder ministries like the Ministry of Women and Child Development and Ministry of Human Resource Development is an essential part of implantation plan of the WIFS programme. Key convergent areas include: joint programme planning, capacity building of nodal service providers including Medical Officers, Anganwadi Worker (AWW) Staff Nurses, School teachers, monitoring and a comprehensive communication component.

Source: Weekly Iron Folic Acid Supplementation / NHM

4

Menstrual Hygiene Scheme

Background

The Ministry of Health and Family Welfare has introduced a scheme for promotion of menstrual hygiene among adolescent girls in the age group of 10-19 year in rural areas.

The major objectives of the scheme

- To increase awareness among adolescent girls on Menstrual Hygiene
- To increase access to and use of high quality sanitary napkins to adolescent girls in rural areas.
- To ensure safe disposal of Sanitary Napkins in an environmentally friendly manner.

The scheme was initially implemented in 2011 in 107 selected districts in 17 States wherein a pack of six sanitary napkins called “Freedays” was provided to rural adolescent girls for Rs. 6. From 2014 onwards, funds are now being provided to States/UTs under National Health Mission for decentralized procurement of sanitary napkins packs for provision to rural adolescent girls at a subsidized rate of Rs 6 for a pack of 6 napkins. The ASHA will continue to be responsible for distribution, receiving an incentive @ Rs 1 per pack sold and a free pack of napkins every month for her own personal use. She will convene monthly meetings at the Aanganwadi Centres or other such platforms for adolescent girls to focus on issue of menstrual hygiene and also serve as a platform to discuss other relevant SRH issues. A range of IEC material has been developed around MHS, using a 360 degree approach to create awareness among adolescent girls about safe & hygienic menstrual health practices which includes audio, video and reading materials for adolescent girls and job-aids for ASHAs and other field level functionaries for communicating with adolescent girls.

Source: Operational guidelines for Menstrual Hygiene Scheme / NHM

5

Adolescent Health and Wellness Day

It is one of the interventions under RKSK to improve coverage with preventive and promotive interventions for adolescents and to increase awareness among adolescents, parents, families, and stakeholders about issues and needs related to adolescent health.

Objectives

1. To increase awareness among adolescents and stakeholders about the determinants of adolescent health such as nutrition, sexual and reproductive health, mental health, injuries and violence (Including Gender-Based Violence), substance misuse, and Non-Communicable Diseases.
2. To improve awareness of other adolescent health-related services in particular Nayi Disha Kendra/ helplines.
3. To increase awareness of parents and other key stakeholders on adolescent health needs.
4. To address concerns of adolescents regarding sexual and reproductive health, mental health, injuries, violence, substance misuse, and Non-Communicable Diseases.

Source: Adolescent Health and Wellness Day / NHM

6

Peer Education Program

Background

The adolescents in the community are covered through Peer Education (PE) Programme. The selected Peer Educators called *Saathiya* ensure that adolescents benefit from regular and sustained peer education covering all six themes of RKSK.

It is envisaged that this approach would facilitate the coverage of out of school adolescents in addition to the school going adolescents. The states may consider the districts with high proportion of out-of-school adolescents through this intervention.

Under the PE programme, four peer educators (two boys and two girls) are selected per village/1000 population/ASHA habitation to reach out to adolescents. Saathiya selection is facilitated by ASHA in consultation with Village Health Sanitation and Nutrition Committee.

Each *Saathiya* forms a group of 15-20 boys or girls from their community and conducts weekly one to two hour participatory sessions using PE kits. *Saathiya* also maintains a diary, including a brief overview of each session and the number of participants. They will sensitize e adolescents towards their health and inform them about existing adolescent friendly health services, so that all the adolescents may optimally utilize it.

Saathiya facilitates the organization of the quarterly Adolescent Health Days (AHD) and participate in the Adolescent Friendly Club (AFC) meetings also.

ASHA acts as the village level *Saathiya* coordinator and takes the lead in ensuring that the peer education activities are carried out smoothly at the village level. ANMs and Male Health Workers moderate the monthly AFC sessions and Medical Officer In-charge and Block Adolescent Health Coordinators provide the oversight.

Adolscent health days

The Quarterly Adolescent Health Day (AHD) is one of the interventions under RKSK to improve coverage with preventive and promotive interventions for adolescents and to increase awareness among adolescents, parents, families and stakeholders about issues and needs related to adolescent health. AHDs are conducted at the village level at Anganwadi Centres or any other public place where adolescents and all stakeholders have

easy accessibility. Block adolescent health coordinator is the focal person to coordinate for AHD, ensuring availability of commodities and services and ensure that publicity is done before hand. ASHAs engage with parents and families of adolescents to increase awareness about the unique needs of adolescents.

Adolescent Friendly Club Meetings

Apart from above, Adolescent Friendly Club (AFC) meetings are also organized once a month at sub-centre level under the overall guidance of ANM. These typically cover 5 villages/5000 population composed of 10-20 Saathiya each. During meetings, Saathiya from different villages meet and clarify issues which they have encountered during their weekly sessions with the help of ANM.

Source: Operational guidelines for Peer Education Programme / www.nhm.gov.in

7

School Health and Wellness Program

The School Health Programme has been incorporated as a part of the Health and Wellness component of the Ayushman Bharat Programme of the Government of India to strengthen the preventive and promotive aspects through health promotion activities. It is a joint initiative of the Ministry of Health and Family Welfare and NCERT.

The programme was started with the objective of providing age-appropriate information about health and nutrition to the children in schools and promoting healthy behaviors among the children that they will inculcate for life.

Two teachers, preferably one male and one female, in every school designated as **"Health and Wellness Ambassadors"** were trained to transact health promotion and disease prevention information in the form of interesting activities for **one hour every week**. These health promotion messages have bearing on improving health practices in the state as students will act as **Health and Wellness Messengers in the society**.

Objectives

- To provide age appropriate information about health and nutrition to the children in schools.
- To promote healthy behaviors among the children that they will inculcate for life.
- To detect and treat diseases early in children and adolescents including identification of malnourished and anemic children with appropriate referrals to PHCs and hospitals.
- To promote use of safe drinking water in schools
- To promote safe menstrual hygiene practices by girls
- To promote yoga and meditation through Health & Wellness Ambassadors.
- To encourage research on health, wellness and nutrition for children.

Package of Services under School Health

School Health Promotion Activities

- Age appropriate incremental learning for promotion of healthy behavior and prevention of various diseases

- Delivered through school teachers/Health and Wellness Ambassadors trained in each school

Health Screening

- The screening of children for 30 identified health conditions for early detection, free treatment and management through dedicated RBSK mobile health teams

Provision of Services

- Provision of IFA and Albendazole tablets by teachers through WIFS and NDD programme respectively.
- Provison of sanitary napkins
- Age appropriate vaccination

Electronic Health Records

- Electronic health record for each child

Imparting skills of emergency care

- Training of teachers on basic first aid

Operationalization of the School Health Programme

The Programme has been developed based on the learning and experiences from a variety of global and national school based interventions. Two teachers, preferably one male and one female, in every school designated as "Health and Wellness Ambassadors" will be trained to transact health promotion and disease prevention information in the form of interesting activities for one hour every week. These health promotion messages will also have bearing on improving health practices in the country as students will act as Health and Wellness Messengers in the society. Every Tuesday may be dedicated as Health and Wellness Day in the schools.

Source: Guidelines for School Health and Wellness Programme / NHM

FAMILY WELFARE

1

National Family Welfare Programme

India was the first country in the world to have launched a National Programme for Family Planning in 1952. Over the decades, the programme has undergone transformation in terms of policy and actual programme implementation and currently being repositioned to not only achieve **population stabilization** goals but also promote **reproductive health** and reduce **maternal, infant & child mortality and morbidity.**

The objectives, strategies and activities of the Family Planning division are designed and operated towards achieving the family welfare goals and objectives stated in various policy documents (NPP: National Population Policy 2000, NHP: National Health Policy 2017, and NHM: National Rural Health Mission) and to honour the commitments of the Government of India (including ICPD: International Conference on Population and Development, MDG: Millennium Development Goals, SDG: Sustainable Development Goals, and others).

Factors influencing population growth

Unmet need of Family Planning: This includes the currently married women, who wish to stop child bearing or wait for next two or more years for the next child birth, but not using any contraceptive method. Total unmet need of Family Planning is 9.4 (NFHS-V) in our country.

Age at Marriage and first childbirth: In India 23.3% (NFHS-V)of the girls get married below the age of 18 years and out of the total deliveries 6.8% are among teenagers i.e. 15-19 years. The situation regarding age of girls at marriage is more alarming in few states like, Bihar (40.8%), Rajasthan (25.4.%), Jharkhand (32.2%), UP (15.8%), and MP (23.1%). Delaying the age at marriage and first child birth could reduce the impact of Population Momentum on population growth.

Spacing between Births: Healthy spacing of 3 years improves the chances of survival of infants and also helps in reducing the impact of population momentum on population growth. SRS 2020 data shows that In India, spacing between two childbirths is less than the recommended period of 3 years in 47.6% of births.

The public sector provides the following contraceptive methods at various levels of health system:

Spacing Methods	Limiting Methods
IUCD 380 A and Cu IUCD 375	**Female Sterilization:**
Injectable Contraceptive MPA (Antara Programme)	Laparoscopic
Combined Oral Contraceptive (Mala-N)	Minilap
Centchroman (Chhaya)	**Male Sterilization:**
	No Scalpel Vasectomy
Condoms (Nirodh)	Conventional Vasectomy
EMERGENCY CONTRACEPTION	
Emergency Contraceptive pills (Ezy pills)	

Above services are provided at various levels of public sector facilities; following table provides details of the same:

Family Planning Method	Service Provider	Service Location
SPACING METHODS		
IUCD 380 A, IUCD 375	Trained & certified ANMs, LHVs, SNs and doctors	Sub centre & higher levels
Injectable Contraceptive MPA (Antara Programme)	Trained ANMs, SNs and doctors	Sub centre & higher levels
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Sub centre & higher levels
Condoms	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Sub centre & higher levels
EMERGENCY CONTRACEPTION		
Emergency Contraceptive Pills (ECPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Sub centre & higher levels

LIMITING METHODS		
Minilap	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels
Laparoscopic Sterilization	Trained & certified MBBS doctors & Specialist Doctors	Usually CHC & higher levels
NSV: No Scalpel Vasectomy	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels

- Mission Parivar Vikas was initially for 146 high priority districts in the 7 high focus states (Bihar, Uttar Pradesh, Assam, Chhattisgarh, Madhya Pradesh, Rajasthan & Jharkhand), is scaled up in all districts of the seven high focus states as well as six north-estern states of the country with an aim to ensure availability of contraceptive products to the clients at all the levels of Health Systems.
- Providing more choices through newly introduced contraceptives : Injectable Contraceptive MPA (Antara Programme) and Centchroman
- Emphasis on Spacing methods like IUCD
- Revitalizing Postpartum Family Planning including PPIUCD in order to capitalise on the opportunity provided by increased institutional deliveries. Appointment of counsellors at high institutional delivery facilities is a key activity.
- Strengthening community based distribution of contraceptives by involving ASHAs and Focussed IEC/ BCC efforts for enhancing demand and creating awareness on family planning
- Availability of Fixed Day Static Services at all facilities.
- Emphasis on minilap tubectomy services because of its logistical simplicity and requirement of only MBBS doctors and not post graduate gynaecologists/ surgeons.
- A rational human resource development plan for IUCD, minilap and NSV be chalked up to empower the facilities (DH, CHC, PHC, SHC) with at least one provider each for each of the services and Sub Centres with ANMs trained in IUD insertion
- Ensuring quality care in Family Planning services by establishing Quality Assurance Committees at state and district levels Plan for accreditation of more private/ NGO facilities to increase the provider base for family planning services under PPP.

- Increasing male participation and promoting Non scalpel vasectomy
- Demand generation activities in the form of display of posters, billboards and other audio and video materials in the various facilities be planned and budgeted
- Strong Political Will and Advocacy at the highest level, especially in states with high fertility rates.

Compensation scheme in Public (Govt.) facilities (amounts in INR)

Category	Type of operation	Facility	Others/ Acceptor	Total
11 High Focus States (Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttrakhand, Assam, Haryana, Gujarat)	Vasectomy (All)	2000	1000	**3000**
	Tubectomy (All)	2000	1000	3000
Other High Focus States (North East states except Assam, Jammu & Kashmir, Himachal Pradesh)	Vasectomy (All)	1300	200	1500
	Tubectomy (All)	1350	150	1500
Non High Focus States	Vasectomy (All)	1300	200	1500
	Tubectomy (BPL +SC/ST)	1350	150	1500

Source: Guidelines for Family Welfare Programme / www.nhm.gov.in

2

National Family Planning Indemnity Scheme (NFPIS)

For the sterilization services undertaken in India, compensation was provided to the beneficiary; however, no viable insurance mechanism was in place to cover for failure or incapacitation on account of undergoing the sterilization procedure and no indemnity cover was provided to doctors/ health facilities providing sterilization services. Moreover, there was a huge demand for indemnity insurance cover since many empanelled doctors were facing litigation on account of claims filed by the beneficiaries for compensation following failures/complications/ deaths. On the directives of the hon'ble Supreme court of India, the GOI therefore launched the NFPIS in November 2005 to compensate the acceptors of sterilization or his/her nominee in the unlikely event of complication, failure or death following a sterilization operation. The scheme also provides for indemnity cover to the medical officers and the health facilities for up to four cases of litigations per year that the healthcare provider or the facility may face as a consequence of performing sterilization operations.

This Insurance scheme underwent many revisions to best suit the everchanging demands and protect the right of both the client and the provider.

Available benefits under the Family Planning Indemnity Scheme

Section	Coverage	Limits
I A	Death attributable to sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital	Rs. 2 lakh
I B	Death attributable to sterilization within 8 – 30 days from the date of discharge from the hospital	Rs. 50,000/-
I C	Failure of sterilization	Rs 30,000/-
I D	Cost of treatment **in hospital and upto 60 days** arising out of complication attributable to sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge	Actual not exceeding Rs. 25,000/-
II	Indemnity per Doctor/Health Facilities but not more than 4 in a year	Upto Rs. 2 Lakh per claim

Source: India's Vision 2020 / NHM

NUTRITION

1

Anemia Mukt Bharat (AMB)

The reduction of anemia is a crucial objective of the POSHAN Abhiyaan launched in March 2018. Complying with the targets of POSHAN Abhiyaan and National Nutrition Strategy set by NITI Aayog, the Anemia Mukt Bharat was launched by the Ministry of Health and Family Welfare in 2018.

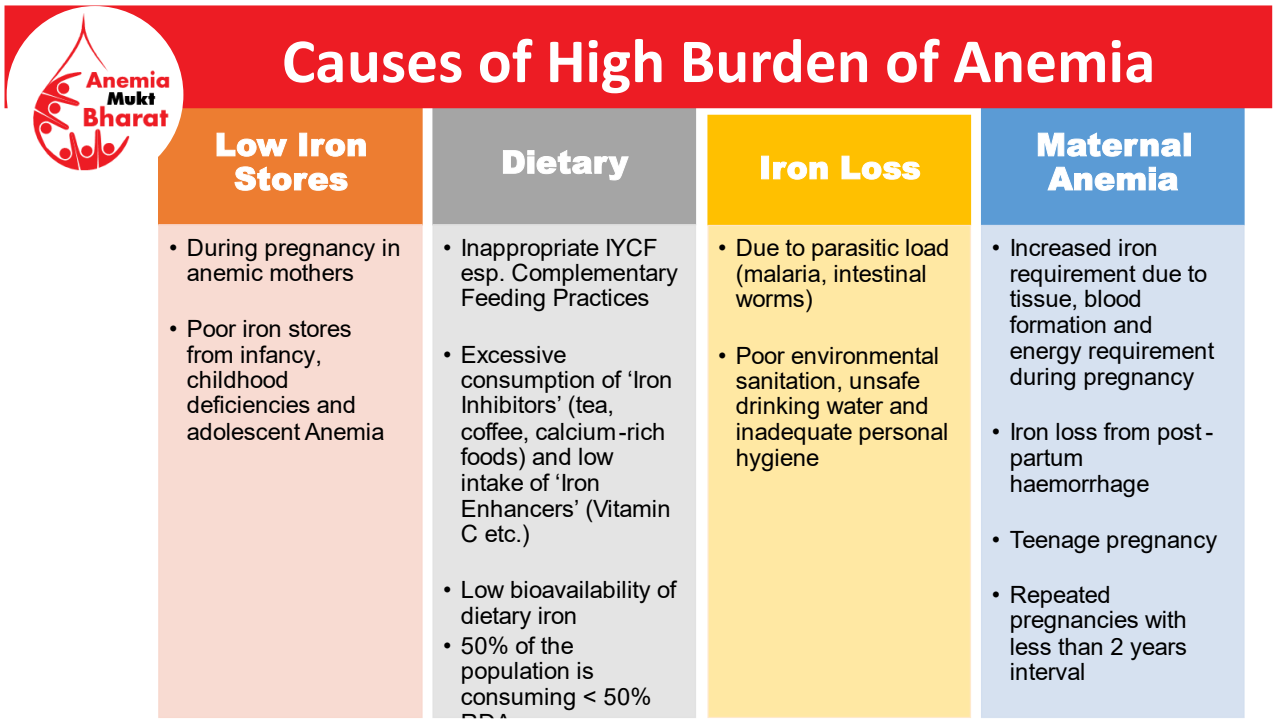
It uses the 6X6X6 strategy and aims to reduce the prevalence of anemia among various groups, including children (6-59 months), children (5-9 years), adolescents (10-19 years), pregnant women, lactating women, and women in reproductive age (15-49 years).

Anemia Mukt Bharat Interventions

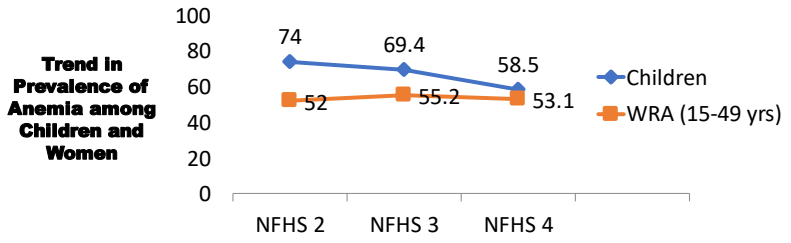
1. Prophylactic Iron and Folic Acid supplementation
2. Deworming
3. Intensified year-round Behaviour Change Communication Campaign focusing on four key behaviors:
    - Improving compliance to Iron Folic Acid supplementation and deworming
    - Appropriate infant and young child feeding practices
    - Increase in intake of iron-rich food through diet diversity/quantity/frequency and/or fortified foods with focus on harnessing locally available resources
    - Ensuring delayed cord clamping after delivery (by 3 minutes) in health facilities
4. Testing and treatment of anemia, using digital methods and point of care treatment, with special focus on pregnant women and school-going adolescents
5. Mandatory provision of Iron and Folic Acid fortified foods in government-funded public health programs
6. Intensifying awareness, screening, and treatment of non-nutritional causes of anemia in endemic pockets, with special focus on malaria, haemoglobinopathies, and fluorosis

Anemia Mukt Bharat Institutional Mechanisms

1. Intra-Ministerial Coordination
2. National Anemia Mukt Bharat Unit
3. National Centre of Excellences
4. Convergence with other Ministries
5. Strengthening Supply Chain and Logistics
6. Anemia Mukt Bharat Dashboard and Digital Portal - One-Stop Shop on Anemia



A Snapshot of Anemia in India



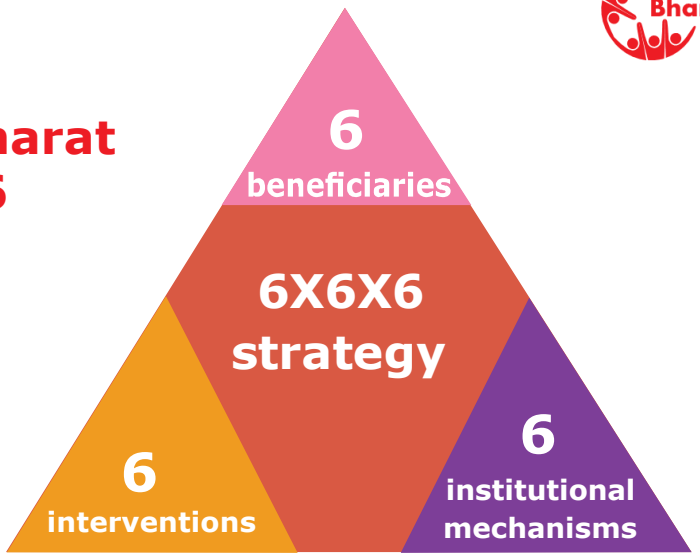
High Prevalence across all ages

Slow progress in most of the States

58% of children (6-59 months)	**54%** of adolescent girls (15-19 years)	**29%** of adolescent boys (15-19 years)	**53%** of women in their reproductive age	**50%** of pregnant women	**58%** of breastfeeding mothers

Anemia Mukt Bharat

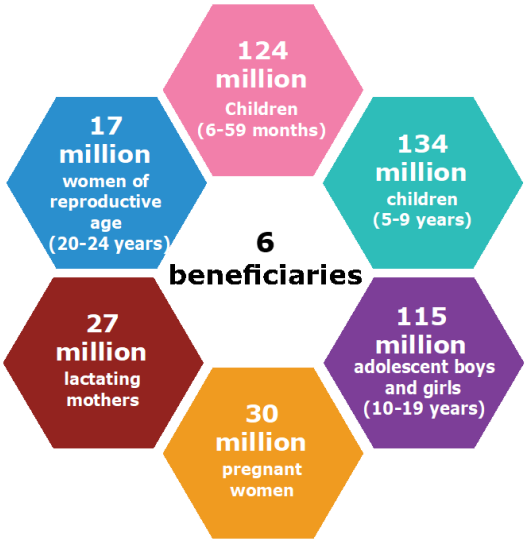
Anemia Mukt Bharat will use a 6x6x6 strategy to combat anemia



Six Beneficiaries

Estimated 450 million beneficiaries

Reaching nearly 50% of the country's population



Six Interventions

1. Prophylactic iron folic acid supplementation
2. Periodic deworming of children, adolescents, pregnant women
3. Intensified year-round Behavior Change Communication Campaign ***Solid Body Smart Mind*** ,delayed cord clamping
4. Testing of anemia using digital methods and point of care treatment
5. Mandatory provision of iron and folic acid fortified foods in public health programmes
6. Addressing non-nutritional causes of anemia in endemic pockets, with special focus on malaria, haemoglobinopathies and fluorosis

Six Institutional Mechanisms

Prophylactic dose and regime for Iron Folic Acid supplementation as per following table.

Target Group		Dose and regime	By Whom
Children 6-59 months of age		Biweekly (Tuesday and Friday) 1 ml IFA syrup	ASHA
Children 5-9 years of age	School Going	Weekly (Shakti Diwas on every Tuesday) 1 Pink IFA tablet	School teachers
	Non-School Going	Weekly (Shakti Diwas on every Tuesday) 1 Pink IFA tablet	ASHA
10–19 years of age adolescent girls	School Going	Weekly (Shakti Diwas on every Tuesday) 1 Blue IFA tablet	School teachers
	Non-School Going	Weekly (Shakti Diwas on every Tuesday) 1 Blue IFA tablet	AWW

Source: Operational Guidelines for Anaemia Mukt Bharat /https://anemiamuktbharat.info/ NHM

2

National Deworming Day (NDD)

About National Deworming Day

- A fixed National Deworming Day approach has the potential to ensure maximum coverage with optimal utilization of resources, by leveraging existing programs and infrastructure. A fixed day approach will:
- Motivate States/UTs to prioritize deworming within current ICDS and school health programs
- Increase public awareness around deworming with standardized campaign messages across the country
- Increase coverage of target beneficiaries
- Establish structures to easily track and respond to any cases of adverse events
- Ensure quality and consistency of coverage reporting

With an aim to intensify efforts towards STH control among children in India, the Ministry of Health & Family Welfare, Government of India (GOI) has decided to observe National Deworming Day (NDD) on 10th February of every year. All Government and Government aided schools and Anganwadi Centers will be the sites for implementation of National Deworming Day across the country. States/UTs are encouraged to involve private schools as well to participate in the NDD.

Objective of NDD

The objective of National Deworming Day is to deworm all preschool and school-age children (enrolled and non-enrolled) between the ages of 1-19 years through the platform of schools and Anganwadi Centers in order to improve their overall health, nutritional status, access to education and quality of life.

Target Beneficiaries

All children (both boys and girls) in the age group of 1-19 years.

States already conducting biannual deworming linked with Vitamin A Prophylaxis program for children under-five shall continue to administer deworming drug along with Vitamin-A. States currently not having bundling of these two interventions are encouraged to use the platform of National Deworming Day for deworming under - five age group children.

Steps of Preparatory Action

- Establishment of National level, State level and District level Coordination Committees
- Orientation and capacity building of stakeholders and providers
- Procurement of Albendazole tablets for target beneficiaries and its supply chain management
- Adaptation of the IEC materials shared by Government of India and contextualize as per local needs
- Printing of monitoring and reporting formats
- Community mobilization and awareness activities
- Planning for monitoring and evaluation activities

Source: National Deworming Day Guidelines / NHM

3

Nutrition Rehabilitation Center

Undernutrition is one of the most concerning health and development issues in India as in other parts of the world. Undernutrition encompasses stunting (chronic malnutrition), wasting (acute malnutrition) and deficiencies of micronutrients (essential vitamins and minerals)

Reproductive, Maternal, Newborn, Child and Adolescent Health

- Weight-for-age (underweight) – it is composite index of height-for-age and weight-for-height. Children with low weight for their age are susceptible to various infections compared to those with the standard weight for age. It is a comprehensive indicator for malnutrition as it takes into account both acute and chronic malnutrition.
- Height-for-age (stunting) – this index is an indicator of linear growth retardation and cumulative growth deficits. Children who are short for their age (stunted) are chronically malnourished.
- Weight-for-height (wasting) – this index measures body mass in relation to body length and describes current nutritional status. Children considered thin (wasted) for their height are acutely malnourished.

Severe acute malnutrition is defined by very low weight-for-height/length (Z- score below -3SD of the median WHO child growth standards) or by the presence of nutritional oedema

Nutrition Rehabilitation Center (NRC) is a unit in a health facility where children with Severe Acute Malnutrition (SAM) are admitted and managed. Children are admitted as per the defined admission criteria and provided with medical and nutritional therapeutic care. Once discharged from the NRC, the child continues to be in the Nutrition Rehabilitation program till she/he attains the defined discharge criteria from the program. In addition to curative care, special focus is given on timely, adequate and appropriate feeding for children; and on improving the skills of mothers and caregivers on complete age appropriate caring and feeding practices. In addition, efforts are made to build the capacity of mothers/caregivers through counselling and support to identify the nutrition and health problems in their child.

Objectives of Facility based management of SAM

- To provide clinical management and reduce mortality among children with severe acute malnutrition, particularly among those with medical complications.
- To promote physical and psychosocial growth of children with severe acute malnutrition (SAM).
- To build the capacity of mothers and other care givers in appropriate feeding and caring practices for infants and young children
- To identify the social factors that contributed to the child slipping into severe acute malnutrition.

The services and care provided for the in-patient management of SAM children include

- 24 hour care and monitoring of the child
- Treatment of medical complications.
- Providing sensory stimulation and emotional care. Social assessment of the family to identify and address contributing factors.
- Counseling on appropriate feeding, care and hygiene.
- Demonstration and practice- by -doing on the preparation of energy dense child foods using locally available, culturally acceptable and affordable food items.
- Follow up of children discharged from the facility

Source: Operational guidelines for Nutrition Rehabilitation Centre / NHM

4

Mother Absolute Affection (MAA)

Objective

- Build an enabling environment for breastfeeding through awareness generation activities, targeting pregnant and lactating mothers, family members and society in order to promote optimal breastfeeding practices as an important intervention for child survival and development.
- Revitalizing efforts towards promotion, protection and support of breastfeeding practices through health systems to achieve higher breastfeeding rates.Reinforclactation support services at public health facilities through trained healthcare providers and through skilled community health workers.
- To incentivize and recognize those health facilities that show high rates of breastfeeding along with processes in place for lactation management.

Key Components

- Promotion of early initiation of breastfeeding and emphasis on exclusive breastfeeding till 6 months of age through ASHA worker and health care provider at health facilities.
- Communication for enhanced awareness and demand generation through mass media and mid media.
- Implementation of breastfeeding policy for hospitals. Training and capacity enhancement of nurses at government institutions, and all ANMs and ASHAs. They will provide information and counselling support to mothers for breastfeeding;
- Community engagement by ASHAs for breastfeeding promotion, who will conduct mothers' meetings. Breastfeeding mothers requiring more support will be referred to a health facility or the ANM sub-centre or the Village Health and Nutrition Day (VHND) organized every month at the village level;
- Celebration of World Breastfeeding Week (WBW) from 1st to 7th August every year across the country to increase engagement and create positive momentum for

breastfeeding with diverse stakeholders. Recognition and team awards will be given to facilities showing good performance

- Establishment of comprehensive lactation management centres and lactation management units for ensuring availability of safe pasteurized donor human milk and expressed mother's own breast milk suitable for feeding sick, preterm and low birth weight babies.

Target Beneficiaries

Pregnant and lactating mothers, , Families Members and Community Members

Source: https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1450&lid=799 / NHM

5

Lactation Management Centre

High to less complex models of lactation management centres can be set up depending upon the need of health facilities in terms of number of newborns requiring donor human milk, availability of space and human resources. The lactation management centres would be established at three levels:

Comprehensive Lactation Management Centres (CLMCs)

Comprehensive Lactation Management Centres (CLMCs) will be established in phases:

First Phase: CLMCs will be established at all Medical Colleges that meet the pre-requisites on assessment carried out by State/District Quality Assurance Committee.

Second Phase: In the second phase, CLMCs will be established in the District Hospitals that meet the pre-requisite for establishing CLMCs on assessment carried out by State/District Quality Assurance Committee.

The CLMCs will follow technical protocols with respect to adequate space, requisite manpower and equipment. It shall also conform to quality standards and protocols with respect to donor screening, collection, processing, storage and dispensation of human milk.

Lactation Management Units (LMUs):

LMUs can be established at all sub-district hospitals and FRUs that meet the prerequisite criteria on assessment carried out by State/District Quality Assurance Committee. These LMUs will facilitate expression and collection of mother's own milk only. LMUs will conform to the quality standards and technical protocol with respect to collection, storage and dispensation of mother's milk for consumption by her own baby admitted at SNCUs.

Lactation Support Units (LSUs):

To maintain the continuum of care, Lactation Support Units (LSUs) will be constituted in all Delivery Points (DPs) by forming a dedicated team of IYCF trained staff to provide round the clock breastfeeding support, lactation counselling and Kangaroo Mother Care (KMC) support to mothers. The lactation support unit would have a dedicated space/room where lactating mothers visiting the health facility can breastfeed in privacy. Information about breastfeeding

space will be prominently displayed for providing greater visibility and support for breastfeeding. The identified space/room for breastfeeding as per MAA guidelines of MoHFW under MAA programme will be utilized for this purpose. The Lactation Support Unit would ensure that the health facility is well equipped with necessary IEC material and display of IEC on breastfeeding in ANC ward/delivery ward and ANC clinics as per MAA Guidelines of MoHFW.

Source: National Guidelines on O Lactation Management Centres in Public Health Facilities / NHM

7

Mission POSHAN

Government is implementing several schemes and programs under the Umbrella Integrated Child Development Services Scheme as direct targeted interventions to address the problem of malnutrition in the country. All these schemes address one or other aspects related to nutrition and have the potential to improve nutritional outcomes in the country.

Malnutrition is not a direct cause of death but contributes to mortality and morbidity by reducing resistance to infections. There are a number of causes of death of children such as prematurity, low birth weight, pneumonia, diarrhoeal diseases, non-communicable diseases, birth asphyxia & birth trauma, injuries, congenital anomalies, acute bacterial sepsis and severe infections, etc.

Prime Minister's Overarching Scheme for Holistic Nutrition (POSHAN) Abhiyaan (National Nutrition Mission) is a flagship programme of the Ministry of Women and Child Development (MWCD), Government of India, which ensures convergence with various programmes i.e., Anganwadi Services, Pradhan Mantri Matru Vandana Yojana (PMMVY), Scheme for Adolescent Girls (SAG) of MWCD Janani Suraksha Yojana (JSY), National Health Mission (NHM), Swachh-Bharat Mission, Public Distribution System (PDS), Department Food & Public Distribution, Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) and Ministry of Drinking Water & Sanitation.

About the Mission

The goals of NNM are to achieve improvement in nutritional status of Children from 0-6 years, Adolescent Girls, Pregnant Women and Lactating Mothers in a time bound manner.

The NNM is a comprehensive approach towards raising nutrition level in the country on a war footing. It will comprise mapping of various Schemes contributing towards addressing malnutrition, including a very robust convergence mechanism, ICT based Real Time Monitoring system, incentivizing States/UTs for meeting the targets, incentivizing Anganwadi Workers (AWWs) for using IT based tools, eliminating registers used by AWWs, introducing measurement of height of children at the Anganwadi Centres (AWCs), Social Audits, setting-up Nutrition Resource Centres, involving masses through Jan Andolan for their participation on nutrition through various activities, among others.

Major impact

The programme through the targets will strive to reduce the level of stunting, under-nutrition, anemia and low birth weight babies.

NNM targets to reduce stunting, under- nutrition, anemia (among young children, women and adolescent girls) and reduce low birth weight by 2%, 2%, 3% and 2% per annum respectively.

Source: Overview of Mission Poshan / NHM

NATIONAL HEALTH PROGRAMMES

1

National Viral Hepatitis Control Program (NVHCP)

Ministry of Health and Family Welfare has launched the 'National Viral Hepatitis Control Program', with the goal of ending viral hepatitis as a public health threat by 2030 in the country.

Viral hepatitis in India

Viral hepatitis is increasingly being recognized as a public health problem in India. Hepatitis A Virus (HAV) and Hepatitis E Virus (HEV) are important causes of acute viral hepatitis and Acute Liver Failure (ALF). Due to paucity of data, the exact burden of disease for the country is not established. However, available literature indicates a wide range and suggests that HAV is responsible for 10-30% of acute hepatitis and 5- 15% of acute liver failure cases in India. It is further reported that HEV accounts for 10-40% of acute hepatitis and 15-45% of acute liver failure.

Hepatitis B surface Antigen (HBsAg) positivity in the general population ranges from 1.1% to 12.2%, with an average prevalence of 3-4%. Anti-Hepatitis C virus (HCV) antibody prevalence in the general population is estimated to be between 0.09-15%. Based on some regional level studies, it is estimated that in India, approximately 40 million people are chronically infected with Hepatitis B and 6-12 million people with Hepatitis C. Chronic HBV infection accounts for 40% of Hepato-cellular Carcinoma (HCC) and 20-30% cases of cirrhosis in India. Chronic HCV infection accounts for 12-32% of HCC and 12-20% of cirrhosis.

A systematic review of available information from published studies and from large unpublished reliable datasets, to assess the prevalence of chronic HCV infection in the Indian population has recently been done to assess the prevalence of overall HCV infections, and by age, sex, risk factors and place in the country. This meta-analysis data estimated that India (current population approx. 1.3 billion) has 5.2-13 million anti- HCV positive persons. As the data on HCV viremia amongst the anti-HCV positive persons were not available, data

from elsewhere was used to estimate that India has about 3 million to 9 million persons with active HCV infections.

Aim

- Combat hepatitis and achieve country wide elimination of Hepatitis C by 2030
- Achieve significant reduction in the infected population, morbidity and mortality associated with Hepatitis B and C viz. Cirrhosis and Hepato-cellular carcinoma (liver cancer)
- Reduce the risk, morbidity and mortality due to Hepatitis A and E.

Key Objectives

- Enhance community awareness on hepatitis and lay stress on preventive measures among general population especially high-risk groups and in hotspots.
- Provide early diagnosis and management of viral hepatitis at all levels of healthcare
- Develop standard diagnostic and treatment protocols for management of viral hepatitis and its complications.
- Strengthen the existing infrastructure facilities, build capacities of existing human resource and raise additional human resources, where required, for providing comprehensive services for management of viral hepatitis and its complications in all districts of the country.
- Develop linkages with the existing National programs towards awareness, prevention, diagnosis and treatment for viral hepatitis.
- Develop a web-based “Viral Hepatitis Information and Management System” to maintain a registry of persons affected with viral hepatitis and its sequelae

Components

The key components include:

Preventive component: This remains the cornerstone of the NVHCP. It will include

- Awareness generation
- Immunization of Hepatitis B (birth dose, high risk groups, health care workers)

- Safety of blood and blood products
- Injection safety, safe socio-cultural practices
- Safe drinking water, hygiene and sanitary toilets

Diagnosis and Treatment:

- Screening of pregnant women for HBsAg to be done in areas where institutional deliveries are < 80% to ensure their referral for institutional delivery for birth dose Hepatitis B vaccination.
- Free screening, diagnosis and treatment for both hepatitis B and C would be made available at all levels of health care in a phased manner.
- Provision of linkages, including with private sector and not for profit institutions,for diagnosis and treatment.
- Engagement with community/peer support to enhance and ensure adherence to treatment and demand generation.
- Monitoring and Evaluation, Surveillance and Research Effective linkages to the surveillance system would be established and operational research would be undertaken through Department of Health Research (DHR). Standardised M&E framework would be developed and an online web based system established.

Training and capacity Building:

This would be a continuous process and will be supported by NCDC, ILBS and state tertiary care institutes and coordinated by NVHCP. The hepatitis induction and update programs for all level of health care workers would be made available using both, the traditional cascade model of training through master trainers and various platforms available for enabling electronic, e- learning and e-courses.

Source : Operational Guidelines of NVHCP /Ministry of Health and Family Welfare/NHM

2

National Viral Hepatitis Surveillance Programme

Viral hepatitis is an inflammation of the liver caused by one of the five hepatitis viruses, referred to as types A, B, C, D and E. The Government of India through the National Centre for Disease Control is implementing the National Viral Hepatitis Surveillance Programme.

Objectives

- To establish laboratory network for laboratory based surveillance of viral hepatitis in different geographical locations of India.
- To ascertain the prevalence of different types of viral hepatitis in different zones of the country.
- To provide laboratory support for outbreak investigation of hepatitis through established network of laboratories.
- To develop technical material for generating awareness among healthcare providers and in the community about waterborne and blood borne hepatitis.

Targets

- Establishment of laboratory based surveillance for viral hepatitis in the country for collection of data. Development of testing and surveillance guidelines and its dissemination.
- A network of laboratories with quality testing for hepatitis markers will be established covering the entire country
- Training of manpower/health care providers in 10 regional labs including NCDC i.e. the reference lab.
- Development of IEC for providers and community.
- Establishment of baseline data for hepatitis to see the impact

Source: ***National Centre for Disease Control (NCDC)***

3

National Mental Health Programme (NMHP)

Introduction

Psychiatric symptoms are common in general population in both sides of the globe. These symptoms – worry, tiredness, and sleepless nights affect more than half of the adults at some time, while as many as one person in seven experiences some form of diagnosable neurotic disorder.

Burden of Disease

The World Bank report (1993) revealed that the Disability Adjusted Life Year (DALY) loss due to neuro- psychiatric disorder is much higher than diarrhea, malaria, worm infestations and tuberculosis if taken individually. According to the estimates daily loss due to mental disorders are expected to represent 15% of the global burden of diseases by 2020.

During the last two decades, many epidemiological studies have been conducted in India, which show that the prevalence of major psychiatric disorder is about the same all over the world. The prevalence reported from these studies range from the population of 18 to 207 per 1000 with the median 65.4 per 1000 and at any given time, about 2 –3 % of the population, suffer from seriously, incapacitating mental disorders or epilepsy.

Most of these patients live in rural areas remote from any modern mental health facilities. A large number of adult patients (10.4 – 53%) coming to the general OPD are diagnosed mentally ill. However, these patients are usually missed because either medical officer or general practitioner at the primary health care unit does not ask detailed mental health history. Due to the under-diagnosis of these patients, unnecessary investigations and treatments are offered which heavily cost to the health providers.

Programme

The Government of India has launched the National Mental Health Program (NMHP) in 1982, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental health care infrastructure in the country to deal with it.

Components of NMHP

1. Treatment of Mentally ill
2. Rehabilitation
3. Prevention and promotion of positive mental health.

Aims

- Prevention and treatment of mental and neurological disorders and their associated disabilities.
- Use of mental health technology to improve general health services.
- Application of mental health principles in total national development to improve quality of life.

Objectives

- To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population.
- To encourage application of mental health knowledge in general health care and in social development.
- To promote community participation in the mental health services development and to stimulate efforts towards self-help in the community.

Strategies

- Integration mental health with primary health care through the NMHP
- Provision of tertiary care institutions for treatment of mental disorders
- Eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority, and State Mental health Authority.

Mental Health care

- The mental morbidity requires priority in mental health treatment
- Primary health care at village and sub center level
- At Primary Health Center level
- At the District Hospital level

- Mental Hospital and teaching Psychiatric Units

Source: ***nihfw.nic.in***

4

National Tobacco Control Programme (NTCP)

Introduction

Tobacco use is one of the main risk factors for a number of chronic diseases, including cancer, lung diseases, and cardiovascular diseases. India is the 2nd largest producer and consumer of tobacco and a variety of forms of tobacco use is unique to India. Apart from the smoked forms that include cigarettes, bidis and cigars, a plethora of smokeless forms of consumption exist in the country.

The Government of India has enacted the national tobacco-control legislation namely, "The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" in May, 2003.

India also ratified the WHO-Framework Convention on Tobacco Control (WHO-FCTC) in February 2004. Further, in order to facilitate the effective implementation of the Tobacco Control Law, to bring about greater awareness about the harmful effects of tobacco as well as to fulfill the obligations under the WHO-FCTC, the Ministry of Health and Family Welfare, Government of India launched the National Tobacco Control Programme (NTCP) in 2007- 08 in 42 districts of 21 States/Union Territories of the country.

Currently, the Programme is being implemented in all States/Union Territories covering over 600 districts across the country.

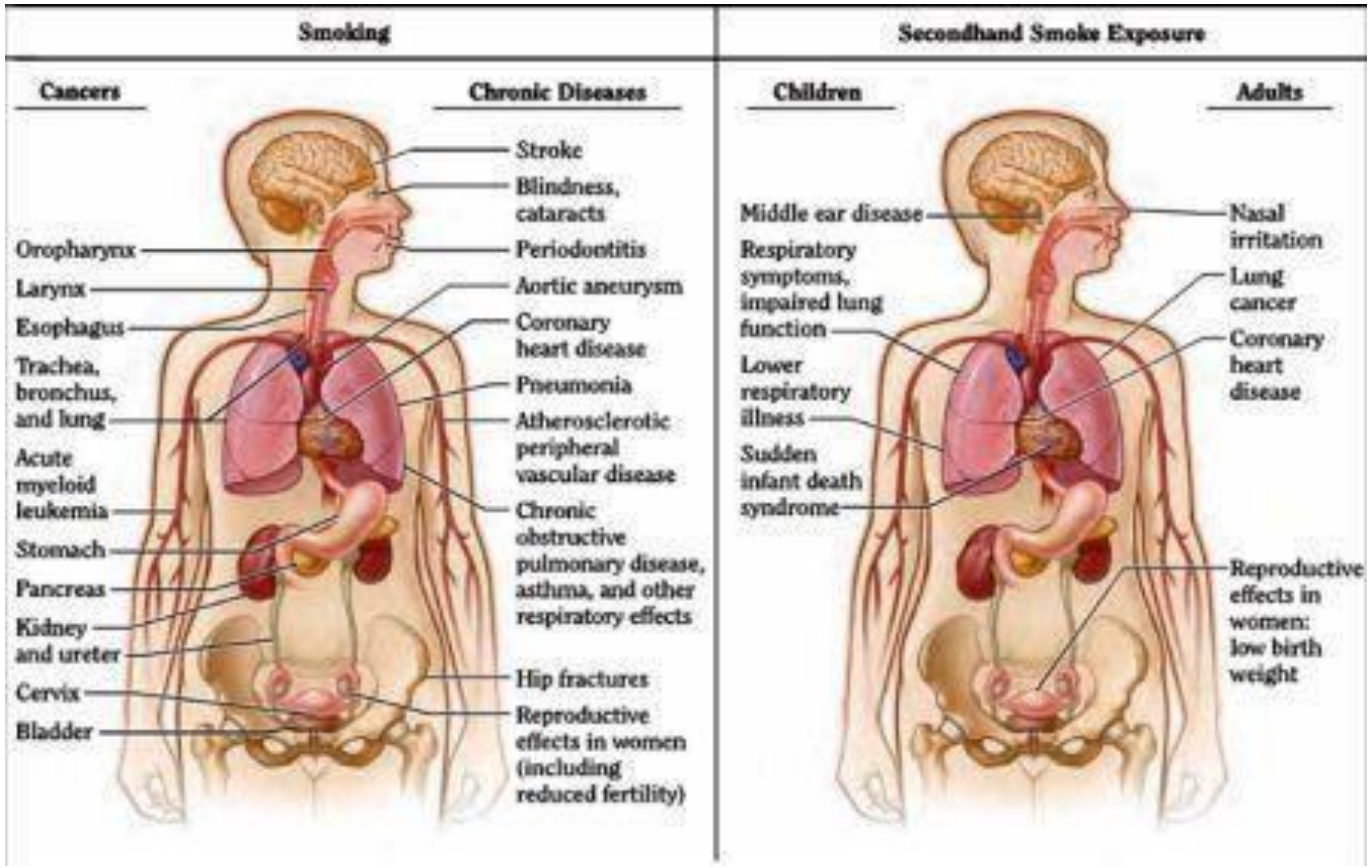
Objectives

- To bring about greater awareness about the harmful effects of tobacco use and Tobacco Control Laws.
- To facilitate effective implementation of the Tobacco Control Laws.

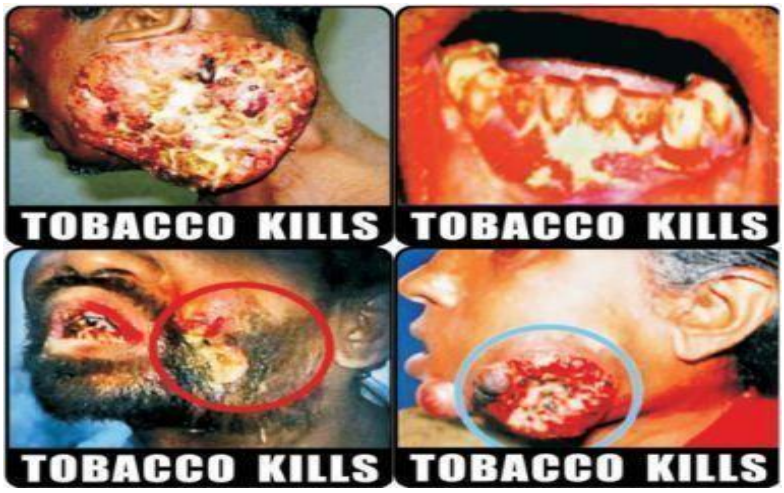
The objective of this programme is to control tobacco consumption and minimize the deaths caused by it. The various activities planned to control tobacco use are as follows:

- Training and Capacity Building
- IEC activity
- Monitoring Tobacco Control Laws and Reporting
- Survey and Surveillance

- Harmful effects of smoking and Second-hand Smoke Exposure



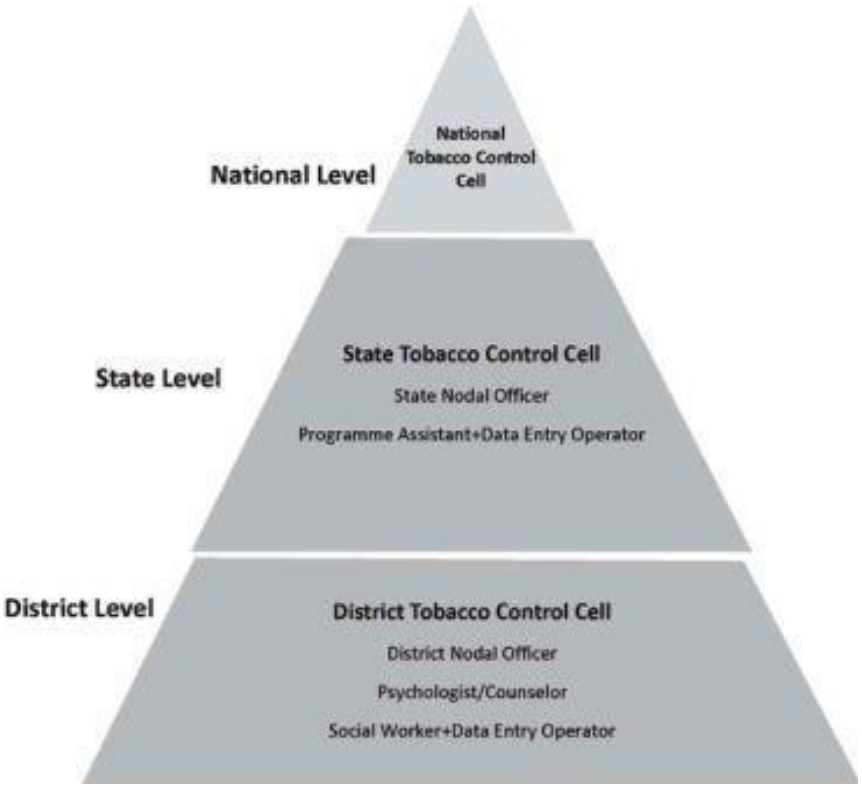
Harmful Effects of using smokeless Tobacco



Implementation

NTCP is implemented through a three-tier structure, i.e.

- National Tobacco Control Cell (NTCC) at Central level
- State Tobacco Control Cell (STCC) at State level &
- District Tobacco Control Cell (DTCC) at District level. There is also a provision of setting up Tobacco Cessation Services at District level.



Major Achievements

- The prevalence of tobacco use has reduced by six percentage points from 34.6% to 28.6% during the period from 2009-10 to 2016-17. The number of tobacco users has reduced by about 81 lakh (8.1 million).
- The Government launched the National Tobacco Cessation Quitline Services (1800-112-356) which aims to guide tobacco addicts to quit tobacco.

- Large specified health warnings on tobacco products covering 85% on both side of the principal display area of tobacco product packs and inclusion of Quitline Number (1800112356) in the specified health warnings for creating awareness among tobacco users, and give them access to counseling services to effect behavior change.
- 'mCessation' initiative is being supported by Ministry to support tobacco users towards successful quitting through text-messaging via mobile phones (011 22901701).
- Regulation of the use of Cigarettes and other tobacco products in films and TV programmes.
- Acceded to the Protocol to Eliminate Illicit Trade in Tobacco Products under the Article 15 of WHO FCTC.
- Issued an Advisory to ban Electronic Nicotine Delivery System (ENDS) including e-Cigarettes, Heat- Not-Burn devices, Vape, e-Sheesha, e-Nicotine Flavored Hookah, and the like devices that enable nicotine delivery except for the purpose & in the manner and to the extent, as may be approved under the Drugs and Cosmetics Act, 1940 and Rules made thereunder.
- Established three National Tobacco Testing Laboratories
- Enacted The Prohibition of Electronic Cigarettes (Production, Manufacture, Import, Export, Transport, Sale, Distribution, Storage and Advertisement) Act, 2019

Source: Operational guidelines of NTCP / National Health Mission

5

National Programme for Prevention and Control of Deafness (NPPCD)

Introduction

Hearing loss is the most common sensory deficit in humans today. World over, it is the second leading cause for *'Years lived with Disability (YLD)'* the first being depression. There are large number of hearing-impaired young people in India which amounts to a severe loss of productivity, both physical and economic.

An even larger percentage of our population suffers from milder degrees of hearing loss and unilateral (one sided) hearing loss against the above background, The Ministry of Health and Family Welfare, Govt. of India launched the pilot phase of *National Program for Prevention and Control of Deafness* (from 2006 to 2008) in 10 States and 1 Union Territory in an effort to tackle the high incidence of deafness in the country, in view of the preventable nature of this disability.

Objectives of the Programme

- To prevent the avoidable hearing loss on account of disease or injury.
- Early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness
- To medically rehabilitate persons of all age groups, suffering with deafness.
- To strengthen the existing inter-sectoral linkages for continuity of the rehabilitation Program, for persons with deafness
- To develop institutional capacity for ear care services by providing support for equipment and material and training personnel.

Components of the Programme

- Manpower training and development– For prevention, early identification and management of hearing impaired and deafness cases, training would be provided from medical college level specialists (ENT and Audiology) to grass root level workers.

- Capacity building – For the district hospital, community health centers and primary health center in respect of ENT/ Audiology infrastructure.
- Service provision – Early detection and management of hearing and speech impaired cases and rehabilitation, at different levels of health care delivery system.
- Awareness generation through IEC/BCC activities – For early identification of hearing impaired, especially children so that timely management of such cases is possible and to remove the stigma attached to deafness.

Strategies

- To strengthen the service delivery for ear care
- To develop human resource for ear care services.
- To promote public awareness through appropriate and effective IEC strategies with special emphasis on prevention of deafness.
- To develop institutional capacity of the district hospitals, community health centers and primary health centers selected under the Programme.

Expected Benefits of the Programme

The Programme is expected to generate the following benefits: -

- Availability of various services like prevention, early identification, treatment, referral, rehabilitation etc. for hearing impairment and deafness as the primary health center / community health centers / district hospitals largely cater to their need.
- Decrease in the magnitude of hearing-impaired persons.
- Decrease in the severity/ extent of ear morbidity or hearing impairment.
- Improved service network/referral system for the persons with ear morbidity/hearing impairment.
- Awareness creation among the health workers/grass root level workers through the primary health centre medical officers and district health officers, which will percolate to the lower-level health workers functioning within the community.
- Capacity building at the district hospitals to ensure better care.

Source: Operational Guidelines of NPPCD/ *National Health Portal*

6

National Programme for Control of Blindness and Visual Impairment (NPCBVI)

National Programme for Control of Blindness was launched in the year 1976 with the goal to reduce the prevalence of blindness from 1.4% to 0.3%. As per Survey in 2001-02, prevalence of blindness is estimated to be 1.1%. Rapid Survey on Avoidable Blindness conducted under NPCB during 2006-07 showed reduction in the prevalence of blindness from 1.1% (2001-02) to 1% (2006-07). Various activities/initiatives undertaken during the Five-Year Plans under NPCB were targeted towards achieving the goal of reducing the prevalence of blindness to 0.3% by the year 2020. The National Blindness Survey (2015-19) has shown reduction in the prevalence of blindness from 1% (2007) to 0.36% (2019).

In the beginning it was a 100% Centrally Sponsored scheme. From 12th FYP it is 60:40 in all States/UTs and 90:10 in hilly states and all NE States. Nomenclature of the programme was also changed from National Programme for Control of Blindness to National Programme for Control of Blindness & Visual Impairment (NPCBVI) in 2017.

Main causes of blindness

- Cataract (66.2 %)
- Corneal opacity (7.4%)
- Cataract surgical complications (7.2%)
- Posterior segment disorders excluding DR and ARMD (5.9%) and
- Glaucoma (5.5%).

Goal

Under the National Health Policy (NHP), the target is to reduce the prevalence of blindness to 0.25% by 2025.

Major activities under the Programme

- Primary eye care services

- Preventive and promotive eye care services: under comprehensive primary health care Ayushman Arogya Mandirs (AAM) are providing preventive and promotive eye care services.
- IEC activities for promotion and preventive eye care and eye donation.
- Secondary eye care services
- Cataract surgeries: Reduction in the backlog of cataract by performing cataract surgeries in Governmental, Non-Governmental Eye Hospitals and private practitioners.
- Screening for Refractive errors and Distribution of free Spectacles: Screening of Children for identification and treatment refractive errors and distribution of spectacles to those who are suffering from refractive errors through school eye screening programme.
- Distribution of free spectacles to old persons suffering from presbyopia to enable them for undertaking near work as a new initiative under the programme.
- Management of Visual impairment: The programme is now geared to take care of all categories of visual impairment including low vision cases. Apart from cataract, now the focus of the programme is on treatment and management of other eye diseases like glaucoma, diabetic retinopathy, vitreo retinal diseases, Corneal blindness and childhood blindness.
- Use of Mobile Ophthalmic Units and Tele- ophthalmology network to expand coverage and reach of the programme in disadvantaged and hard to reach areas.
- Eye banking Services: Strengthening of eye banking services and collection of donated eyes.

Tertiary Eye care Services

- Under the tertiary care component of NPCB&VI
- Grant in Aid for strengthening of Regional Institute of Ophthalmology and Medical Colleges to provide super-speciality eye care services
- Hands on Training of Govt. Eye Surgeons for upgradation of their clinical and surgical skills.
- IEC campaigns
- Research and surveys
- Infrastructure Development and Capacity building

- Grant in Aid for strengthening of eye care units at primary and secondary level.
- Training of Paramedical Ophthalmic Assistant and Eye donation counsellors.

Newer Initiatives/ Focus Areas under the program

Revision of NPCBVI guidelines to provide Comprehensive eye health care through AB-Ayushman Arogya Mandirs

"Standards of eye banking in India 2020" have been launched for improvement in eye donation, collection, processing, and maintenance of quality standards, equitable distribution of scarce corneal tissue, strengthening of institutional capacity for corneal transplantation, community awareness and training of health personnel.

Development of a network of eye banks and eye donation centres and linked with medical colleges and RIOs to promote collection and timely utilization of donated eyes in a transparent manner

Focus on other causes of Visual impairment, besides Cataract, treatment/management of other eye diseases like Diabetic retinopathy (DR), Retinopathy of prematurity (ROP). Corneal Blindness and glaucoma have been increased. DR screening and glaucoma clinics have been made integral part at district and sub-district hospitals.

In order to achieve elimination of trachoma by the year 2020 as per WHO global action plan, surveillance, case detection and treatment of Trachoma trichiasis (TT) is being executed which will be followed by TT only survey in all previously trachoma endemic districts.

Issuing of COVID 19 guidelines to all stakeholders for safe ophthalmology practices to minimize and avoid the spread of COVID 19 in eye care facilities. Setting up of super-specialty clinics for all major eye diseases including diabetic retinopathy, glaucoma, retinopathy of prematurity etc. in state level hospitals and medical colleges all over the country.

Linkage of tele-ophthalmology centres at PHC/ Vision centres with super-specialty eye hospitals to ensure delivery of best possible diagnosis and treatment for eye diseases, especially in hilly terrains and difficult areas.

Source: National Programme for Control of Blindness & Visual Impairment (NPCBVI)/NHM

7

National Programme on Climate Change & Human Health (NPCCHH)

The Ministry of Health & Family Welfare launched the National Program for Climate Change and Human Health (NPCCHH) in 2019.

Objectives

The NPCCHH objectives with some initially identified key actions are:

- To create awareness among general population (vulnerable community), health-care providers and Policy makers regarding impacts of climate change on human health.
- To strengthen capacity of healthcare system to reduce illnesses/ diseases due to variability in climate
- To strengthen health preparedness and response by performing situational analysis at national/ state/ district/ below district levels.
- To develop partnerships and create synchrony/ synergy with other missions and ensure that health is adequately represented in the climate change agenda in the country
- To strengthen research capacity to fill the evidence gap on climate change impact on human health

Key activities

- Development of IEC material on health impacts of Climate variability & change
- Advocacy on health impacts of Climate variability & change
- Strengthening of health care system in context of climate change
- Capacity building for vulnerability assessment at various levels and liaison with centre
- Develop/ strengthen the monitoring and surveillance systems for climate sensitive diseases
- Develop mechanisms for EWS/ alerts and responses at state, district and below district level
- Develop joint action plan with other deptt. / Organizations in view of their capabilities and complementarities

- Integrate, adopt and implement environment friendly measures suggested in other missions on climate change
- Strengthening of healthcare services based on researches on climate variables and impact on human health

Expected Output

- Awareness & Behavior modification of general population for impact, illnesses, prevention and adaptive measures for climate sensitive illnesses.
- Increase in trained healthcare personnel and equipped institutes/ organization towards achievement of climate resilient healthcare services and infrastructure at district level in each state.
- Integrated monitoring system for collection and analysis of health-related data with meteorological parameters, environmental, socio-economic and occupational factors
- Regulation on key environmental determinants of health: air quality, water quality, food, waste management, agriculture, transport.
- Evidence–based support to policy makers, programme planners and related stakeholders

Source: NPCCHH operational guidelines

National Programme for the Health Care for the Elderly

The National Programme for the Health Care for the Elderly (NPHCE) is an articulation of the International and national commitments of the Government as envisaged under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), National Policy on Older Persons (NPOP) adopted by the Government of India in 1999 & Section 20 of "The Maintenance and Welfare of Parents and Senior Citizens Act, 2007" dealing with provisions for medical care of Senior Citizen.

Vision

- To provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an Ageing population; Creating a new "architecture" for Ageing;
- To build a framework to create an enabling environment for *"a Society for all Ages";*
- To promote the concept of Active and Healthy Ageing.

Specific Objectives

- To provide an easy access to promotional, preventive, curative and rehabilitative services to the elderly through community based primary health care approach
- To identify health problems in the elderly and provide appropriate health interventions in the community with a strong referral backup support.
- To build capacity of the medical and paramedical professionals as well as the care-takers within the family for providing health care to the elderly.
- To provide referral services to the elderly patients through district hospitals, regional medical institutions

Convergence with National Rural Health Mission, AYUSH and other line departments like Ministry of Social Justice and Empowerment.

Core Strategies

- Community based primary health care approach including domiciliary visits by trained health care workers.
- Dedicated services at PHC/CHC level including provision of machinery, equipment, training, additional human resources (CHC), IEC, etc

- Dedicated facilities at District Hospital with 10 bedded wards, additional human resources, machinery & equipment, consumables & drugs, training and IEC
- Strengthening of 8 Regional Medical Institutes to provide dedicated tertiary level medical facilities for the Elderly, introducing PG courses in Geriatric Medicine, and in-service training of health personnel at all levels Information, Education & Communication (IEC) using mass media, folk media and other communication channels to reach out to the target community
- Continuous monitoring and independent evaluation of the Programme and research in Geriatrics and implementation of NPHCE

Supplementary Strategies

- Promotion of public private partnerships in Geriatric Health Care.
- Mainstreaming AYUSH – revitalizing local health traditions, and convergence with programmes of Ministry of Social Justice and Empowerment in the field of geriatrics.
- Reorienting medical education to support geriatric issues.

Expected Outcomes

- Regional Geriatric Centres (RGC) in 8 Regional Medical Institutions by setting up Regional Geriatric Centres with a dedicated Geriatric OPD and 30-bedded Geriatric ward for management of specific diseases of the elderly, training of health personnel in geriatric health care and conducting research;
- Post-graduates in Geriatric Medicine (16) from the 8 regional medical institutions;
- Video Conferencing Units in the 8 Regional Medical Institutions to be utilized for capacity building and mentoring;
- District Geriatric Units with dedicated Geriatric OPD and 10-bedded Geriatric ward in 80-100 District Hospitals;
- Geriatric Clinics/Rehabilitation units set up for domiciliary visits in Community/Primary Health Centres in the selected districts;
- Sub-centres provided with equipment for community outreach services;
- Training of Human Resources in the Public Health Care System in Geriatric Care.

Source: Operational guidelines of NPHCE / NHM-Ministry of Health & Family Welfare

9

National Rabies Control Programme

Background

Rabies is responsible for extensive morbidity and mortality in India. The disease is endemic throughout the country. With the exception of Andaman & Nicobar and Lakshadweep Islands, human cases of rabies are reported from all over the country. The cases occur throughout the year. About 96% of the mortality and morbidity is associated with dog bites. Cats, wolf, jackal, mongoose and monkeys are other important reservoirs of rabies in India. Bat rabies has not been conclusively reported from the country.

To address the issue of rabies in the country, National Rabies Control Programme was approved during 12th FYP by Standing Finance Committee meeting held on 03.10.2013 as Central Sector Scheme to be implemented under the Umbrella of National Health Mission.

Objectives

- Training of Health Care professionals on appropriate Animal bite management and Rabies Post Exposure Prophylaxis.
- Advocacy for states to adopt and implement Intradermal route of Post exposure prophylaxis for Animal bite Victims and Pre exposure prophylaxis for high-risk categories.
- Strengthen Human Rabies Surveillance System.
- Strengthening of Regional Laboratories under NRCP for Rabies Diagnosis.
- Creating awareness in the community through Advocacy & Communication and Social Mobilization.

Programme components

- The Programme had two components – Human and Animal Components.
- Human Component for roll out in the all States and UTs through nodal agency National Centre for Disease Control (NCDC), Ministry of Health & Family Welfare, Government of India
- Animal Health Component for pilot testing in Haryana and Chennai through nodal agency Animal Welfare Board of India (AWBI) under the aegis of MoEF&CC, GOI.

- Animal Health Component by AWBI has been ended with effect from 31.3.2017. The Human Health Component has been rolled out in 26 States and UTs.

Strategies

Provision of rabies vaccine & rabies immunoglobulin through national free drug initiatives training on appropriate animal bite management, prevention and control of rabies, surveillance and intersectoral coordination strengthening surveillance of animal bites and rabies deaths reporting creating awareness about rabies prevention.

Source: Operational guidelines of NRCP / NHM

10

National Programme for Palliative Care (NPPC)

Brief Description

Palliative care is also known as supportive care which is required in the terminal cases of Cancer, AIDS etc. and can be provided relatively simply and inexpensively. Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources. It can be provided in tertiary care facilities, in community health centres and even in patients' homes. It improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement.

The Ministry of Health & Family Welfare, Government of India constituted an expert group on Palliative care which submitted its report 'Proposal of Strategies for Palliative Care in India' in November, 2012. On the basis of the Report, an EPC note for 12th Five Year Plan was formulated. No separate budget is allocated for the implementation of National Palliative Care Program. However, the Palliative Care is part of the 'Mission Flexipool' under National Health Mission (NHM).

A model PIP, a framework of operational and financial guidelines, for the states has been designed. On the basis of a model PIP, the states/UTs may prepare their proposals related with Palliative Care and incorporate them in their respective PIPs to seek financial support under NHM.

Goal

Availability and accessibility of rational, quality pain relief and palliative care to the needy, as an integral part of Health Care at all levels, in alignment with the community requirements.

Objectives

- Improve the capacity to provide palliative care service delivery within government health programs such as the National Program for Prevention and Control of Cancer, Cardiovascular Disease, Diabetes, and Stroke; National Program for Health Care of the Elderly; the National AIDS Control Program; and the National Rural Health Mission.

- Refine the legal and regulatory systems and support implementation to ensure access and availability of Opioids for medical and scientific use while maintaining measure for preventing diversion and misuse
- Encourage attitudinal shifts amongst healthcare professionals by strengthening and incorporating principles of long-term care and palliative care into the educational curricula (of medical, nursing, pharmacy and social work courses).
- Promote behaviour change in the community through increasing public awareness and improved skills and knowledge regarding pain relief and palliative care leading to community owned initiatives supporting health care system.
- Develop national standards for palliative care services and continuously evolve the design and implementation of the National program to ensure progress towards the vision of the program.

Implementation mechanism

It is envisaged that activities would be initiated through National Program for prevention and control of cancer, CVD, Diabetes & Stroke. The integration of national programs are being attempted under the common umbrella for synergistic activities. Thus, strategies proposed will provide essential funding to build capacity within the key health programs for non-communicable disease, including cancer, HIV/AIDS, and efforts targeting elderly populations. Working across ministries of health and finance, the program will also ensure that the national law and regulations allow for access to medical and scientific use of Opioids.

The regulatory aspects, as mentioned in the Program, for increasing Morphine availability would be addressed by Department of Revenue in coordination with Central Drug Standards Control Organization. Cooperation of international and national agencies in the field of palliative care would be taken for successful implementation of the program.

The major strategies proposed are provision of funds for establishing state palliative care cell and palliative care services at the district hospital.

Source: Operational Guidelines of NPPC / NHM

11

National Iodine Deficiency Disorders Control Programme (NIDDCP)

Introduction

Iodine is an essential micronutrient required daily at 100-150 micrograms for normal human growth and development. Deficiency of iodine can cause physical and mental retardation, cretinism, abortions, stillbirth, deaf mutism, squint & various types of goiters.

Realizing the magnitude of the problem, the Government of India launched a 100 per cent centrally assisted National Goiter Control Programme (NGCP) in 1962. In August, 1992 the National Goiter Control Programme (NGCP) was renamed as National Iodine Deficiency Disorders Control Programme (NIDDCP) with a view of wide spectrum of Iodine Deficiency Disorders like mental and physical retardation, deaf mutism, cretinism, still births, abortions etc. The programme is being implemented in all the States/UTs for entire population.

Goal

- To bring the prevalence of IDD to below 5% in the country
- To ensure 100% consumption of adequately iodated salt (15ppm) at the household level.

Objectives

- Surveys to assess the magnitude of Iodine Deficiency Disorders in the districts.
- Supply of iodated salt in place of common salt.
- Resurveys to assess iodine deficiency disorders and the impact of iodated salt after every 5 years in the districts.
- Laboratory monitoring of iodated salt and urinary iodine excretion.
- Health Education and Publicity.

Policy

On the recommendations of Central Council of Health in 1984, the Government took a policy decision to Iodate the entire edible salt in the country by 1992. The programme

started in April, 1986 in a phased manner. To date, the annual production of iodated salt in our country is 65 lakh metric tones per annum.

Nodal Ministry: Ministry of Health & Family Welfare is the nodal Ministry for implementation of National Iodine Deficiency Disorders Control Programme (NIDDCP).

Under NIDDCP financial assistance is also being provided to Salt Commissioner's Office, Jaipur, (M/o Industries) which is responsible for promoting production of iodated salt, monitoring, distribution and quality control of Iodated salt at the production level through nine quality control laboratories.

Source: Operational guidelines of NIDDCP / NHM/MoHFW

12

Integrated Disease Surveillance Programme

Integrated Disease Surveillance Project (IDSP) was launched by Hon'ble Union Minister of Health & Family Welfare in November 2004 for a period upto March 2010. The project was restructured and extended up to March 2012. The project continues in the 12th Plan with domestic budget as Integrated Disease Surveillance Programme under NHM for all States with Budgetary allocation of 640 Cr.

A Central Surveillance Unit (CSU) at Delhi, State Surveillance Units (SSU) at all State/UT headquarters and District Surveillance Units (DSU) at all Districts in the country have been established.

Mission

To strengthen the disease surveillance in the country by establishing a decentralized State based surveillance system for epidemic prone diseases to detect the early warning signals, so that timely and effective public health actions can be initiated in response to health challenges in the country at the Districts, State and National level.

Mandate/ Objectives

- Integration and decentralization of surveillance activities through establishment of surveillance units at Centre, State and District level.
- Human Resource Development – Training of State Surveillance Officers, District Surveillance Officers, Rapid Response Team and other Medical and Paramedical staff on principles of disease surveillance.
- Information Communication Technology - for collection, collation, compilation, analysis and dissemination of data.
- Strengthening of public health laboratories.

Programme Components

- Integration and decentralization of surveillance activities through establishment of surveillance units at Centre, State and District level.

- Human Resource Development – Training of State Surveillance Officers, District Surveillance Officers, Rapid Response Team and other Medical and Paramedical staff on principles of disease surveillance.
- Use of Information Communication Technology for collection, collation, compilation, analysis and dissemination of data.
- Strengthening of public health laboratories.
- Inter sectoral Co-ordination for zoonotic diseases

Type of Surveillance

- Syndromic: Information of diseases on the basis of clinical pattern by paramedical personnel and members of community.
- Presumptive: Diagnosis made on typical history, pattern and clinical examination by medical officers
- Confirmed: Clinical diagnosis by medical officer confirmed by positive laboratory investigation.

Five-year Strategic plan for IDSP-IHIP

Building on the Vision and SWOT analysis this section proposes a time-bound road map for institutionalization of the IDSP-IHIP within the MOHFW and the NCDC. Four distinct phases, some of which will run in parallel, are proposed for implementation of this roadmap.

Institutionalization (2023-24):

During this phase, the core IT and programming including cloud storage will shift from the WHO to the MOHFW/NCDC. The MOHFW has established a new central health information unit/health observatory at the National Institute of Health and Family Welfare to guide this process under the leadership of the Ministry's e-Health division.

The MOHFW is in advanced stage of procuring services of an agency to operate a dedicated Technical Support Unit (TSU) with about eighteen IT experts including programmers, specialists in application development, data analytics and AI to facilitate full institutionalization of IHIP within its domain.

Appropriate hardware and cloud servers need to be put in place quickly to support this process. In addition, the 24/7 help services and backup support systems should be sustained and further strengthened.

As this process moves forward, The IDSP CSU team needs to develop core in-house skills to steer the process and effectively manage the TSU to ensure timely delivery of services and products as per the contract. The WHO has indicated its willingness to support this transition and provide required hand holding support to IDSP till the systems get established and fully functional. A transition team from WHO consisting of programmers, public health specialists and experts in data analytics including could backup is placed at the IDSP to facilitate this process.

Key performance Indicators:

- MOHFW approves financing plan for IHIP institutionalization and scaleup- July 31,2023
- IDSP-IHIP TSU is fully in position by August 1, 2023
- Transition of IDSP-IHIP to MOHFW/NCDC fully accomplished by March 31, 2024

Expansion (2024-2025)

During this phase four specific areas of expansion will receive priority focus by the IDSP CSU, NCDC and MOHFW.

First, sustained high level advocacy will be undertaken with remaining two states (Kerala and West Bengal) to bring them on board to start real-time reporting using IHIP. Continued engagement with all States and UTs will be continued in this phase to sustain timely and high-quality reporting by public sector units including effective use of automated alert systems to promptly identify unusual health events/outbreaks, pinpoint vulnerable populations through GIS to ensure a well-coordinated comprehensive response for containment. The CSU supported by the Regional NCDCs will support competency-based capacity building of States and District Surveillance Units in data analytics and high-quality outbreak response including documentation through weekly epidemiological bulletins. Back-up systems will be in place to ensure there is no down time during system glitches (if any) thereby minimizing risks of downtime.

Second, the introduction of innovations to augment engagement with the private sector. Building on the ongoing options emerging from consultations with the private sector a comprehensive engagement strategy including financing for enhanced private sector participation in India's disease surveillance will be developed. After obtaining MOHFW endorsement and budget, the private sector partnership strategy will be rolled out giving priority to PMJAY hospitals, medical colleges and attached laboratories.

Third, continuation of ongoing data integration initiatives by linking more national health programs and establish linkages with other One health surveillance systems with the IHIP. There will be enhanced advocacy efforts to engage program managers and policy makers of remaining national health programs as well as improving case-based reporting by linking IHIP with ABHA health records.

Fourth, establishing partnerships with other countries in South Asia region and international peers by creating a joint learning network in disease surveillance and applied epidemiology.

Key performance indicators:

- Increase in public sector reporting units meeting performance parameters.
- Endorsement of Private sector strategy by MOHFW for rolling out of private sector strategy by April 2024.
- Increase in % of selected private hospitals and laboratories reporting regularly on IHIP.
- The IHIP will have linkages with National Animal Disease Surveillance system.
- Number of State/District Surveillance officers having competency in data analytics and implementing high-quality outbreak response.
- Increase in national health programs/ABHA digital health records integrated with IHIP.

Consolidation: (2025-2028):

In this phase, the emphasis will be on consolidation of gains made and promote efforts improve quality and consistency of real-time reporting by both public

and private sector players. Efforts will be made to further enhance private sector engagement involving smaller hospitals and solo practitioners including development of mobile applications for SOS reporting. The CSU will establish performance bench marking system for the IHIP in consultation with states and assess system performance during outbreaks/simulation exercises. The feedback will be confidentially shared with states and additional hand holding support will be provided to those lagging. Weekly IDSP-IHIP bulletin will be published describing trends in priority diseases and syndromes including morbidity and mortality with case studies on outbreak investigations.

Key performance indicators:

- IDSP-IHIP performance benchmarking system established through a consultative process.
- Increase in private sector reporting with participation of smaller private hospitals and solo practitioners in IHIP.
- Number performance appraisals/simulation exercise undertaken by CSU IDSP.
- Number of new publications by the CSU, IDSP in peer reviewed journals.

Innovation (2028 onwards):

By 2008 the IHIP system is expected to be fully stabilized, financing will be sustained, and more emphasis will be given to system improvements and introduction of new innovations in reporting and data analytics including application of AI. In addition, linkages with nonhealthy information systems/data bases such as animal health, climate change, water and sanitation, population mobility etc. will be further enhanced.

Key performance indicators:

- Sustained financing for IDSP-IHIP by MOHFW.
- Number of new modules added to the IHIP to improve reporting.
- Mobile application introduced to improve reporting of health events by citizens.
- Increase in number of non-health information systems integrated with IHIP.

Key syndromes and diseases under IDSP- IHIP, India

1. Only Fever >= 7 days
2. Only Fever < 7 days
3. Fever with Rash
4. Fever with Bleeding
5. Fever with Altered sensorium
6. Cough <= 2 weeks with fever
7. Cough <= 2 weeks without fever
8. Cough > 2 weeks with fever
9. Cough > 2 weeks without fever
10. Jaundice of < 4 weeks
11. Acute Flaccid Paralysis
12. Animal Bite - Snake Bite
13. Animal Bite - Dog Bite
14. Animal Bite – Others
15. Acute Diarrheal Disease
16. Acute Encephalitic Syndrome
17. Acute Hepatitis
18. ARI/Influenza Like Illness (ILI)
19. Severe Acute Respiratory Infection (SARI)
20. Dysentery
21. Anthrax
22. Chickenpox
23. Chikungunya
24. Crimean-Congo Hemorrhagic Fever

25. Dengue
26. Diphtheria
27. Human Rabies
28. Kayasanur Forest Disease
29. Leptospirosis
30. Malaria
31. Measles
32. Meningitis
33. Mumps
34. Pertussis
35. Scrub Typhus
36. Typhoid

Source: https://idsp.mohfw.gov.in/showfile.php?lid=7047 / https://idsp.mohfw.gov.in/index.php

13

National Vector Borne Disease Control Programme (NVBDCP)

The National Vector Borne Disease Control Programme (NVBDCP) is an umbrella programme for prevention and control of vector borne diseases (VBDs), viz., Malaria, Lymphatic Filariasis, Kala-azar, Dengue, Chikungunya and Japanese Encephalitis (JE). These diseases pose major public health problems and hamper socio-economic development. Generally, the rural, tribal and urban slum areas are inhabited mostly by people of socio-economic groups who are more prone to develop VBDs and are considered as high-risk groups.

About 75 million malaria cases and 0.8 million deaths were estimated annually during pre-Independence era. Malaria morbidity and mortality had affected agriculture, industrial development and national economy. Repeated attacks of malaria were responsible for deterioration in mental and physical capabilities resulting into enormous loss of productive man days. Global experience in malaria control and availability of the cost-effective intervention measures for malaria control with use of insecticides in fifties indicated that with their effective and efficient use, malaria could be controlled or even eradicated within a short period. Considering this concept, after independence, a centrally sponsored National Malaria Control Programme (NMCP) was launched in 1953 for malaria control in high endemic areas. This was modified in 1958 to a countywide National Malaria Eradication Programme (NMEP) in view of spectacular success of NMCP. The success achieved in preventing deaths due to malaria and also reducing annual malaria incidence to an all-time low of 0.1 million cases by 1965 could not be sustained because of various technical, administrative and financial constraints. Resurgence of malaria became noticeable in 1976 with 6.47 million cases that necessitated launching of the Modified Plan of Operation (MPO) in 1977 with the immediate objectives to prevent deaths and to reduce morbidity due to malaria. MPO successfully brought down annual incidence of malaria from 6.47 million (0.85 million P. falciparum) in 1976 to 2.18 million cases (0.65 million P. falciparum) by 1984. The developmental activities like rapid and unplanned urbanization, construction, river valley projects, mega-industry, irrigation projects, etc. with deficient water management and inadequate mosquito control provisions again led to increased malaria incidence.

Migration of population from endemic to other areas on account of such developmental projects also increased malaria transmission.

A major outbreak of malaria was reported from Rajasthan in 1994 which led to high level review by the then Prime Minister on 5th December, 1994. As a follow up of programme review, an Expert Committee was constituted which submitted its report on 27th January, 1995. Based on the recommendations of the Expert Committee, a Malaria Action Programme (MAP) 1995 was developed and disseminated to the states and Union Territories for prioritizing the high-risk areas for implementation of revised strategy accordingly. During this period outbreaks were also reported from other states like Nagaland, Manipur, Gujarat Goa and Haryana. As a result of these outbreaks the annual incidence of malaria reached up to 3.04 million cases in 1996. By adapting MAP with focused approach and additional inputs provided to high endemic areas, the annual incidence of malaria was brought down to 1.51 million cases by the year 2007.

To tackle malaria problem in high-risk areas other than North-Eastern (NE) states, an "Enhanced Malaria Control Project (EMCP)' with the assistance of World Bank was implemented during 1997-2005 with additional inputs in human resource, effective insecticidal spraying and IEC/BCC activities along with capacity building. The malaria incidence reduced in the project areas significantly. The strategies were focused on control of malaria; hence, the programme was changed from NMEP to National Anti-Malaria Programme (NAMP) during the year 1998. To sustain the impact of this project, 124 high endemic districts in 9 states have been identified for additional inputs through World Bank assisted Project in 2008 for a period of five years which is being implemented from 2009.

In North Eastern states, malaria control activities were intensified with additional financial supports provided under Global Fund supported Intensified Malaria Control Projects (IMCP) from July 2005 to June 2010. The Global Fund Supports have been extended through another Global Fund supported project Round 9 for a period of further five years (from Oct 2010 to Sep.2015) to cover all 86 districts of seven North-Eastern States.

The prevention and control of other vector borne diseases namely Lymphatic Filariasis, Kala- azar, was also being dealt by the Directorate of NAMP in addition to need based support for Japanese Encephalitis and Dengue. In view of synergies in prevention & control of vector borne diseases including Japanese Encephalitis and Dengue, the programme was renamed as National Vector Borne Disease Control Programme in the year 2003 with the integration of three ongoing centrally sponsored schemes viz., NAMP, NFCP and Kala-Azar Control Programme and converging prevention and control of JE and Dengue. In the year 2006, Chikungunya re-emerged in country and was also brought under purview of this Directorate since 2006.

Urban Malaria Scheme (UMS)

The implementation of control measures under erstwhile 'NMEP' showed reducing malaria incidence in rural areas of the country till 1965, but at the same time increasing trend of malaria was observed in some towns/ cities as a result of which, Madhok Committee (1969) reviewed the problem and found that 10 urban areas in Andhra Pradesh and Tamil Nadu contributed 11.2% of the total malaria cases in the two states during 1963. The Committee felt that if effective antilarval measures were not undertaken in urban areas, the proliferation of malaria cases from urban to rural areas might occur in a bigger way in many states and recommended adequate central assistance for tackling the problem. Accordingly, the 'Urban Malaria Scheme' was approved during 1971 as 100% centrally sponsored scheme which from 1979-80 was changed to 50:50 sharing basis between central and state governments. The UMS scheme was scaled up in phased manner by including 23 towns in 1971-72; 5 in 1972-73; 87 in 1977-78; 38 in 1978-79; 12 in 1979-80 and 17 in 1980-81 making total towns of 182. Since states have the responsibility of providing human resource and infrastructure, the scheme could be implemented only in 131 towns for which GoI is supplying antilarval. The drugs are made available through states. At present Urban Malaria Scheme is protecting about 116 million people from malaria and other mosquito borne diseases in 131 towns.

National Filaria Control Programme (NFCP)

The programme was launched in 1955 to delimit the problem and implement the treatment of microfilaria carriers and disease cases with Diethylcarbamazine tablets along with anti-larval measures in urban areas. Filaria is endemic in 20 States/UTs except Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, Sikkim, Jammu & Kashmir, Himachal Pradesh, Haryana, Punjab, Chandigarh, Rajasthan, Uttarakhand and Delhi and NFCP activities are implemented through 206 control Units, 224 Filaria Clinics and 22 Filaria Survey Units located in urban areas of endemic states. The programme has

undergone various paradigm shifts and revised the strategy. Currently the disease has been targeted for elimination which is defined as “Microfilaria carrier rate less than 1% and the children born after initiation of elimination activities are free from circulating antigenemia (presence of adult filaria worm in human body)”. The strategy of elimination is interruption of transmission by annual Mass Drug Administration (MDA) with DEC and Albendazole to the population living at risk of LF excluding children below 2 years, pregnant women and seriously ill persons. This programme is being implemented in 250 LF endemic districts since 2004.The anti-larval operations in 227 towns covered under NFCP is continued and the budget of NFCP merged with UMS for this support. As per National Health Policy 2002, LF is targeted for elimination by 2015.

Kala-azar Elimination Programme

Kala-azar was highly endemic in India during pre-DDT era and had affected economic growth of country due to its high morbidity and mortality rates. Cyclic epidemics used to occur with an inter-epidemic period of about 10 years or more. With the launching of extensive insecticidal spraying under National Malaria which, Madhok Committee (1969) reviewed the problem and found that 10 urban areas in Andhra Pradesh and Tamil Nadu contributed 11.2% of the total malaria cases in the two states during 1963. The Committee felt that if effective antilarval measures were not undertaken in urban areas, the proliferation of malaria cases from urban to rural areas might occur in a bigger way in many states and recommended adequate central assistance for tackling the problem. Accordingly, the ‘Urban Malaria Scheme’ was approved during 1971 as 100% centrally sponsored scheme which from 1979-80 was changed to 50:50 sharing basis between central and state governments. The UMS scheme was scaled up in phased manner by including 23 towns in 1971-72; 5 in 1972-73; 87 in 1977-78; 38 in 1978-79; 12 in 1979-80 and 17 in 1980-81 making total towns of 182. Since states have the responsibility of providing human resource and infrastructure, the scheme could be implemented only in 131 towns for which GoI is supplying antilarval. The drugs are made available through states. At present Urban Malaria Scheme is protecting about 116 million people from malaria and other mosquito borne diseases in 131 towns.

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Dengue, Chikungunya and JE

For prevention and control of these viral diseases, there were no separate programmes but need based assistance and technical supports were being provided by the Directorate. However, during 11th Plan period, separate budgeting was planned and various initiatives were taken to prevent outbreaks and contain the disease by strengthening surveillance, diagnosis, case management and awareness etc.

Entomological Surveillance

The three important components of vector borne disease transmission are causative organism (parasite or pathogen), human being as host and the transmitting agent – the vector. Not all the mosquitoes transmit the disease, hence the knowledge about the capacity of disease-causing vectors to transmit disease and their predominance in terms of time and space are very crucial to facilitate the decision about their control strategies. Entomological surveillance covers all these aspects and for such entomological surveillance, 72 zonal malaria offices were established in the country with support of entomologists, insect collectors and support staff. The expenditure on this human resource is met by the States from state resources. In addition, 16 Regional Offices for Health & FW, GoI were also equipped with entomologists for carrying out entomological activities in addition to other public health activities. Gradually, due to non-adherence of due importance to the entomological work and inability to fill up many vacant posts by the States, the progress on entomological surveillance has suffered. However, some states like Tamil Nadu, Andhra Pradesh, Gujarat and Maharashtra etc. have attached more importance on zonal teams and strengthened them with entomologists and better infrastructure supports. Presently out of 72 zones, only 50% are functional. To generate latest information about various entomological parameters in the country for revising prevention and control strategies against vectors at national, state and local level, the entomological zones need to be strengthened with additional human resource and infrastructure with basic minimum facilities like mobility support for field visits etc.

Objectives under NVBDCP:

During XI Plan, following objectives were enlisted:

- To prevent mortality due to Vector Borne Diseases Namely Malaria, Kala-azar, Dengue/DHF and Japanese Encephalitis
- To reduce morbidity due to Malaria, Dengue/DHF, Chikungunya and Japanese Encephalitis Elimination of Kala-azar and Lymphatic Filariasis.

In pursuance to achieve the objectives under NVBDCP, Government of India has taken various initiatives and set the goal as under

- To reduce the case incidence including morbidity on account of malaria, dengue, chikungunya and Japanese encephalitis by 50% by 2017,
- To achieve elimination of Kala-azar and lymphatic filariasis by 2015.

Initiatives taken by GoI

The programme has also been subsumed under National Rural Health Mission (NRHM) to improve the availability of services and access to health care to people, especially for those residing in rural areas, the poor, women and children.

Malaria:

- Strengthening of Human Resource by providing Contractual male Multi-Purpose Workers (MPW), Lab. Technicians, District Vector Borne Disease Consultants, Malaria Technical Supervisor (MTS) and Involvement of ASHAs in high malaria endemic districts for diagnosis & treatment by imparting training and providing them performance based incentive @ Rs.5 for preparing blood slide, Rs.20 for complete treatment of malaria positive cases detected through Rapid Diagnostic Test (RDT) and Rs.50 for complete treatment of malaria positive case detected by microscopy, in identified high malaria endemic districts.
- Up-scaling use of RDT in the periphery through peripheral health workers and involving ASHAs.
- Expansion of effective drug – Artemisinin-based Combination Therapy (ACT) for all falciparum cases in the entire country (extending to village level).
- Up-scaling of use of Long-Lasting Insecticidal Nets (LLIN) in high malaria endemic areas supported under externally assisted projects. Focused intervention in high malaria endemic districts with intensified supervision and monitoring.
- Identification of Sentinel surveillance hospital in high malaria endemic districts with strengthening of referral services for management of severe cases of malaria and avert malaria deaths. Dengue & Chikungunya:
- A Long-Term Action Plan was developed and sent to the States in 2007. Further in 2011, the Mid Term Plan for prevention and control of dengue has been developed which was approved by Committee of Secretaries (CoS) under the chairpersonship of Cabinet Secretary on 26.05.11.
- Diagnostic facilities have been increased from 170 Sentinel Surveillance Hospitals (SSH) to 311 which are linked to 14 Apex Referral Laboratories.
- Introduced ELISA based NS1 tests (antigen based) which can detect a case from the 1st day of disease in addition to existing Mac ELISA test (antibody based) which can detect a case only after 5th day of the disease.
- Monitoring of vector population in vulnerable areas.
- With the initiative of GOI, NIV field Unit at Allapuzha, Kerala has been established to strengthen the surveillance of Arbo-viral diseases in the State.

- Capacity building for the medical officers in case management.
- Intensive social mobilization campaigns through IEC/BCC activities and community participation in reducing breeding of mosquitoes.

Japanese Encephalitis (JE):

- Vaccination for Japanese Encephalitis under Routine Immunization in endemic districts.
- Special vaccination campaign in 7 districts of Uttar Pradesh and 2 districts of Assam.
- Strengthening of Sentinel Surveillance Hospitals for diagnosis of JE cases and treatment facilities at peripheral level.
- Strengthening of trained manpower.
- Involvement of Medical Colleges in AES/JE control programme.
- JE sub-office of Regional Office for Health & Family Welfare (ROH&FW) which is manned by Public Health Specialist has been established in Gorakhpur.
- GOI has also established Vector Borne Disease Surveillance Unit (VBDSU) at BRD Medical College, Gorakhpur for taking timely preventive measures.
- With the initiative of GOI, NIV field Unit at Gorakhpur has been established for detection and isolation of non-JE viruses.
- A model action plan to strengthen public health measures for prevention and control of JE/AES was developed at Kushinagar, Uttar Pradesh under the chairmanship of DGHS, GoI in consultation with state health authorities and other stakeholders and same is under implementation.
- Following the visit of Honorable Union Minister of Health & Family Welfare to Gorakhpur, it was suggested to evolve a multi-pronged strategy towards prevention and control of JE/AES which resulted in the formation of Group of Ministers (GoM) constituted on 4th Nov. 2011. The recommendations of GoM have been approved by the cabinet for establishing National Programme for prevention & control of JE/AES in 60 high priority districts of 5 endemic states namely Assam, Bihar, Uttar Pradesh, Tamil Nadu and West Bengal.

Kala-azar:

- Up-scaling use of new diagnostic tools i.e. Rapid diagnostic test. Expansion of oral drug Miltefosine as the first line of treatment to all endemic districts in a phased manner.
- Incentives to Patient for loss of wages during the period of treatment.
- Free diet support to patient and one attendant.

- Incentive to Kala-azar activist / health volunteer / ASHA for referring a suspected case and ensuring complete treatment.
- Support to states for engaging 31 VBD Consultants and 186 Kala-azar Technical Supervisors (KTS) in 46 districts under World Bank Supported Project.

Elimination of Lymphatic Filariasis:

- Dissemination of guidelines for MDA and other technical aspects. Capacity building of states/districts and PHC.
- Prototype IEC material to all LF endemic states/UTs.
- Cash assistance for various activities towards LF elimination.
- Supply of drugs to all the endemic states. (This has been decentralized during 2011 to be procured by the state out of cash grant provided by GoI.

Source: Operational Guidelines of NVBDCP / https://ncvbdc.mohfw.gov.in/Doc/Annual-report-NVBDCP-2014-15.pdf

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National Leprosy Eradication Programme (NLEP)

National Leprosy Eradication Programme (NLEP), India is a Centrally Sponsored Scheme under the umbrella of National Health Mission (NHM). The primary goal of the Programme is to detect the of leprosy cases at an early stage and to provide complete treatment at free of cost, in order to prevent the occurrence of disabilities in the persons affected and stop the transmission of disease at the community level. The Programme also aims to spread awareness about the disease and reduce stigma attached with the disease

Leprosy is a chronic infectious disease caused by the bacteria M. Leprae. It can produce disability which is the main cause of stigma. The bacteria enter and exit the body through the respiratory tract. The incubation period is long and variable (Average 5-7 years).

Objective

- Reducing the Burden of Leprosy cases & improving the quality of services.
- Integration of Leprosy Services with Primary Health Care System.
- Referral Services & long-term care of cases.
- Prevention and Management of impairment and disability.
- Improving community awareness and involvement, Rehabilitation & Stigma Reduction.

PROGRAMME STRATEGY

To achieve the objectives of the plan, the main strategies to be followed are:

- Strengthening of integration of leprosy services through General Health Care system.
- Early detection & complete treatment of new leprosy cases.
- Carrying out house hold contact survey for early detection of hidden cases like FLC, ACD & RS.

- Involvement of Accredited Social Health Activist (ASHA) in the detection Follow-up & completion of treatment of Leprosy cases in time.
- Strengthening of Disability Prevention & Medical Rehabilitation (DPMR) services.
- Information, Education & Communication (IEC) & IPC activities in the community to improve self reporting to Primary Health Centre (PHC) and reduction of stigma.
- Intensive monitoring and supervision at all levels.

To make NLEP planning compliant with NHM guidelines, the following 8 results are to be achieved:

1. Improved early case detection.
2. Improve case management.
3. Stigma reduction.
4. Development of Leprosy expertise sustained.
5. Research supported evidence base programme practices. 6. Monitoring Supervision and Evaluation system improved.
6. Increased participation of Persons affected by Leprosy in Society.
7. Involvement of community in accepting persons affected by leprosy.
8. Programme management ensured.

PROGRAMME COMPONENTS

The following components are under NLEP:-

- Case Detection and Management – Active Case Detection & Regular Surveillance (ACD&RS), FLC, PEP etc.
- Disability Prevention and Medical Rehabilitation – RCS, MCR &Self-care Kits distribution to the patients etc.
- Information, Education and Communication (IEC) including Behaviour Change Communication (BCC)
- Capacity building
- Programme Management
- PPP activity.

NLEP Emblem

- Symbolizes beauty and purity in **lotus**:
- Leprosy can be cured and a leprosy patient can be a useful member of the society in the form of a partially affected thumb; a normal fore-finger and the shape of **house**;
- the symbol of hope and optimism in a **rising sun**.

NLEP – Milestones (1)

Year	PROGRAMME MILESTONES	Key implementations
Before 1955	Gandhi Memorial Leprosy Foundation (GMLF) Wardha / Hind Kusht Nivaran Sangh / NGOs	Survey, Education and Treatment (SET) programme Precursor for NLCP and organized leprosy control services
1955	National Leprosy Control Programme (NLCP)	LCU – 4.5 L popl, SET centres – PR 5/1000 Dapsone Monotherapy
1983	National Leprosy Eradication Programme (NLEP)	Introduction of MDT in Phases, initially high endemic districts Urban leprosy centres , Mobile treatment units
1991	World Health Assembly resolution – 44.9	Eliminate leprosy as PHP at global level by the year 2000 [PR < 1/10000 popl]
1993 – 2000	First phase World Bank supported project	MDT made available to all registered patients, NLEP extended to all districts in the country Midterm appraisal of NLEP (1997)
1998 - 04	Modified Leprosy Elimination Campaign (MLEC) SAPEL (2000)	Increasing awareness about leprosy, training to GHC personnel and to detect the hidden cases [> 1 Million cases detected] Difficult, inaccessible/hard to reach population

NLEP – Milestones (2)

Year	PROGRAMME MILESTONES	Key implementations
2001-04	World Bank supported project II phase	Decentralization of NLEP responsibilities, integration under general health care system, training GHC personnel, Surveillance for early diagnosis with prompt MDT, awareness for voluntary reporting
2002	National Health Policy 2002 Simplified Information System introduced	NHP set the goal of leprosy elimination by 2005 SIS - Better monitoring of NLEP with recording and reporting made easier for GHC staff.
2004-05	Block Leprosy Awareness Campaign (BLAC)	High priority districts & blocks with an aim to increase the awareness for self reporting, detection of hidden cases with capacity building of service providers
Dec 2005	Leprosy elimination as Public Health Problem	PR <1/10000 (0.95) elimination declared at the National level
2005	National Rural Health Mission (NRHM)	Vertical programme integrated with general health care system under NRHM Dist. Nucleus Team (DNT) – Health societies Urban leprosy control programme

NLEP – Milestones (3)

Year	PROGRAMME MILESTONES	Key implementations
2006	Disability Prevention & Medical Rehabilitation (DPMR) introduced	Guidelines for management at primary, secondary and tertiary level.
2012	12th plan [2012 – 2017]	Special action plan for 209 high endemic districts in 16 States/UTs Target to reduce the visible disabilities <1 per 10,00,000 population in by 2020.
2014	Upgraded Simplified Information System (USIS) implementation	ULF formats introduced for uniformity and better decision making
2016-17	Newer initiatives in the programme Three Pronged strategy Chemoprophylaxis	LCDC – 14 day active case detection campaign in high endemic districts FLC – non-endemic districts Special plan for hard to reach areas SDR implementation to eligible contacts of new cases Immunotherapy - MIP Vaccine as pilot phase
2017	Sparsh Leprosy Awareness Campaign (SLAC)	Increasing the awareness, addressing high level of stigma & discrimination - Convening special Grama sabha meeting

NLEP – Milestones (4)

Year	PROGRAMME MILESTONES	Key implementations
2017 - 18	Newer initiatives: Introduction of "NIKUSTH" ASHA based Surveillance for Leprosy Suspects (ABSULS)	Real time monitoring of leprosy patients across the country and facilitating better monitoring and evaluation of NLEP. ABSULS - active surveillance of leprosy suspects with prioritizing leprosy case detection by ASHA & treatment followup
2018 - 19	Sparsh Leprosy Elimination Campaign (SLEC) 150th Birth anniversary of Mahatma Gandhiji	Enhancement of recently launched initiatives – LCDC, SLAC G2D target to reduce <1case/Million & reduce backlog of RCS cases Grade II disability investigation
2018 -19	WHO Guidelines for Diagnosis, treatment and prevention of Leprosy	Evidence based recommendations in accordance with procedures established by the WHO Guidelines Review Committee Independent Evaluation of NLEP by WHO (2019)

Source: Operational guidelines of NLEP/NHM and https://cltri.gov.in/

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National Tuberculosis Elimination Programme (NTEP)

Introduction

The National Tuberculosis Programme of India (NTP) was initiated in 1962 and was originally designed for domiciliary treatment, using self- administered standard drug regimens. A combined review of the programme in 1992 concluded that the NTP could not achieve its objectives of TB control and hence, on the recommendations of an expert committee, a revised strategy to control TB was pilot-tested in 1993. A full-fledged programme was started in 1997 and rapidly expanded with excellent results. This Revised National Tuberculosis Control Programme (RNTCP) that uses the DOTS (Directly Observed Treatment, Short-course chemotherapy) strategy achieved country coverage on World TB Day, 24th March, 2006. The programme has achieved several milestones related to diagnosis and treatment services of TB since 2006. Since inception in 1997 and up to December 2015, more than 19 million patients were initiated on treatment and more than 3.5 million additional lives have been saved.

National AIDS Control Programme and RNTCP have developed a "National framework of joint TB/HIV Collaborative Activities". Nationwide coverage of services for programmatic management of drug-resistant TB, which began in 2007, has been achieved in March 2013. The Government is also proactively engaging with private practitioners, a number of private organizations, NGOs and professional bodies like Indian Medical Association, in order to enhance notification of TB cases. Central TB Division, in collaboration with National Informatics Centre, has developed a case-based web-based platform- 'Nikshay' in 2012, which has now been scaled up nationally.

The Standards for TB Care in India (STCI) have been published jointly by RNTCP and World Health Organization in 2014, which lays down uniform standards for TB care for all stakeholders in the country.

About NTEP:

National TB Elimination Programme is a Centrally Sponsored Scheme being implemented under the aegis of National Health Mission with resource sharing between the State Governments and the Central Government. It is managed by the Central TB Division (CTD), the technical arm of the Ministry of Health and Family Welfare

(MoH&FW). The CTD is assisted by six national level institutes, namely the National TB Institute in Bengaluru, the National Institute of TB and Respiratory Disease in New Delhi, the National Institute of Research in Tuberculosis in Chennai and the JALMA Institute of Leprosy and other Mycobacterial Diseases, Agra, BMHRC, Bhopal, and RMRC, Bhubaneshwar. Fourteen committees have been constituted at national level to provide technical guidance for programme implementation.

a. **At the State level,** State Health Secretary and MD-NHM are responsible for programme implementation in the State where in the planning, training, supervising and monitoring of the programme in their respective states is as per the guidelines of the State Health Society and CTD. State TB Training and Demonstration Centre (STDC) supports the State TB Cell in most of the larger states. State Drug Store (SDS) has been established for the effective management of anti-TB drug logistics. The STDC is supported by the State TB Forums for community engagement, State level PMDT committee for implementation guidance and review of PMDT, State level TB comorbidity coordination committee and Technical Working Group for HIVTB for smooth TB- comorbidity coordination. Nodal Drug Resistant TB centres are established for management of drug-resistant TB with newer drugs, adverse drug reactions and as referral unit.

b. **The district** is the key level for the management of the primary health care services. The District Tuberculosis Centre (DTC) is the nodal point for all TB control activities in the district and has the overall responsibility of management of NTEP at the district level as per the programme guidelines and the guidance of the District Health Society. District level TB comorbidity coordination committee is in-place for smooth TB comorbidity coordination.

c. **At the sub-district level** End TB activities are implemented through a Tuberculosis Unit (TU) which consists of a designated Medical Officer-Tuberculosis Control (MO-TC) supported by two full-time NTEP contractual supervisory staff exclusively for tuberculosis work - a Senior TB Treatment Supervisor (STS) and a Senior TB Laboratory Supervisor (STLS). The TU is generally aligned with the administrative blocks in the district with 1 STS /TU at NHM block or urban area (approx. pop 1.5-2.5 l) and 1 STLS /5 lac population (~ 5 DMCs).

d. **Peripheral Health Level:** For the purpose of NTEP, a Peripheral Health Institution (PHI) is a health facility which is manned by at least a medical officer. At this level there are public or private (including NGO supported) dispensaries, PHCs, CHCs,

referral hospitals, major hospitals, specialty clinics or hospitals, medical colleges. Some of these PHIs may also serve as a Tuberculosis Diagnostic Centers (TDCs), previously called Designated Microscopy Centre (DMC), which is the most peripheral level laboratory in the NTEP structure. Through these TDCs, tuberculosis case-finding activities take place. Treatment may be initiated at the PHIs and in some instances (such as drug-resistant TB) where initiation is at higher levels, the treatment of the patients may continue at PHI level. For establishment of a TDC in the lab of a PHC, it must have adequate physical infrastructure, binocular microscope and a trained LT.

e. **Ayushman Arogya Mandirs (AAMs):** Under Ayushman Bharat, around 1, 50,000 existing Sub- Health Centres (SHCs) and Primary Health Centers (PHCs) are being transformed to Ayushman Arogya Mandirs (AAMs) to deliver Comprehensive Primary Health Care (CPHC), that is universal and free to users, with a focus on wellness and the delivery of an expanded range of services close to the community. The wide range of services provided at these Ayushman Arogya Mandirs will encompass maternal and child health services, communicable and non-communicable diseases, services for the elderly and palliative care including free essential drugs and diagnostic services. For the treatment of tuberculosis, it will serve as the last level of healthcare facility for continuation of treatment and for receiving ancillary drugs to support TB treatment.

f. **Program Implementation Plan and Planning Process:** As with other components of NHM, financial support to NTEP is provided through the Program Implementation Plan (PIP) mechanism of the National Health Mission. NTEP / NHM follow a Bottom-Up approach for planning and budgeting. The process begins at the district level by NTEP preparing the district PIP at the District TB Centre (DTC) which gets incorporated into the integrated District Health Action Plan (IDHAP) which is further sent to the state level to form the State PIP. The PIP indicates the physical targets and budgetary estimates in accordance with the approved pattern of assistance under the NHM. This will cover all aspects of activities required to be carried out under NTEP in one financial year. The State PIPs are approved by the Union Secretary of Health and Family Welfare, as Chairperson of the EPC, based on appraisal by the National Programme Coordination Committee (NPCC) which is chaired by the Mission Director and includes representatives of the State, Technical and Programme divisions of the MoHFW, other Departments and Ministries, as required. The approved Record of Proceeding (ROP) includes Central as well as State share, and includes cash as well as commodity component. The preparation of the PIP follows a standardized template specified by the NHM.

g. **Collaborative activities with other NHM Components:** NTEP work in collaboration with other Programmes such as the National AIDS Control Organization (NACO) and the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS). Bi-directional screening for HIV and Tuberculosis, along with testing for Diabetes Mellitus is offered for all TB patients. Testing for co-morbidities is part of the bouquet of services provided to patients being treated under NTEP, in order to provide comprehensive care and support.

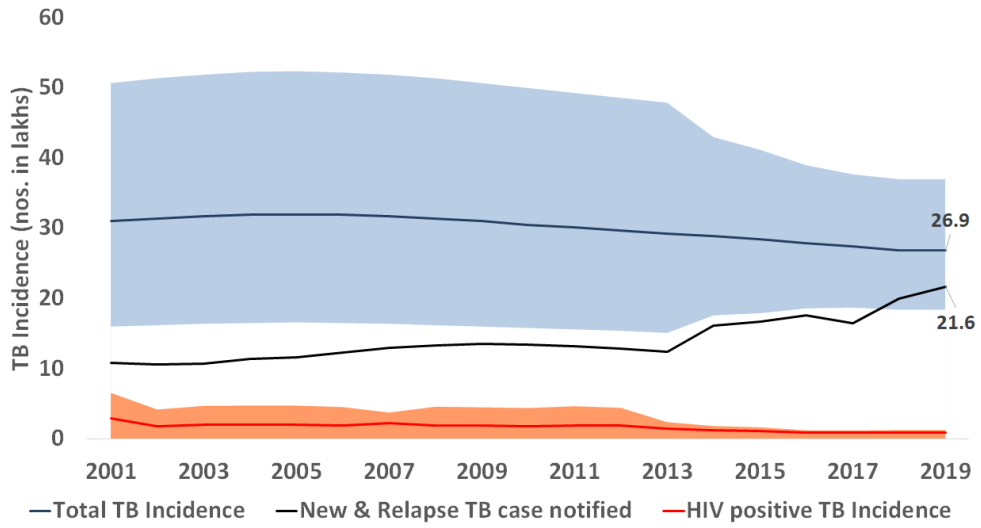
h. NTEP adopts the Health Systems Approach of the NHM, as per which the entire health system machinery works together to achieve common goals of improved health, better responsiveness and better financial protection to the patients. Human resources and infrastructure of the general health system and also of medical colleges are utilized to achieve maximum utility. For example, many drug-resistant TB treatment centres are situated in medical colleges, with medical college staff and infrastructure playing crucial role in the treatment of drug-resistant TB. Likewise, laboratory technicians from the general health system pool are re-appropriated for work under NTEP; a single counsellor in some low work-load districts/ blocks provides counselling support across various disease programmes, including Tuberculosis.

TB epidemiology in India

a. TB Incidence:

In 2019, India notified 24,04,815 (M-1511309, F-891210, TG-2296) patients, representing a 51% percent increase in total notifications as compared to 2015. The total estimated TB incidence in 2018 was 199 patients per 100,000 persons (Male – 239, Female – 156) (95% Confidence Limits [95%CL]: 136–273). TB incidence appears to be on the decline; with an 8.3 percent rate decrease since 2015 (2015 ir: 217; 95%CL: 112–355). These trends appear to be consistent among new, previously treated and HIV positive patients (Figure 4).

Trends in annual number of notified TB patients, estimated TB incidence among new, previously treated (relapse), and HIV positive – India: 2000–2019.
Source: World Health Organization. WHO Global TB Report, 2019. Data for 2019 from NTEP



It should be noted that current estimates of incidence rely on the extent of under-reporting (assumed at 40 percent based on expert opinion). However, recent analysis of private drug sales data suggested that that an enormous number of TB patients are seeking treatment in the private sector (1.2–5.3 million patients per year). While it is unknown how many of the patients studied were over-diagnosed, there are concerns that the true incidence may be much higher than has been estimated, despite consistent and stable trends in drug sales. The pending results of the national prevalence survey holds promise to recalibrate our assumptions and calculate more accurate burden estimates.

b. TB Prevalence

Direct estimates of TB prevalence have not been obtained since the first nationwide prevalence survey in 1955–1958. Current estimates for national TB prevalence are mathematically derived from previously conducted state-based surveys. In 2009, national TB prevalence was estimated at 301 per 100,000 population.

Nationwide national prevalence survey has begun (September 2019), and results from the 500,000 persons, 625 survey sites are likely to be available in 2021. In the interim, a recent publication summarized recent sub-national surveys and revealed wide geographic variation and discordance with the corresponding annual notification rates (Table 4).

c. TB Mortality

The estimated mortality rate in India declined from almost 58 deaths per lakh population (HIV-negative) in 2000 to 32 per lakh in 2018, while the global mortality rate declined at the same rate, from 30 per lakh to 16 per lakh.

Vision, Goals and Targets of NSP

The NSP proposes bold strategies with commensurate resources to rapidly decline TB incidence and mortality in India by 2025 to achieve the Sustainable Development Goals on its march towards attaining the vision of a TB-free India.

VISION

TB-Free India with zero deaths, disease and poverty due to TB

GOAL

To achieve a rapid decline in burden of TB, morbidity and mortality to achieve the Sustainable Development Goals of 80% reduction in incidence and 90% reduction in deaths by 2025; five years earlier of the global targets.

Objectives

Objective 1: Build, strengthen and sustain enabling policies, empowered institutions, multi-sectoral collaborations, engaged communities, and human resources with enhanced capacities to create a supportive ecosystem which accelerates **PREVENT – DETECT – TREAT** pillars to END TB.

Objective 2: Prevent the emergence of TB in vulnerable populations.

Objective 3: Early identification of presumptive TB, at the first point of contact (private or public sectors), and prompt diagnosis using high sensitivity diagnostic tests to provide universal access to quality TB diagnosis including drug resistant TB in the country.

Objective 4: Initiate and sustain, equitable access to free high quality TB treatment, care and support services responsive to the community needs thereby protecting the population especially the poor and vulnerable from TB related morbidity and mortality.

The NSP strategic framework

Significant progress has been made towards achieving the objectives laid down in the NSP 2017-25, especially in the last 3 years. The 2019 JMM provided NTEP with direction on the way forward to accelerate the progress towards ending TB. It recommended

comprehensively deployed interventions to accelerate the decline in TB incidence, to more than 6 - 7 % annually to achieve the 2030 SDG by 2025. The prerequisites for moving towards ending TB and ultimately TB elimination have been integrated into the four strategic pillars of **BUILD - PREVENT - DETECT – TREAT** to accelerate the achievement of programme goals**.** The following table describes the renewed approach to END TB in the country.

Table: Pillars, Objectives, Strategic area and Interventions in the NSP 2021-25

PILLAR 1: BUILD, STRENGTHEN AND SUSTAIN AN ENABLING ENVIRONMENT FOR TB ELIMINATION	
Objective 1. Build, strengthen and sustain enabling policies, empowered institutions, multi-sectoral collaborations, engaged communities, and human resources with enhanced capacities to create a supportive ecosystem which accelerates PREVENT – DETECT – TREAT pillars of the NSP	
SRATEGIC AREA: 1.1 to 1.14	**INTERVENTIONS**
1.1. Ensure a fully funded NSP	1.1.1 Improve health financing 1.1.2 Improve financial flow
1.2. Enhance the human resource and its management within the NTEP	1.2.1 Create and fill key positions in line with the scope of new NSP activities 1.2.2 Update the staffing structures for NTEP staff in the states. 1.2.3 Training 1.2.4 Strengthening the capacity of the STDCs to execute key functions
1.3. Increase efficiency and effectiveness of governance and programme management mechanisms for TB elimination	1.3.1. National TB Policy and TB Bill 1.3.2. Expedite setting up of prescribed governance structures 1.3.3. Extend the governance and management structures to the States and District 1.3.4. Strengthen governance for private sector engagement
1.4. Strengthen and scale-up the existing private sector engagement	1.4.1. Continue to Improve TB notification from private healthcare providers

	mechanisms with new additionalities to enlist greater pvt sector participation and programme reach	1.4.2. Strengthen collaboration with corporate hospitals 1.4.4. Improve access to diagnostics for TB patients notified from private sector 1.4.5. Improve access to drug for TB patients notified from private sector 1.4.6. Enhance Surveillance and Quality improvement 1.4.7. Expand ICT support to support the TB patients and private provider 1.4.8. Involvement of AYUSH Providers 1.4.9. Involvement of Health Establishments under other line Ministries, PSUs, Corporates, etc.
1.5.	Expedite multi sectoral collaboration with a focus on the implementation of multisectoral accountability framework	1.5.1. Adopt a National multisectoral accountability framework to end TB 1.5.2. Drive multisectoral action, based on the right to health, via a TB Elimination Board/Committees and state/local counterparts, and inter-sectoral committees 1.5.3. Strengthen the Inter ministerial committee 1.5.4. Actions to ensure major national initiatives/programmes are and can contribute to ending TB 1.5.5. Undertake mapping of key populations and interventions
1.6.	Support to create empowered and engaged communities to fight TB	1.6.1. Amplify and scale up active engagement of communities affected by Tuberculosis, especially TB survivors and key populations 1.6.2. Expand community participation in the mission to end TB 1.6.3. Build new need-based collaborations and strengthening current partnerships at national and sub-national levels with Community-Based and Civil Society Organizations 1.6.4. Institute mechanisms at various levels for ensuring accountability of the health system to the

		community and making the programme responsive to the community needs. 1.6.5. Explore innovative resource mobilization strategies for community engagement, including but not limited to leveraging CSR funds. 1.6.6. Build a knowledge base and sharing of experiences and good practices with potential for replication in different settings 1.6.7. Build capacity of community structures and institutions for supporting different facets of TB elimination
1.7.	Advocacy and strategic communication	1.7.1. Engage in high-level advocacy with the National Parliament and State Assemblies 1.7.2. Conduct round-the-year communication campaigns that are strategically designed in close collaboration with affected communities to influence positive behaviors and improved awareness. Implement, monitor and evaluate the impact of communication campaigns
1.8.	Enhance and strengthen surveillance, monitoring and evaluation of NTEP	1.8.1. Build and mentor a strong surveillance, epidemiology, and monitoring and evaluation workforce. 1.8.2. Use local data for local action; create process indicators that are vital for larger outcomes. 1.8.3. Develop user-friendly, virtual "workspaces" and data visualizations to prompt local public health action. 1.8.4. Accelerate alignment with all health information systems and applications. 1.8.5. Phase out paper-based recording systems.
1.9.	Research	1.9.1. Improve the institutional structure and capacity for TB research 1.9.2. Address issues related to Operational Research and Implementation Science 1.9.3. Undertake research in key priority areas like Case Finding,

	treatment, and prevention among different high-risk populations
1.10. Strengthen procurement and supply chain management	1.10.1 Create an alternative back-up mechanism to speed up procurement of drugs and diagnostics 1.10.2 Develop E-Pharmacy / commerce platforms to enable door-step delivery of drugs 1.10.3 Strengthening of procurement and supply chain management systems by upgrading institutional and individual capacities 1.10.4 Increase uptake of Digital Technologies for SCM 1.10.5 Create mechanisms for enabling the availability of NTEP drugs to patients in the private sector 1.10.6 Strengthening of Nikshay Aushadi 1.10.7 Improve supply chain efficiency and effectiveness 1.10.8 Strengthen and upgrade drug store infrastructure at state, district and block levels 1.10.9 Set up state level PSM units 1.10.10 Build capacity at state level 1.10.11 Establish / strengthen transportation system through third party logistics 1.10.12 Prepare and execute mechanism for thorough upkeep and uptime maintenance of Mobile Medical Vans & Equipment 1.10.13 Strengthen supervision and M&E in PSM 1.10.14 Establish Policies for decentralized write off up to 2% of cost of annual supply for expired drugs and commodities
1.11. Digital information ecosystem for TB care	1.11.1 Strengthen Central TB Division, to be equipped with resources to develop and maintain IT Systems, manage and use real time information for program management 1.11.2 Systems for monitoring TB Epidemiology, information dissemination and capacity building

	1.11.3 Strengthen National TB Call Centre for provision of comprehensive inbound and outbound call services.
1.12. Secure cutting-edge technical assistance	1.12.1. Strengthen the TSN and make TA responsive to the emerging TB landscape in India. 1.12.2. Extend TA to other line ministries 1.12.3. Expedite the establishment of the TSU's for high priority States 1.12.4. Create a platform/mechanism to enlist and provide information on the available TA subject experts
1.13. Address human rights and gender related barriers in access to TB services	1.13.1. Provide equitable, rights-based TB services for women, men and transgender persons by adopting a gender-specific programmatic approach at all levels 1.13.2. Mobilize, empower and engage women, men and transgender persons in the TB response at the health system and community levels 1.13.3 Create empowered community monitoring system for ensuring human right centric care for people affected by TB.
1.14. TB care in the era of COVID-19 : Build a resilient, responsive and agile NTEP to respond to complex emergencies	1.14.1. Leverage the momentum generated on anti-COVID-19 response across institutions, policies, regulations and behavioral risk communication for NTEP. 1.14.2. Pandemic preparedness actions 1.14.3. Pandemic response 1.14.4 Post pandemic restoration response
PILLAR 2: PREVENT	
Objective 2: Prevent the emergence of TB in vulnerable populations using a combination of biomedical, behavioral, social and structural targeted interventions.	
SRATEGIC AREA : 2.1 to 2.2	**INTERVENTIONS**
2.1. TB Preventive Treatment (TPT) and Programmatic management of TPT	**2.1.1** Saturation of TPT coverage and integrated monitoring of TPT among PLHIV, contacts of TB patient and other target populations

	2.1.2 Introduce and expand phase wise LTBI management coverage among adolescent and adult contacts in households, proximity contacts, vulnerable populations and workplace contacts 2.1.3 Introduce and expand coverage of newer and effective TPT diagnostics and shorter TB preventive treatment regimens 2.1.4 Expedite research and fast-tracking adoption of new products and innovations
2.2. Scale up TB - infection control (TB-IC) measures at home, community, and health care facilities	2.2.1 Enhance policy support and human and financial resources to mainstream Airborne Infection Control (AIC) 2.2.2 Strengthen AIC through effective implementation of administrative, environmental measures and personal protection measures at healthcare, community and workplace settings 2.2.3 Strengthened and responsive system for surveillance of TB among health workers
PILLAR 3: DETECT ALL	
Objective 3: Early identification of presumptive TB, at the first point of contact (private or public sectors), and prompt diagnosis using high sensitivity diagnostic tests to provide universal access to quality TB diagnosis including drug resistant TB in the country.	
SRATEGIC AREA: 3.1 to 3.3	**INTERVENTIONS**
3.1. Scale-up free, high sensitivity diagnostic tests and algorithms	3.1.1. Enhance the use of novel and improved strategies to enable diagnosis of latent as well as active TB (including DR TB) 3.1.2. Strengthen the laboratory and diagnostic systems to shift from sputum microscopy to molecular diagnostics for diagnosis of TB, in a phased manner 3.1.3 Strengthen efficient specimen transport mechanisms

	3.1.4 Establish and implement systems for monitoring of quality assurance and time-bound delivery of laboratory services
3.2. Intensify TB case finding efforts through a whole of sector approach to cover all programmes within the MOHFW and other line ministries	3.2.1 Create an Integrated diagnostic algorithm to detect all forms of TB (latent, active, and DR-TB) 3.2.2. Integrate TB diagnosis with public health laboratories at sub district levels within the existing health system and decentralize molecular diagnostics to block levels for extensive outreach 3.3.3. Conduct predictive analysis for hot spot identification and vulnerability mapping 3.3.4 Conduct systematic screening of high-risk / vulnerable groups through outreach and community-based approaches using digital x-rays and rapid and more sensitive molecular diagnostics 3.3.5 Institute systematic screening for TB symptoms in health care institutions/ OPDs including COVID screening 3.3.6 Intensified contact tracing/investigation using community-based and other approaches to cover households, proximal contacts and workplace settings and follow up
PILLAR 4: TREAT ALL	
Objective 4: Initiate and sustain, equitable access to free high quality TB treatment, care and support services responsive to the community needs thereby protecting the population especially the poor and vulnerable from TB related morbidity and mortality.	
STRATEGIC AREA 4.1 to 4.4	**INTERVENTIONS**
4.1. Strengthen treatment of DSTB	4.1.1. Continue with the current modalities for treatment that include daily regimens for DSTB and expand coverage among patients seeking care in the private sector

	4.1.2. Strengthen adherence monitoring and post treatment follow up for the prevention of relapse and development of drug resistance 4.1.3. Care cascade monitoring 4.1.4. Redesign Directly Observed Treatment (DOT) modalities and expand options for adherence monitoring and supervision through involvement of Ayushman Arogya Mandirs and innovative digital tools 4.1.5. Strengthen Clinical management support through tele-medicine and digital artificial intelligence driven tools 4.1.6. Strengthen implementation and monitoring of Pharmacovigilance for DS-TB and DR-TB	
4.2. Expand and strengthen treatment and management of DRTB	4.2.1 Introduction and scale up of effective all oral regimens with shortened duration 4.2.2 Estimate burden and protocols for addressing Non-tuberculous Mycobacteria (NTM) 4.2.3 Build capacity and linkages to existing programs for palliative care and rehabilitation.	
4.3. Address TB in priority populations and scale up integrated action on TB and comorbidities	4.3.1. Common strategic interventions for strengthening TB care services in priority populations 4.3.2 Pediatric TB and TB among Adolescent population 4.3.3. Malnutrition and TB 4.3.4. Alcohol dependence/substance use 4.3.5. Tobacco use 4.3.6. TB – Diabetes 4.3.7. TB-HIV	4.3.8. TB-Gender 4.3.9. TB-Pregnancy 4.3.10. TB in Congregate settings/incarcerated population including juveniles 4.3.11. TB-Geriatrics 4.3.12. TB-Mental Health 4.3.13. TB-Hepatitis 4.3.14. TB-Silicosis 4.3.15. Tribal TB 4.3.16. TB in urban slums

		4.3.17. TB among migrants 4.3.18. TB among Truckers, public transport workers 4.3.19. TB among TGs/MSMs/IDUs and Sex Workers 4.3.20 TB and COVID-19
4.4. Strengthen and expand coverage of patient support mechanisms	4.4.1 Expand the coverage of treatment adherence mechanisms for all TB patients. 4.4.2 Provide social benefits to patients available under NTEP and linkages to other relevant social support schemes with line ministries 4.4.3 Initial Screening and review of data and improvement of monitoring tools in Nikshay 4.4.4 Call Centre support for strengthening and monitoring treatment adherence	
4.5. Institutionalize mechanisms to monitor Catastrophic Health Expenditures (CHE) in persons affected by TB	4.5.1 Undertake regular analysis of CHE through dip-stick studies, review missions and direct patient feedback through national call center	

Source: National Tuberculosis Elimination Programme: NATIONAL STRATEGIC PLAN TO END TUBERCULOSIS IN INDIA 2020–25

16

National Programme for Prevention and Control of Non-Communicable diseases (NP-NCD)

Burden of Non-Communicable Diseases

Global Scenario:

The global NCD burden remains unacceptably high. NCDs are responsible for 41 million of the world's annual deaths. 17 million of these deaths were premature (30 to 70 years). Burden is greatest within low- and middle-income countries, where 77 percent of all NCD deaths and 80% of premature deaths occurred. Among NCDs, the four top killers that together account for more than 80% of all premature NCD deaths annually include cardiovascular diseases (17·9 million), cancers (9.3 million), chronic respiratory diseases (4.1 million), and diabetes (2.0 million).

Indian Scenario:

As per the WHO – NCD India profile - 2018, NCDs are estimated to account for 63% of all deaths in country of which cardiovascular diseases lead with 27% overall mortality cause followed by chronic respiratory diseases (11%), cancers (9%), diabetes (3%) and others (13%).

Risk factors

Most NCDs are strongly associated with major risk factors such as:

1. Tobacco use (smoking and smokeless)
2. Alcohol use
3. Unhealthy diets
4. Insufficient physical activity
5. Air pollution (indoor and outdoor)

If the above risk factors are not managed/modified, they may lead to the following biological risk factors:

1. Overweight/obesity
2. Raised blood pressure
3. Raised blood sugar

4. Raised total cholesterol/lipids

The other factors due to which an individual might develop NCDs are:

1. Stress
2. Hereditary factors

Objectives

The objectives of NP-NCD are as follows:

- Health promotion through behaviour change with involvement of community, civil society, community-based organizations, media and development partners.
- Screening, early diagnosis, management, referral and follow-up at each level of healthcare delivery to ensure continuum of care.
- Build capacity of health care providers at various levels for prevention, early diagnosis, treatment, follow-up, rehabilitation, IEC/BCC, monitoring and evaluation, and research.
- Strengthen supply chain management for drugs, equipment and logistics for diagnosis and management at all health care levels.
- Monitoring, supervision and evaluation of programme through proper implementation of uniform ICT application across India.
- To coordinate and collaborate with other programmes, departments/ministries, civil societies.

Strategies of NP-NCD

Following are the strategies of the programme:

- Health promotion for prevention of NCDs and reduction of risk factors.
- Screening, early diagnosis, management, referral and follow up of common NCDs.
- Capacity building of health care providers.
- Evidence-based standard treatment protocols.
- Uninterrupted drug and logistics supply.
- Task sharing and people-cantered care.
- Information system for data entry, longitudinal patient records.
- Monitoring, supervision, evaluation and surveillance including technology enabled interventions.
- Multi-sectoral coordination and linkages with other National Programmes.

- Implementation research and generation of evidences.

Some of the other health programmes related to NCDs where linkages with NP-NCDs is required:

• National Mental Health Programme (NMHP)
• National Programme for Control of Blindness and Visual Impairment (NPCB&VI)
• National Programme for Prevention and Control of Deafness (NPPCD)
• National Programme for Prevention and Control of Fluorosis (NPPCF)
• National Programme for Health Care of the Elderly (NPHCE)
• National Programme for Tobacco Control and Drug Addiction Treatment (NPTCDAT)
• National Oral Health Programme (NOHP)
• National Programme for Prevention and Management of Trauma and Burn Injuries (NPPMTBI)
• National Organ Transplant Program (NOTP)
• National Programme for Palliative care (NPPC)
• National Iodine Deficiency Disorders Control Programme (NIDDCP)

Package of services

Level of care	Package of services
Community level	• Active enumeration of the eligible population and registration of the families, risk assessment of NCDs using Community Based Assessment Checklist (CBAC), Mobilization of community for screening of NCDs at nearest AB-AAM. • Health promotion, lifestyle modification, follow up for treatment compliance and lifestyle modification.
Sub-centre / SHC-AAM	• Health education for awareness generation and behaviour change, organising wellness activities. • Screening of Diabetes, Hypertension, three common cancers (oral, breast and cervical). • Referral of suspected cases to PHC/PHC-AAM or nearby health facility for diagnosis confirmation and management. SHC- AAM team to also facilitate the referrals and follow up on referred suspected patients. • Dispensing of prescribed medicines and follow up of patient for treatment compliance and lifestyle modification.

	• Teleconsultation services from SHC-AAM to AAM- PHC/UPHC. • Maintaining Electronic Health Records (EHR) and generation of ABHA IDs.
PHC / PHC-AAM/ UPHC-AAM	• Health promotion activities including wellness activities for behaviour change. • Screening of Diabetes, Hypertension, three common cancers (oral, breast and cervical), COPD and Asthma, CKD, NAFLD among OPD attendees. • Confirmation of diagnosis, treatment initiation, and management of common NCDs as per standard management protocol and guidelines. • Referral of complicated NCD cases to higher facilities. Bi-directional referral linkages to be established and follow up to be ensured. • Teleconsultation services and counselling services. • Maintaining Electronic Health Records (EHR) and generation of ABHA IDs.
CHC/SDH	• Health promotion including counselling. • Opportunistic screening of Diabetes, Hypertension, three common cancers (oral, breast and cervical). • Screening of COPD and Asthma, CKD, NAFLD, STEMI among suspected cases. • Confirmation of diagnosis, treatment initiation, and management of common NCDs as per standard management protocol and guidelines. • Teleconsultation services and counselling services. • Maintaining Electronic Health Records (EHR) and generation of ABHA IDs. • Management of cases of common NCDs and regular follow-up. • Referral of complicated cases to District Hospital/higher healthcare facility.
District Hospital	• Opportunistic screening of Diabetes, Hypertension, three common cancers (oral, breast and cervical). • Screening of COPD and Asthma, CKD, NAFLD, STEMI among suspected cases.

	• Diagnosis and management of cases of common NCDs: outpatient and inpatient care, including emergency care particularly for cardiac and stroke cases. • Management of complicated cases of common NCDs, or referral to higher healthcare facility. • Follow-up cancer chemotherapy and palliative care services for cancer cases, physiotherapy services for NCDs including Stroke patients, Dialysis facilities for CKD patients, etc. • Health promotion for behaviour change and counselling for NCD cases. IEC activities on important Health Days. • Bidirectional referral linkages and follow up mechanism to be established and ensured. • Teleconsultation services and counselling services. • Maintaining Electronic Health Records (EHR) and generation of ABHA IDs.
Medical College/ Tertiary Cancer Centres	• Diagnosis and management of complicated cases of common NCDs acts as tertiary referral facility. • Comprehensive cancer care including prevention, early detection, diagnosis, treatment, palliative care and rehabilitation at Tertiary Cancer Centres. • Support programme in capacity building of health staff. • Support programme in preparing standard guidelines and protocols. • Support in supervision, monitoring, evaluation and operational research. • Bidirectional referral linkages and follow up mechanism to be established and ensured. • Teleconsultation services and counselling services. • Maintaining Electronic Health Records (EHR) and generation of ABHA IDs

Source: Operational guidelines National Programme For Prevention and Control of NON-COMMUNICABLE DISEASES 2023-2030

17

Pradhan Mantri National Dialysis Program (PMNDP)

Introduction

Every year, about 2.2lakh new patients of End-Stage Renal Disease (ESRD) get added in India resulting in additional demand for 3.4 Crore dialysis every year. The high cost of dialysis care leads to financial catastrophe for practically all families with such patients.

Towards this, Ministry of Health & Family Welfare launched the 'Pradhan Mantri National Dialysis Program' (PMNDP) under the National Health Mission in Public Private Partnership (PPP) mode in Union Budget 2016-17 at all the District Hospitals, to make renal-care services accessible & affordable to BPL (Below Poverty Line) patients.

The Pradhan Mantri National Dialysis Programme (PMNDP) was rolled out on 07th April 2016 as part of the National Health Mission (NHM) for the provision of free dialysis services to the poor. The programme has two components namely Haemodialysis (HD) services & Peritoneal dialysis (PD) services.

National Health mission supports establishment of dialysis centres (In-house & public private partnership/hybrid models) for HD service delivery as per the state/UT requirement. Haemodialysis Services under PMNDP is operational in Private Public Partnership (PPP) mode in 14 States/UTs, in-house mode in 16 States/UTS and hybrid mode in 6 States/UTs.

The PMNDP portal (IT platform) was launched on 05 May 22 by Hon'ble Union Minister of Health & Family Welfare Dr Mansukh Mandaviya at the 14th CCHFW Meeting. The portal will integrate all the dialysis centres operational in the state under NHM and facilitate building of renal registry and ensuring portability within the state (one state one dialysis) and later throughout the country (One Nation-One Dialysis).

ABHA number is a 14-digit number that will uniquely identify one as a participant in India's digital healthcare ecosystem. ABHA number will establish a strong and trustable identity for the dialysis patients that will be accepted by healthcare providers and payers across the country.

ABHA Address

ABHA (Ayushman Bharat Health Account) Address is a unique identifier (self-declared username) that enables you to share and access your health records digitally. Your ABHA address may look like 'yourname@consent manager'. For instance, xyz@abdm is a ABHA address with ABDM Consent Manager that will facilitate health data exchange for you with appropriate consent on the ABDM network

Benefits of ABHA Health ID card

- Unique & Trustable Identity
    - Establish unique identity across different healthcare providers within the healthcare ecosystem
- Unified Benefits
    - Link all healthcare benefits ranging from public health programmes to insurance schemes to the unique ABHA number
- Hassle-free Access
    - Avoid long lines for registration in healthcare facilities across the country
- Easy PHR Sign Up
    - Seamless sign up for PHR (Personal Health Records) applications such as ABDM ABHA application for Health data sharing

The ABHA number will be used for the purposes of uniquely identifying persons, authenticating them, and threading their health records (only with the informed consent of the patient) across multiple systems and stakeholders.

Vision

Aligning with the concept of **'One Nation-One Service'** concept the One Nation-One Dialysis programme was conceived under NHM to facilitate dialysis services to needy patients anywhere in the country.

The dialysis patient can take the dialysis service in any dialysis centre throughout the country in case of availability of free slots.

Goal

Health Facility Registry is a comprehensive repository of health facilities of the country across modern and traditional systems of medicine. It includes both public and private health facilities including hospitals, clinics, diagnostic laboratories and imaging centres, pharmacies, etc.

Registration will enable health facilities to get connected to India's digital health ecosystem and allow their listing on a national platform. This will instil trust in citizens seeking healthcare services by improving discovery of health facilities. Health facilities signing up will be able to gain access to a host of digital services.

Source: https://pmndp.mohfw.gov.in/en

18

National Oral Health Programme (NOHP)

Taking into account the oral health situation in the country, Government of India has initiated a National Oral Health Programme to provide integrated, comprehensive oral health care in the existing health care facilities.

Objectives

- To improve the determinants of oral health
- To reduce morbidity from oral diseases
- To integrate oral health promotion and preventive services with general health care system
- To encourage Promotion of Public Private Partnerships (PPP) model for achieving better oral health.

In order to achieve above listed objectives, Government of India has decided to assist the State Governments in initiating provision of dental care along with other ongoing health programmes implemented at various levels of the primary health care system. Funding has been made available through the State PIPs for establishment of a dental unit [at district level or below]

This dental unit equipped with necessary trained manpower, equipments including dental chair and support for consumables would be provided to the states through the NOHP. These units, according to the level of saturation of state's own dental units, may be established at district hospitals or in the health facilities below the level of district hospitals.

Manpower

Manpower, if required, [such as a Dental Surgeon, a Dental Hygienist & a Dental Assistant] may be appointed on contractual basis. The TORs is at Annexure I

Equipment

Equipment's for the dental unit such as dental chair, x-ray machine and other supportive instruments may also be procured by the State Government.

Consumables

The sanctioned funds can be used for procurement of consumables required for the unit. The National Oral Health Cell will also help in imparting training to the Oral health manpower as well as general health manpower for better integrated approach to better oral health.

In order to increase the level of awareness, the Government of India will help preparation of prototype Information, Education and Communication (IEC) materials/Behaviour Change Communication (BCC) materials for dissemination of information. 3 Public Private Partnership model may also be utilized with the private dental colleges, various dental associations and community-based organizations to promote community based oral health awareness and service delivery, wherever feasible

The National Oral Health Cell (NOHC) will be monitoring the implementation and progress of the programme from time to time through established mechanisms.

Source: Operational Guidelines of NOHP / NHM

19

National Programme for Prevention & Control of Flurosis (NPPCF)

Fluorosis, a public health problem is caused by excess intake of fluoride through drinking water/food products/industrial pollutants over a long period. It results in major health disorders like dental fluorosis, skeletal fluorosis and non-skeletal fluorosis.

Problem

Dental Fluorosis affects children and discolours and disfigures the teeth. The teeth could be chalky white and may have white, yellow, brown or black spots or streaks on the enamel surface. Discoloration is away from the gums and bilaterally symmetrical. Skeletal Fluorosis affects the bones and major joints of the body like neck, back bone , shoulder, hip and knee joints with severe pain, rigidity or stiffness in joints. In severe forms results in marked disability. NonSkeletal fluorosis is an earlier manifestation of fluorosis seen as gastro-intestinal complaints etc and may overlap with other diseases leading to misdiagnosis.

Prevalence

Fluoride prevalence was reported in 230 districts of 19 States earlier. As per recent data from Ministry of Drinking Water and Sanitation, there are 14,132 habitations (as on 1.4.2014) from 19 States which are yet to be provided with safe drinking water. The population at risk based on population in habitations with high fluoride in drinking water is 11.7 million.

Programme coverage

The National Programme for Prevention and Control of Fluorosis (NPPCF) was a new health initiative during 11th Five Year Plan, initiated in 2008-09 and is being expanded in a phased manner. 100 districts of 17 States were covered during 11th Plan, further 11 districts were taken up during 2013-15 (over 19 States) and additional 84 new districts are to be taken up during the remaining period of 12th Plan.

Goal and Objectives

The NPPCF aims to prevent and control Fluorosis cases in the country. The Objectives of the National Programme for Prevention & Control of Fluorosis are as follows:

To collect, assess and use the baseline survey data of fluorosis of Ministry of Drinking Water and Sanitation for starting the project; Comprehensive management of fluorosis in the selected areas; Capacity building for prevention, diagnosis and management of fluorosis cases.

Strategy

- Surveillance of fluorosis in the community;
- Capacity building (Human Resource) in the form of training and manpower support;
- Establishment of diagnostic facilities in the medical hospitals;
- Management of fluorosis cases including treatment surgery, rehabilitation Health education for prevention and control of fluorosis cases.

Activities

Community Diagnosis of Fluorosis village/block/cluster wise. Facility mapping from prevention, health promotion, diagnostic facilities, reconstructive surgery and medical rehabilitation point of view – village/block/district wise. Gap analysis in facilities and organization of physical and financial support for bridging the gaps, as per strategies listed above.

- Diagnosis of individual cases and providing its management.
  (b) Public health intervention on the basis of community diagnosis.
  Behaviour changes by IEC.
- Training

Source: Operation guidelines of NPPCF / NHM

20

National Programme for Prevention and Management of Trauma and Burn Injuries (NPPMTBI)

Burn Injury Programme

As per WHO (2017), Burns are a global public health problem, accounting for an estimated 1,80,000 deaths every year. The majority of these occur in low- and middle-income counties and almost two thirds occur in the WHO African and South-East Asia regions. In India, over 1,000,000 people are moderately or severely burnt every year. The high incidence is attributed to illiteracy, poverty and low-level safety consciousness in the population. The situation becomes further grim due to the absence of organized burn care at primary and secondary health care level. However, the death and disability due to burn injury are preventable to a great extent provided timely and appropriate treatment is provided by trained personnel. Keeping in view the magnitude of the problem, a pilot programme on burn care was initiated in the year 2010 by Ministry of Health & Family Welfare in the name of "Pilot Programme for Prevention of Burn Injuries" (PPPBI). This was initiated in three Medical Colleges and six Districts Hospitals.

The goal of PPPBI was to ensure prevention of Burn Injuries, provide timely and adequate treatment in case of burn injuries, so as to reduce mortality, complications and ensuing disabilities and to provide effective rehabilitative interventions if disability has set in. The pilot project continued as full-fledged programme during the 12th Five Year Plan period. The financial assistance towards District Hospital component was undertaken under National Health Mission (NHM). The programme has now been extended up to 2020 for continued financial support on reimbursement basis to already approved Burn Units. The objectives of the scheme are as under: To reduce incidence, mortality, morbidity and disability due to Burn Injuries To improve awareness among the general masses and vulnerable groups especially the women, children, industrial and hazardous occupational workers. To establish adequate infrastructural facility and network for behaviour change communication, burn management and rehabilitation interventions. To carry out Research for assessing behavioural, social and other determinants of Burn Injuries in our country for effective need-based program planning for Burn Injuries, monitoring and subsequent evaluation.

Source: NPPMTBI guidelines / NHM

21

eSanjeevani - National Telemedicine Service

eSanjeevani - the National Telemedicine Service of MoHFW, Government of India has evolved into the world's largest documented telemedicine implementation in the primary healthcare. The National Telemedicine Service of India has already served over 308,766,000 patients at over 129,200 Ayushman Arogya Mandirs (as spokes) through 16,360+ hubs and over 660 online OPDs serviced by more than 225,000 doctors, medical specialists, super-specialists and health workers as telemedicine practitioners *[as on 03 November 2024]*.

Aligned with Hon'ble Prime Minister Narendra Modi's vision of the Digital India where quality healthcare percolates right up to the remotest regions powered by e-Healthcare eSanjeevani was launched in November 2019. As a cornerstone of Ayushman Bharat Scheme – world's largest health insurance to achieve Universal Health Coverage, eSanjeevani – is testimony to the fact that digital health has come of age in India. eSanjeevani has digitally brought health services to the masses in rural areas and remote communities.

The cloud-based eSanjeevani platform is implemented in two modes:

1. eSanjeevani AB-AAM (a provider-to-provider telemedicine platform): this variant provides assisted teleconsultations for patients who walk into Ayushman Arogya Mandir (AAMs), community health officers in Ayushman Arogya Mandir facilitate the teleconsultation for the patient who are connected to the doctors and specialists in hubs established in secondary/tertiary level health facilities or medical colleges. This variant is based on a Hub-and-Spoke model.

2. eSanjeevani OPD (a patient to provider telemedicine platform): it empowers citizens to access health services in the confines of their homes through smartphones of laptops etc.

eSanjeevani - National Telemedicine Service of India is providing health services remotely across the length and breadth of the country, it is offering improved access to healthcare even in resource limited settings. This marvel of ICT is bridging the digital health divide in the country. With phenomenal adoption amongst patients and telemedicine practitioners and its mammoth network extending to all parts of the country including the

islands in Lakshadweep and Andamans and peaks in Ladakh, eSanjeevani is seen as one of the crown jewels of Digital India.

Soon after COVID 19 touched Indian shores, the Telemedicine Practice Guidelines were released by the Govt. of India. eSanjeevani was customized to be used for patient to provider teleconsultations and during COVID 19 it was the only hope for millions of citizens to access doctors and medical specialists for non-COVID 19 as well as COVID 19 related health issues from within the confines of their homes. Closely working with policy makers at the Union Health Ministry, team eSanjeevani's rapidly developed and rolled out eSanjeevaniOPD within 19 days. This indigenously developed telemedicine technology has brought in a tectonic shift in the domain of digital health by enabling a massive digital transformation in delivery of health services even at the primary level.

eSanjeevani has shown up as a blessing especially to people in rural areas where it was harder to access care, it has since found much wider application across the health spectrum and has revolutionized primary healthcare services in India. This first-of-its-kind, government owned telemedicine platform that has brought a colossal populace (doctors as well as patients) in the fold of the digital health ecosystem by providing free of cost consultations to one and all.

It is reassuring to note that over 57% of the beneficiaries of eSanjeevani are females and around 12% of all the beneficiaries are senior citizens. It also goes to reflect that the platform is finding its reach in the more vulnerable sections of the population where its effect is fetches maximum impact. This speaks volumes about the telemedicine platform and the extent to which it has reinvented itself over time to meet the growing demands of healthcare in India.

Apart from the direct benefit of being able to facilitate care on demand, and leveraging the potential of information technology, eSanjeevani successfully overcomes the challenges of geography, accessibility, cost and distance to provide equitable and quality care to populations across India. eSanjeevani has proved to be a yardstick for swift capacity building as well as utilising digital technology to strengthen healthcare.

eSanjeevani is also shaping into the harbinger of Ayushman Bharat Digital Mission that aims to, develop the backbone necessary to support the integrated digital health infrastructure of the country. The success of this initiative is analogous with the impact and success of Digital India Mission.

After tapping the potential of teleconsultations to the fullest, the Ministry of Health and Family Welfare (MoHFW), Govt. of India has augmented eSanjeevani further to add the logical next dimension of telediagnosis in eSanjeevani2.0 that was rolled out in March 2023. This entails seamless integration of a vast spectrum Point of Care Diagnostic devices (PoCDs), also known as near patient testing. PoCDs provide results of various clinical tests including physiological parameters within minutes of taking a test there by facilitating rapid diagnosis and quick decisions.

Source: https://esanjeevani.mohfw.gov.in/

COMMUNITY LEVEL INTERVENTIONS

1

Mahila Arogya Samiti (MAS)

Mahila Arogya Samiti (MAS) as the name suggest are local women's collective. They are expected to take collective action on issues related to Health, Nutrition, Water Sanitation and its social determinants at Slum/Ward level. They were particularly envisaged as being central to 'local community action', which would gradually develop to the process of decentralized health planning. Thus, MASs are expected to act as a leadership platform for woman's and focal community group in each slum area for improving awareness and access of community for health services, support the ASHA / Front line health worker/ ANM, to develop health plans specific to the local needs and serves as a mechanism to promote community action for health.

Main purpose of Mahila Arogya Samiti (MAS) includes, demand generation, ensuring optimal utilization of services, establishing referral linkages, increasing community ownership and sustainability and establishing a community-based monitoring system.

Objectives and Goals of MAS

- To provide an institutional mechanism for the community to be informed of health and other government initiatives and to participate in the planning and implementation of these programmes, leading to better outcomes.
- Organize or facilitate community level services and referral linkages for health services for Maternal, New born, Child health and Nutrition (MNCHN) and other related services for water sanitation and hygiene (WASH), adolescent health issues and non-communicable diseases for increased access of the community for these services.
- To provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.
- To provide mechanism for the community to voice health needs, experiences and issues with access to health services, such that the institutions of local government and public health service providers can take a note and respond appropriately

- Generate community awareness on MNCHN, WASH and locally relevant health issues and to promote the acceptance of best practise in health by the community members.
- To focus on preventive and promotive health care and management of untied fund.
- Provide support and facilitate the work of community health workers like ASHA and other frontline health care providers who form a crucial interface between the community and health institutions.

Process of formation of Mahila Arogya Samiti:

- Selection of an ASHA for a designated "slum/vulnerable cluster" will be done by women's group which can later potentially serve as Mahila Arogya Samitis in that area.
- Constitution of a team at slum level: The ASHA, ASHA facilitator/Community organizer with support of NGO field functionary (if any), AWW and ANM will constitute a team for selecting the MAS members. As far as possible the community women's group involved in the selection of ASHA should be part of MAS. Each ASHA will supervise the formation of two-five MAS.
- Meetings with slum women: The team (ASHA and others) conduct a series of meetings with women from the slum to understand the health conditions and to sensitize the women to work towards improving the health of the men, women and children in the slum It is generally observed that the initial meetings have a large number of slum women attending mainly due to curiosity or with expectations to get some benefits (monetary).
- Identification of active and committed women: At least a gap of 1-2 weeks is given between women to reflect, discuss with others and determine their commitment to serve their slum community. Generally, towards the 3rd or 4th meeting, the numbers of women attending falls and only interested women come for the meeting. Active, interested and committed women will be identified and over a period of time, encouraged to work collectively on community issues to form the base of the Mahila Arogya Samiti. It may be borne in mind that each community responds differently and takes its own time to crystallize, and interventions would have to be designed, keeping in alignment with the community. Social acceptance should be ensured by talking to family members.

Coverage of MAS

The MAS is to be formed at Slum level, will approximately covers approximately 50-100 households. However, this can be modified based on the ground realities in each slum area, e.g. small slum of less than 50 families or presence of disparate groups within each slum. In case of existing Anganwadi Centres in the slum, the coverage of each MAS should be aligned with the coverage area of the Anganwadi Centre and has to cover all pockets of the slum.

Composition of MAS

Mahila Arogya Samithi should have 10 -12 members, depending on the size of the slum, but the group should not be less than 8 members and not more than 20 members. In case of MAS formed in a slum with different social groups, representation should be ensured from all groups and from all pockets of the slum.

Characteristics of members of Mahila Arogya Samiti

- The membership in the group would be a natural process, guided by ASHA and others. Therefore, the following parameters not be seen as eligibility criteria but it can be used for preferential inclusion of members
- Woman with a desire to contribute to 'well-being of the community' and with a sense of social
- commitment and leadership skills.
- Woman's age is not being kept as a barrier as the role of the woman in the house and the community is either as a target beneficiary or as an influencing force.
- If a group is being formed over a number of pockets of different communities, membership from all such pockets shall be ensured.
- If the slum has a presence or history of collective efforts (as a self-help group, Development of Women and Children in Urban Areas (DWCUA) group, Neighbourhood Group under SJSRY, thrift and credit group), women involved in these efforts should be encouraged to be part of MAS
- Service users like pregnant women, lactating mothers, Mothers with children of up to 3 years of age and patients with chronic diseases who are using the public services should also find place in the MAS
- ASHA will be the Member secretary of MAS

Office Bearers and their roles

- Chairperson: MAS members will elect the chairperson of the group. The chairperson will lead the meeting and ensure smooth coordination among members for effective decision making. She is accountable for ensuring that meetings are held monthly. Planning awareness generation activities and other advocacy events and helping member secretary in maintenance and updating group record and registers are her other functions.
- A coordination mechanism of MAS needs to be built with the urban local bodies. One way to do this could be to form a federation of a group of MAS at the ward level which will be chaired by an elected women member of the urban local body.
- Member Secretary: ASHA will be the member secretary and will fix the schedule and venue for monthly meetings of the samiti and ensure that meetings are conducted regularly with participation of all members. She will draw attention of the samiti on specific constraints and achievements related to health status of the community and enable appropriate planning and maintaining records and registers and arrangements for the Urban health and Nutrition days.

Activities of Mahila Arogya Samiti:

- Mapping and listing of slum households; also, preparation of resource map in the communities for identifying vulnerable and socio-economically disadvantaged group.
- Monitoring and facilitating access to essential public services: ensuring that all the people in the community or geographical area of MAS, particularly marginalised, vulnerable groups and disabled are receiving the services related to health, water, sanitation nutrition and education.
- Organising local collective action for Preventive and Promotive Health activities: MAS serves as an inspiring organization and bring the community together for collective action on health. This could be done by motivating for community mobilisation and utilising support for organizing cleaning drives, improving sanitation. It will promote convergent and community action in partnership with all other urban area initiatives for Vector control, environmental health, water, sanitation, housing.
- Facilitating service delivery and service providers in the community.

Responsibility

- Supporting ANM, AWW and ASHA in organising the Urban Health Nutrition Day and immunization sessions.
- Mobilizing pregnant women and children, particularly from marginalized families, and coordinate with ASHA and ANM in organising outreach sessions (both routine and special) activities in the community.
- Allowing outreach workers and community service providers to articulate their problems in the meetings. The meeting should identify who the ANM, Anganwadi worker and the ASHA are unable to reach and help these providers to reach these sections.
- Community health planning is a continuous process and is to be done in each monthly meeting.
- Maintain records of births and deaths in the slum cluster.

Monthly Meetings:

Meetings of MAS should be at least once every month. It is suggested that there be one regular date-like 10th of every month or second Saturday of every month-when the meeting is held to ensure that members can plan on ensuring attendance. A regular venue fixed at a convenient place like AWC, School etc. a minute's register and meeting attendance register would also facilitate proper functioning. In a 15 member Samiti,7 members represent a minimum quorum, but with a large samiti whose composition is intended for social inclusion and mobilization, the meeting quorum could be even 33%. monthly meeting reviews work done, plans future activities and decides on how the untied funds are to be spent.

Management of untied funds:

An untied fund for Rs.5,000 is given annually to MAS: MAS can use these funds for any purpose aimed at improving health of the community. It is to be utilized as per decision of the MAS. Nutrition, education, sanitation, environmental protection, public health measures, emergency transport are the key areas where this fund could be utilised.

- Decision for utilisation of funds should be taken during the meetings. The fund shall only be used for community activities that involve benefit to more than one household. Exceptions to this are in case of a destitute women or very poor

household, where the untied grants could be used for health care needs of the poor household especially for enabling access to care. MAS fund should preferably be not used for works or activities for which an allocation of funds is available through urban local bodies or other departments. The MAS is encouraged to contribute additional funds to its account. Decisions taken on expenditure should be documented in the minutes. It is preferably adopted as a written resolution that is read out and then incorporated into the minutes in a meeting where there was adequate quorum.

Source: Operational guidelines for MAS / NHM

2

Jan Arogya Samiti (JAS)

Background

- Under Ayushman Bharat, -Ayushman Arogya Mandirs (AB-AAMs), Sub Health Centres (SHCs) and Primary Health Centres (PHCs) are being transformed to Ayushman Arogya Mandirs to provide Comprehensive Primary Health Care (CPHC) services. Such a transformation is expected to enable these AB-AAMs to serve as the first port of call for a range of primary health care services spanning preventive, promotive, curative, rehabilitative and palliative care to the population in their coverage area. AB-AAMs are also expected to play a critical public health role and focus on collective community action for Social and Environmental Determinants of Health, and support Social Accountability and Community Feedback processes.

- Rogi Kalyan Samities (RKS) were established under the National Health Mission (NHM) in health care facilities at the level of the PHC and above. RKS were envisioned as a local level institutional mechanism to enable action for improvement in the availability and quality of hospital infrastructure and services, and promote a culture of accountability amongst service providers in the public health system. The RKS were also seen as a mechanism for promoting active public participation in health care.

- RKS is a registered society to manage the affairs of health facilities in consonance with the principle of decentralization and devolution of administrative and financial powers. Their composition includes members from Panchayati Raj Institutions (PRIs), NGOs, persons of eminence, and officials from Government sector including health who are responsible for proper functioning and management of the facilities. RKS at all facilities have the autonomy to generate and use its funds for smooth facility functioning, maintaining the quality of services and enabling the delivery of patient-cantered care. RKS at various levels also receive untied funds as budgetary allocation under NHM.

- At the SHC level, ASHA and Village Health Sanitation and Nutrition Committees, (and subsequently, ASHA and Mahila Arogya Samit (MAS) in urban areas) were expected to undertake community action for health, in the form of monitoring health and related public services through undertaking semi-annual Jan Sunwais or community hearings, at which staff from AB-AAMs / SHCs are expected to be present. Under Ayushman Bharat, the SHC level AB-AAMs, are provided Rs. 50,000 as united fund, enhancing the amount from Rs. 20,000 that is provided to all SHCs. This untied fund is expected to be used primarily for supporting the essential requirements for AB-AAM. There have been requests from states to form a similar committee at AB-AAM-SHC level. This committee which is being proposed to be formed at the SHC level AB-AAM shall be named as ***Ayushman Bharat - Jan Arogya Samiti (JAS).***

- With the launch of Ayushman Bharat, Primary Health Centres are also being upgraded as Ayushman Arogya Mandirs throughout the country. Understandably, the scope of services and responsibilities at Primary health Centre have also increased. ***In view of this, Rogi Kalyan Samiti at PHC is being reformed as Jan Arogya Samiti- PHC (JAS-PHC)***. The composition and role of JAS-PHC have also been included in these guidelines. The tenets for JAS at both SHC and PHC are similar unless explicitly stated.

Objectives of Jan Arogya Samiti (JAS)

The following are key objectives of JAS:

- Serve as institutional platform of SHC/PHC level AB-HWCs (similar to RKS at PHC / CHC), for community participation in its management, governance and ensuring accountability, with respect to provision of healthcare services and amenities.
- Support AB-HWC team in working with VHSNCs, for Health Promotion and Action on Social and Environmental Determinants of Health, in community level activities of National Health Programmes and other community interventions.
- Serve as an umbrella for VHSNCs, providing mentorship to VHSNCs and supporting them in management of Untied Funds and coordination with the health system.

- Engage the VHSNCs of its area, in community level interventions of AB-HWCs, particularly, in the facilitation of screening for various age-groups, promoting follow-up and treatment adherence (including support to patient support groups).
- Leverage existing organized volunteers [NSS, NCC, Red cross, Scouts and Guide, Youth groups] for patient follow up, counselling, community mobilization, conducting surveys and other related action.
- Support and facilitate the conduct of activities pertaining to social accountability at AB-HWC in coordination with VHSNCs.
- Act as Grievance Redressal Platform for families who access healthcare services at ABHWCs, ensuring availability and accountability for quality services.
- Co-ordinate with Community Health Officers (CHOs) at SHC/Medical Officers (MO) at PHC to manage and be accountable for the use of untied funds at HWC.
- Mobilise resources (both monetary and non-monetary) from rural and urban local bodies, other Government Schemes and Programmes, Corporate Social Responsibility (CSR) Funds, and Philanthropy and Charity Organisations, and ensure its use for improving quality of services and undertaking Health Promotion activities at AB-HWCs.
- Facilitate and support Gram Panchayats of the area in undertaking health planning.

Structure and Composition of JAS

A. The Proposed composition of JAS-SHC is –

1. Chairperson -

The Sarpanch of the Gram Panchayat (GP) falling under the AB-HWC area shall be designated Chairperson.

2. Co- Chair - The Medical Officer of the concerned PHC of the HWC area shall be the Co-
Chairperson of JAS

3. Member Secretary - Community Health Officer (CHO) of the HWC.

4. Members.

Ex-Officio

a. Sarpanches of the other GPs of AB-HWC area

b. President of VHSNCs: One per GP amongst those under AB-HWC area. This shall be on rotation (among VHSNCs under a GP) for 2 years to allow greater participation.

c. ASHAs – ASHAs/Member Secretary of all VHSNCs in AB-HWC area

d. All Multi-Purpose Health Workers (Male and Female) of AB-HWC

General

1. Women Self Help Groups - President of one SHG from each Gram Panchayat of the AB-HWC area – nominated by GP
2. School Health Ambassadors: One representative from among the Ayushman Bharat School Health & Wellness Ambassadors of the AB-HWC area (representative from the school with highest enrolment)
3. Peer Educator - One from AB-HWC area (Senior peer educator in the area)

Special Invitees- Tuberculosis survivor, Youth representatives and "any male" who has undergone sterilization after one / two children"

Composition of JAS-PHC

1. Chairperson-Zila Panchayat Member/Janpad Panchayat member of the corresponding area
2. Co-chair- Block Medical Officer / Taluka Health Officer
3. Member Secretary - Medical Officer In-charge of PHC level AB-HWC
4. Members –

a) Other Medical Officer / AYUSH Medical Officer of PHC
b) Senior Staff nurse / LHV / ANM of PHC
c) Chairperson of Janpad Panchayat's Health Sub-committee
d) Sector Supervisor of Dept. of Women and Child (DWCD) / ICDS of the area
e) Block level officer of Dept. of Public Health Engineering Dept. (PHED) / Department of Water and Sanitation (DWS)
f) Block level officer of School Dept. / Principal / Headmaster of local School
g) Block level officer of PWD
h) Chairpersons of all JAS of SHC level AB-HWCs of PHC area (may be up to 5-6)
i) Block level representative from NYK/Youth volunteers
j) 2 Civil society representatives (Total number of members is likely to be up to 18-20)

Roles and responsibilities of JAS

1. Role of JAS in Enabling quality service delivery.
2. Role of JAS in Leading Health Promotion efforts
3. Role of JAS in Catalysing Grievance Redressal
4. Role of JAS in Social Accountability exercise

Capacity Building of JAS Members:

- Since JAS is a newly created committee, capacity building of members will be undertaken to enable them to fulfil their roles effectively. Orientation of JAS members will be conducted by the States/UTs. The training content will be developed at national level in consultation with states. The cascade of national, state and district will be followed for training JAS members.
- Online mechanisms of training will also be explored including the online mentoring platform set up for CHOs. States should explore the possibility of involving NGOs to train JAS at block and districts. Development partners could also be approached for support.

Meetings of JAS

- The JAS will meet at-least once every month on a fixed day, which will be decided by the states/UTs.
- The member secretary will organize the meeting, and will communicate the day, date of the meeting, with the list of agenda items to all members, at-least seven days in advance. Every effort should be made to ensure that the clear information about the meeting has reached every member. The essential quorum for the meeting will be 50% of the members of the committee. If the required quorum is not fulfilled in a JAS meeting, the meeting will be adjourned, and reconvened the same day after notification of a suitable time to rest of the members to fulfil the quorum. In the reconvened meeting, normal business will be conducted, even if the 50% quorum is not fulfilled.

Record Keeping

The following registers will have to be maintained by the member Secretary of JAS:

- Record of proceedings of the JAS committee meetings.
- Financial Account register.

Annual Public Dialogue

The JAS will organize a public dialogue, every year, to share an account of the activities, successes, and challenges of AB-HWC, with respect to its roles of healthcare service delivery and community level interventions. JAS will take steps to ensure active community participation from every village, especially from the vulnerable sections of community and panchayat under its area. The event should be timed appropriately, so that the consolidated issues or requirements articulated by community during the event, can be incorporated in the annual planning process of health department and NHM, as well as the planning cycle of the panchayat structures.

Untied Fund of JAS

- The purpose of the untied fund is to make available a flexible fund, to cater to unanticipated minor requirements, based on decisions taken at the AB-HWC level, in consultation with JAS.
- Under Ayushman Bharat, an annual untied fund is provided @ Rs. 50,000 for SHC level AB--HWCs and Rs.1,75,000 for PHC level AB-HWCs.

Source: Guidelines for Jan Arogya Samiti - AAM/ NHM

3

Village Health, Sanitation and Nutrition Committee

Background

Village Health, Sanitation and Nutrition Committee (VHSNC) is formed at the village level to take collective action on issues related to health including malnutrition, clean and safe drinking water, healthy living conditions, health education, and awareness. The VHSNC serves as an inspiring village organization that brings the community together for collective action on health. This can be done by identifying volunteers from the community and utilizing their support for organizing cleaning drives, improving village sanitation, and vector control. The committee also acts as a grievance redressal forum on health and nutrition issues. The committee should have a minimum of 15 members

Steps for the process of formation of the committee

1. The ASHA and ASHA Facilitator (or Block Mobilizer) will hold meetings in the village to discuss the composition of the VHSNC and its role.
2. The Gram Panchayat members, ASHA, ASHA facilitator (or Block Mobilizer) and ANMs/CHOs will then select members through a consultative process with the community at the village level.
3. This list will be ratified with the inclusion of further suggestions at the next Gram Sabha meeting.
4. The ANM/CHO, AWW (Anganwadi worker) and ASHA along with the Panchayat members are expected to ensure that every section is represented. 50% of total members of VHSNC must be women. SC, ST and minorities should be adequately represented as per their population in the village.

Key principles Governing the Composition of the VHSNC

1. Elected members, especially women members of the panchayat residing in the village should be enabled to lead, such as women ward-panch.
2. All those working for health or health-related services should be able to participate, such as the ANMs/CHOs and the Anganwadi workers.

3. The voices of service users of health services, especially of mothers should find a place.
4. There should be representation from all community sub-groups, especially from poorer and more vulnerable sections.
5. All habitations/hamlets should have representation.
6. Ideally, the concerned medical officer and block development officer should participate in every VHSNC meeting at least once or twice a year.
7. Representatives of existing community-based organizations such as Self Help Groups, Forest Management Committees, Youth Committees, any prominent NGO working in the community, and committees on School Education, Water and Sanitation or Nutrition should also become member of these committees.
8. The Chairperson of the VHSNC is a woman-elected member of the gram panchayat (panch) preferably from among the SC/ST communities, who is a resident of that village. If there is no woman panch from that village, then preference should be given to any panch from the SC/ST. But this is decided by the gram panchayat and VHSNC, with the ANM and ASHA playing a facilitating role.
9. ASHA will play the role of convenor/Member-Secretary of VHSNC. ASHA has been assigned this important role as she has better community ownership and acceptance. She belongs to the community and is knowledgeable about health. For the successful achievement of her objectives related to health promotion, prevention and community mobilization, the ASHA also requires active VHSNC Monthly Meetings
10. The VHSNC functions through meetings. Therefore, at least one meeting should be convened every month. It is through the meetings that the VHSNC monitors and health plans. It is a platform for taking and initiating action, identifying, discuss the problems, and plan for ways to mitigate them. The meeting also serves as an important platform for service providers to learn about the gaps from the community feedback.

Maintaining the VHSNC records

1. Maintain a record of meetings with minutes and attendance of participants
2. Record expenses done by the committee
3. Bank passbook
4. VHSNC Statement of Expenditure
5. Village health register

6. Public services monitoring tool and register
7. Birth and death register

Facilitating Service Delivery and Service Providers in the Village

1. Organizing the MCHN Day (VHND) and support in immunization sessions. VHSNC members should facilitate mobilization of pregnant women and children, particularly from marginalized families and support the ANM/CHOs, AWW and ASHA in conducting the VHND.
2. Create awareness about nutritional issues, including Nutritional needs in the Village Health Plan, and identify locally available foodstuffs of high nutrient value that can be encouraged for use by the families of malnourished children.
3. Facilitate early detection of malnourished children in the community; tie-up referral to the nearest Malnutrition treatment center (MTC)as well as follow up for sustained outcome.
4. VHSNC should act as a medium to allow outreach workers and community health workers to articulate their problems and provide support in overcoming their challenges. The meetings should identify the sections/hamlets of the community where the ANM, Anganwadi worker, the school teacher, and the ASHA are unable to reach and help these CHWs to reach those sections/hamlets.
5. Help in providing important amenities missing in the Anganwadi Center or Sub-Center-AAM or School.
6. Learn about the gaps in services from the community feedback and possible gaps from the provider feedback and act as a platform for dialogue and action.
7. Support ambulance service by organizing local tie-ups with vehicle owners to transport a patient to the hospital in time of need.
8. Undertake registration of births and deaths and ensure that a birth certificate is issued by the appropriate authority and reaches the family within the given time standard. All deaths too should be followed by the issuance of a death certificate, including for stillbirths.
9. The VHSNC should focus on the cause of death and report such causes, as this is likely to form the basis for village planning.
10. Information on any maternal death, child death, and any outbreak should be immediately provided to the AAM-Sub center ANM/CHO/Medical officer Incharge.

Community Monitoring of Healthcare Facilities

1. Monitor healthcare services in primary and secondary healthcare facilities. Fill scorecards for health facilities and visit PHCs/CHCs and AAM-SHCs for monitoring and dialogue with service users to understand key issues and gaps related to service delivery and quality of care.
2. Organize Jan Samvads, forums for dialogue between the community and the authorities, and also perform the task of grievance redressal.

Other public services monitored by VHSNC are:

1. MNREGA
2. PDS
3. Mid-day meals at schools.
4. AWC services: Supervise the functioning of the Anganwadi Centre (AWC) in the village and facilitate its work in improving the nutritional status of women and children.
5. Access to clean toilets
6. Access to safe drinking water

Thus, the VSHNCs perform a key role in improving the health and well-being of the community through prioritizing, collective action, and demanding services from various government agencies.

Source: https://bhs.org.in/a-gentle-introduction-to-vhsnc/ and https://nhm.gov.in/images/pdf/communitisation/vhsnc/order-guidelines/vhsnc_guidelines.pdf

QUALITY ASSURANCE

1

Kayakalp

Clean environment improves healing and Fastens recovery, besides enhancing patients' experience at health facility. The Union Health and Family Welfare Minister Shri J P Nadda has launched 'Kayakalp Award Scheme' on May 15, 2015 as an extension of 'Swachh Bharat Mission'. Aim of initiative which to improve and promote the cleanliness, hygiene, waste management and infection control practices in public health care facilities and incentivize the exemplary performing facilities. The scheme is intended to encourage and incentivize Public Health Facilities (PHFs) in the country to demonstrate their commitment for cleanliness, hygiene and infection control practices.

Initiated from District hospitals in 2015, the scheme expanded to PHC level (2016) and then covered all Urban Health Facilities by 2017.

The objectives of the award scheme are :

1. To inculcate a culture of ongoing assessment and peer review of performance related to hygiene, sanitation and infection control.
2. To incentivize and recognize public healthcare facilities that show exemplary performance in adhering to standard protocols of cleanliness, infection control and sanitation,
3. To create and share sustainable practices related to improving cleanliness in public health facilities which lead to positive health outcomes.

ECOFRIENDLY HOSPITALS: AN INITIATIVE UNDER KAYAKALP

It is evident fact that a stable and functional environmental ecosystem leads to the good health of its inhabitants, that is why it is often named a life support system. At the same time, we all are aware that many of the natural systems are constantly under pressure due to an increase in the number of humans & their economic activities.

According to the Centre for Disease Control & Prevention, climate change directly or indirectly affects all the organs of the human body. It has also projected that between 2030 and 2050, climate change will cause approximately 2,50,000 additional deaths per

year, from malnutrition, malaria, diarrhoea, and heat stress. “Health Care without Harm-September 2019 report has reflected that the health sector alone contributes 4.4% to global Green House Gas (GHG) emissions. So, it is very much important that hospitals start working to reduce their climate footprints & move toward net-zero emissions.

A National Action Plan for Climate Change and Human Health (NAPCCHH) was prepared in 2018 to strengthen health care services against the adverse impact of climate change on health. In alignment, the Ministry of Health and Family Welfare (MoHFW) has approved National Programme for Climate Change & Human Health (NPCCHH) in February 2019.

To support the NPCCHH’s objectives, a concept of green hospitals is introduced in public healthcare facilities. The concept would be an integral part of the existing Kayakalp scheme. Under Kayakalp, a new theme i.e., Eco-friendly Facilities ‘has been added. The theme not only helps to keep facilities clean, green, infection, and pollution-free, but also promotes speedy healing.

Summary of Additional theme

a. Energy efficiency in the hospital
b. Air and noise pollution
c. Reduce –reuse and recycle of waste.
d. Save earth and environment.
e. Health and wellbeing

Source: https://qps.nhsrcindia.org/kayakalp-swachh-swasth-sarvatra

2

Swachh Swastha Sarvatra

Ministry of Health & Family Welfare (MoHFW) & Ministry of Drinking Water and Sanitation (MDWS) have started an integrated scheme under Swachh Bharat Mission named as "Swachh Swasth Sarvatra" on December 29, 2016. The aim of this scheme is to strengthen Community Health Centres in open defecation-free (ODF) blocks across the country along with behavioural change to enable them achieve higher levels of cleanliness and hygiene with the goal of making India free of open defecation. Three broad objectives of this scheme are: -

1. Enabling Gram Panchayat where Kayakalp awarded PHCs are located to become ODF.
2. Strengthening Community Health Centre (CHC) in ODF blocks to achieve higher level of cleanliness to meet Kayakalp standards through a support of Rs 10 Lakh under NHM.
3. Build capacity through training in Water, Sanitation and Hygiene (WASH) Of nominees from covered PHC and CHC.

Source: https://qps.nhsrcindia.org/kayakalp-swachh-swasth-sarvatra

3

NQAS

Introduction

World Health Organization defines the Quality of Care as “the extent to which health care services provided to individual and patient populations improve desired health outcome”. To ensure Quality of Care, the healthcare needs to be safe, effective, timely, efficient, equitable and person centered. It is thereby essential to deliver healthcare services that meet the Quality Standards, to attain the Universal Health Coverage (UHC) and Sustainable development goals (SDG)

National Health Policy, approved and adopted by the Government of India in the year 2017, laid down the broad principles of professionalism, integrity, and ethics; equity; affordability; universality; patient centered quality care; accountability; pluralism; inclusive partnerships and decentralization. It has definite time bound quantitative goals, which are aligned with existing national and global strategic directions. The health outcomes envisaged under National Health Policy cannotbe achieved without excellent, safe and quality care.

Ensuring Quality in delivered services is always a key priority of Ministry of Health & Family welfare, Govt. of India and it is well reflected in National Health policy, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM- JAY), Comprehensive primary healthcare CPHC etc.

Since 2005, India is constantly working towards improving the Quality of services delivered and it has built its foundation by setting standards for service delivery and Quality (NQAS) for all level of public Healthcareinstitutions. The minimum standards aligned with the global benchmarks are defined by World Health Organization (WHO), and it is duly recognized by International Society of Quality in Healthcare (ISQua).

NATIONAL QUALITY ASSURANCE FRAMEWORK

In 2013, MoHFW has established the National Quality Assurance Program with systematically institutionalized Central Quality Supervisory Committee (CQSC) at the National level, followed by the State and District Quality Assurance Committees

(SQACs & DQACs), which are further grounded with the FacilityLevel Committees and departmental circles. The designed institutional framework maintains the transparency at every step and reinforces continuous assessment process, training capacity building, certification and incentivization of public health facilities; thereby strengthening the public health system as a whole. All the 28 States and 8UTs of the country have operationalized SQACs, acting mainstay in implementation and sustenance of the program. Predominantly, the program has a robust mentoring system and an effective periodic mentoring mechanism; endorsed with an organized assessment tool which covers all the facets of a public health facility from stem to stem.

QUALITY IN HEALTHCARE

Quality in Healthcare system has 2 components –

1. Technical Quality – on which, usually service providers (doctors, nurses & para-medical staff) are moreconcerned and has a bearing on outcome or end-result of services delivered. e.g., Clinical Protocols.

2. Service Quality - pertains to those aspects of facility-based care and services, in which patients are often moreconcerned, and have bearing on patient satisfaction. e.g. behavior of staff., promptness of services etc.

According to **Donabedian Model**, Quality of care is categorized into three aspects – Structure, Process and Outcome. **Structure** includes availability of material resources like infrastructure, drugs and equipment; and human resources such as availability of adequate personnel with requisite knowledge andskill.

Care can also be evaluated in terms of **processes** & sub-processes required for delivery of services. Thisrefers to what takes place during its delivery – such as how quickly registration of a patient is done, courteous behavior of the service providers, especially of doctors & nurses, conduct of examination with respect to privacy etc.

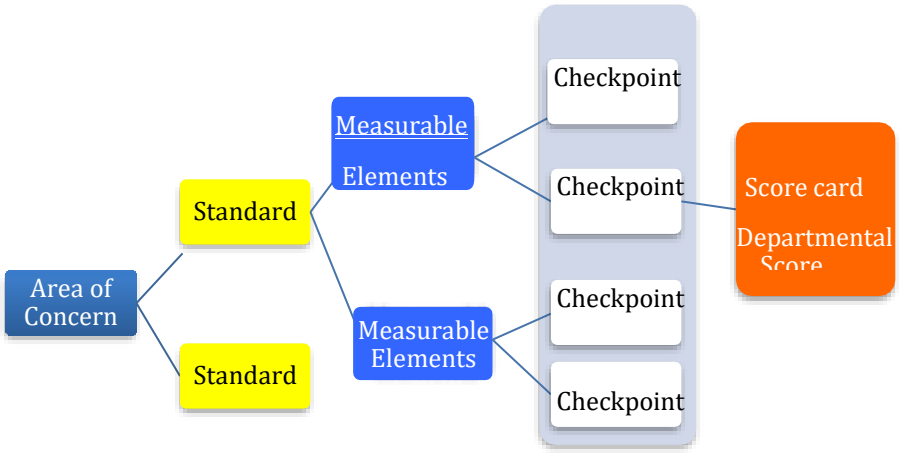
The other aspect of quality of care can be assessed in terms of **outcome** measurements, which denote to what extent goals of the care have been achieved.

Holistic Quality standards must meet the specific requirements of public health system and encompass allthe three aspects of Donabedian model of Quality of care.

STRUCTURE OF THE NATIONAL QUALITY ASSURANCE STANDARDS

The main pillars of Quality Measurement Systems are Quality Standards. These standards have been grouped within the eight **Areas of Concern**. Each Standard further has specific **Measurable Elements**. These standards and measurable elements are checked in each department of a health facility through department specific **Checkpoints**. All Checkpoints for a department are collated, and together they form assessment tool called '**Checklist**'. Scored/ filled-in Checklists would generate scorecards.

Functional Relationship between the components of Quality Measurement System



Area of Concern

Area of Concern is broad area/ theme for assessing different aspects for quality. The eight areas of concerns are as shown in table below:

AREA OF CONCERN FOR UNDER NQAS FOR HEALTHCARE FACILITIES			
A.	**Service Provision**	**B.**	**Patient Rights**
C.	**Inputs**	**D.**	**Support Services**
E.	**Clinical Services**	**F.**	**Infection Control**
G.	**Quality Management**	**H.**	**Outcome**

Standards are the statement of requirements for a particular aspect of quality components

Measurable Element is specific attribute of a standard which should be looked into for assessing the degreeof compliance to a particular standard.

Checkpoints are tangible measurable points which can be objectively **observed** and scored.This is illustrated in the table below.

	Example 1	Example 2	Example 3
Area of Concern	Infection Control	Clinical Service	**Patient Rights**
Standards	Hand Hygiene	Intrapartum Care	**Privacy & Confidentiality**
Measurable Element	Hand washing facility	Active management of third stage of labour	**Visual Privacy**
Checkpoints	**Availability of Soap**	**Administration of Oxytocinwithin 1 minute of birth**	**Availability of screensand curtains**

All the applicable standards and measurable element for one department have been collated in the checklists. It enables measurement of all aspect of quality of care in a department in one go. After assessingthe departments on the checklist, their scores can be calculated to see compliance to different standards inthe department.

Currently National Quality Assurance Standards are available for following level of facilities and programs:

1. District Hospital
2. Community Health Centre
3. Primary Health Centre (24x7)
4. Urban Primary Health Centre
5. Ayushman Arogya Mandir (Sub-centre)

6. Adverse Events Following Immunization (AEFI) Surveillance Program
7. Comprehensive Lactation Management Centers and Units

Following is the summary of Standard, Measurable Element & Departmental Checklist for various levelof facilities and programs:

Component	DH	CHC	PHC	UPHC	HWC SC	AEFI	CLMC
Area of Concern	**8**	**8**	**8**	**8**	**8**	**8**	**8**
Standards	**75**	**65**	**50**	**35**	**50**	**40**	**30**
Measurable Elements	**380**	**297**	**250**	**200**	**129**	**230**	**90**
Checklists	**21**	**12**	**6**	**12**	**1**	**4**	**1**

AREA OF CONCERN 'A': SERVICE PROVISION

This area of concern measures availability of services. Public hospitals in addition to the curative services are mandated to provide preventive and promotive services at all levels of care i.e., District Hospital (DH), Community Health Centre (CHC), Primary Health Centres (PHC) both urban & rural and Ayushman Arogya Mandir- Sub Centre (HWC-SC).

Reproductive and Child Health services are grouped as RMNCHA & National Health program, which includes major chunk of the services. These services are also priority for the government, to have direct impact on the key indicators such as MMR and IMR.

CHC constitute the First Referral Units (FRUs) and are designed to provide referral or direct services for cases in need of specialist care. Indian Public Health Standards (IPHS) defines minimum assured services,which should be available at a Community Health Centre. It is an important link between PHC and DH. CHC is usually 30-bedded Hospital providing broadly Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, specialist services.

Primary Health Centres in rural and urban areas have pivotal role in providing preventive & promotive healthcare to community apart from limited level of primary curative care. Indian Public Health Standards guidelines (IPHS) have defined minimum assured service to be provided at Primary Health Centres, whichare also hub of the services provided under the National Health Programmes.

Ayushman Arogya Mandir (Sub-Centre) ensures provision of comprehensive primary care to the population in its catchment area. It provides preventive, promotive, curative, rehabilitative and palliative aspects of care as per scope of services. The scope of HWC SC includes 12 packages of care along with inclusion of services which lead the community towards wellness e.g., promotion and prevention activities under NCD, Yoga Sessions etc. Another important aspect of service provision is Health promotion and disease prevention by undertaking multi-sectoral convergence activities like campaigns, meetings of VHSNC, Self-help groups, Patient support groups etc.

As highlighted earlier this area of concern measures availability of functional services. "Availability of functional services" means service is available to end-users because mere availability of infrastructure or human resources does not always ensure into availability of the services.

Compliance to these standards and measurable elements should be checked, preferably by observing delivery of the services, review of records, ensuring utilization of the service through end user's interview.

Examples:

At District Hospital despite having functional OT, Blood Bank, and availability of Obstetrician andAnesthetist it may not be providing CEmOC services on 24x7 basis

- At CHC Operation Theatre, Surgeon and Anesthetist may be available, but no LSCS are being conducted due to varied reasons.
- At PHC, ANC clinic may be available, but all the services like mandatory diagnostic test & nutritional counseling are not being provided to the beneficiary. In this case it is assumed that ANC services are not completely available at the facility.
- At HWC SC, as per staff, the facility may have functional NCD services, but if there are hardly any diagnostic test undertaken or medicines provided or regular assessments being done for ensuring continuity of care at the HWC, it may be assumed that the services are either not available or non- accessible to users.

S. no	Area of Concern: Service Provision	DH	CHC	PHC	UPHC	HWC SC
1.	Standards	6	6	4	5	2
2.	**Measurable Elements**	52	43	32	29	16

AREA OF CONCERN 'B': PATIENT RIGHTS

Mere availability of services does not serve the purpose until the services are accessible to the users and are provided with dignity and confidentiality. Access includes physical access as well as financialaccess. The Government has launched many schemes, such as JSSK, RBSK and PMJAY, for ensuringthat the service packages are available cashless to different targeted groups. There is evidence to suggest that patients' experience and outcome improves when they are involved in the care. So,availability of information is critical for access as well as enhancing patients' satisfaction. Patients' rightsalso include that service provider give due consideration to patients' cultural and religious preferences. Patient Rights include the information to care seeker, attendants & community, sensitive to gender, religious and cultural needs and non-discrimination on account of economic or social reasons, services are provided free of cost services. It also ensures that service providers maintain privacy, confidentialityand dignity of the patient and service provider follow the ethical practices.

S. no	Area of Concern: Patients' Rights	DH	CHC	PHC	UPHC	HWC SC
1.	Standards	6	5	4	3	5
2.	**Measurable Elements**	40	28	21	17	13

AREA OF CONCERN 'C': INPUTS

This area of concern predominantly covers the structural part of the facility. Indian Public Health Standards (IPHS) defines infrastructure, human resources,

medicines, and equipment requirements for different level of health facilities. Quality standards given in this area of concern take into cognizance ofthe IPHS and program specific requirements. However, focus of the standards is in ensuring compliance to minimum level of inputs, which are required for ensuring delivery of committed level of the services.

The words like 'adequate' and 'as per load 'has been used in the requirements for many checkpoints, as it would be hard to set structural norms for every level of the facility that commensurate with patient load. For example, a 100 bedded hospital having 40% bed occupancy may not have same requirements as the similar hospital having more than 100% occupancy. So structural requirement should be based more on the utilization of the services, rather than fixing the criteria like, beds available in the hospital. Assessor should use his/her discretion to arrive at decision, whether available structural component is adequate for committed service delivery or not. At PHC and HWC (SC) level infrastructure for delivery of assured services, and infrastructure as per theprevalent norm is mandatory.

Inputs area of concern also standards include physical safety including fire safety of the infrastructure, adequate qualified and trained staff for providing the assured services to the current caseload, providing drugs and consumables required for assured services and equipment & instruments required for assured list of services. These standards ensure that at least these services should be present at the primary level to give expanded range of services which will address the primary health care needs of the entire population in the catchment area. Area of concern C also give emphasis on regular evaluation of competence and performance of all cadre i.e., Govt. and outsourced.

S. no	Area of Concern: Inputs	DH	CHC	PHC	UPHC	HWC SC
1.	Standards	7	5	5	4	5
2.	**Measurable Elements**	**40**	**30**	**25**	**20**	**12**

AREA OF CONCERN 'D': SUPPORT SERVICES

Support services are backbone of every health care facility. The expected clinical outcome cannot be envisaged in absence of sturdy support services. This area of

concern includes equipment maintenance, calibration, drug storage & inventory management, security, facility management, water supply, power backup, dietary services and laundry. Administrative processes like functioning of Rogi Kalyan Samitis (RKS), financial management, legal compliances, staff deputation and contract management have also been included in this area of concern.

It also includes defined and established procedures for promoting public participation in management of hospital transparency and accountability. The standard talks about monitoring of quality of outsourced services, compliance to applicable statutory and regulatory requirement imposed by local, state, or central government. The roles & responsibilities of administrative and clinical staff, regulations. In primary care, standard also include monitoring & reporting of National Health Program as per National & State mandate.

In HWC SC, it also gives emphasis on conduction of regular meetings for Jan Arogya Samitis, Village Health Sanitation and Nutrition Committee (VHSNCs), Patient support groups and Self-Help Groups (SHGs), social accountability etc.

S. no	Area of Concern: Support Services	DH	CHC	PHC	UPHC	HWC SC
1.	Standards	12	10	8	5	6
2.	**Measurable Elements**	44	42	51	43	15

AREA OF CONCERN 'E': CLINICALSERVICES

The ultimate purpose of existence of a hospital is to provide clinical care. Therefore, clinical processes are the most critical and important in the hospitals. These are the processes that directly define the outcome of services and quality of care. The area of concern is focused on assessment of quality of services provided which include early identification, primary clinical management, care coordination for ensuring Continuity of care, provision of basic diagnostic and dispensing of medicines. It also includes

adherence to clinical protocols while delivering the services, ensuring continuity of care, safe drug administration practices, no over-prescription, rational use of drugs, regular monitoring and follow up of critical, NCD & defaulter cases etc.

The Standards under this area of concern are grouped into three categories:

- First: a set of standards are concerned with those clinical processes that ensure adequate care to the patients. It includes registration, admission, consultation, clinical assessment, continuity of care, nursing care, identification of high-risk and vulnerable patients, prescription practices, safe drug administration, maintenance of clinical records and discharge from the hospital.
- Second: Standards are concerned with specific clinical and therapeutic processes, including intensive care, emergency care, diagnostic services, transfusion services, anesthesia, surgical services and end-of-life care.
- Third: Set of standards is concerned with specific clinical processes for Maternal, Newborn, Child, Adolescent & Family Planning services, National Health Programs and Hemodialysis Unit.

These standards are based on the technical guidelines published by the Government of India on respective programs and processes.

It may be difficult to assess clinical processes, as direct observation of all clinical procedures may not be possible at the time of assessment. Therefore, assessment of these standards would largely depend a upon review of the clinical records. Interaction with the staff to know their skill level and how they practiceclinical care (Competence testing) would also be helpful.

Assessment of these standards would require thorough domain knowledge.

S. no	Area of Concern: Clinical Services	DH	CHC	PHC	UPHC	HWC SC
1.	Standards	24	22	15	9	18
2.	**Measurable Elements**	126	101	78	58	49

AREA OF CONCERN 'F': – INFECTION CONTROL

The first principle of health care is "to do no harm". As public hospitals usually have high occupancy, infection control practices become more critical to avoid cross-

infection and its spread. The standards underthis area of concern include infection prevention and control practices in place for the prevention and measurement of hospital-associated infection. Area of concern F, ensure hand hygiene practices, availability of material for personal protection, facility staff follow standard precaution for personal protection, procedures for decontamination, disinfection & sterilization of equipment and instruments, physical layout and environmental control of the patient care areas as well as segregation, collection, treatment and disposal of Bio Medical and hazardous waste.

S. no	Area of Concern: Infection Control	DH	CHC	PHC	UPHC	HWC SC
1.	Standards	6	6	6	4	5
2.	**Measurable Elements**	21	21	15	10	9

AREA OF CONCERN 'G': - QUALITY MANAGEMENT

Quality management requires a set of interrelated activities that assure quality of services according to set standards and strive to improve upon it through a systematic planning, implementation, checking and acting upon the compliances. The standards in this area concern are the opportunities for improvement to enhance quality of services and patient satisfaction. These standards are in synchronization with facility-based quality assurance and improvement programme mentioned in 'Operational Guidelines for Improving Quality in Public Healthcare Facilities, 2021. It includes standards like organizational framework for facility level Quality Improvement, patient, and employee satisfaction, assuring and improving quality of clinical & support services by internal & external program, Standard Operating Procedures for all key processes. It also helps facility to define their mission, values, quality policy and objectives, to achieve quality. Area of concern G covers use of quality tools and methods, risk management plan and establishment of clinical governance framework to improve quality and safety in clinical care processes

S. no	Area of Concern: Quality Management	DH	CHC	PHC	UPHC	HWC SC
1.	Standards	10	7	4	3	5

2.	**Measurable Elements**	**49**	**23**	**19**	**17**	**7**

AREA OF CONCERN 'H': - OUTCOME

Measurement of the quality is critical to improvement of processes and outcomes. This area of concern has four standard measures for quality- Productivity, Efficiency, Clinical Care and Service quality in terms of measurable indicators. Every standard under this area has two aspects – Firstly, there is a system of measurement of indicators at the health facility; and secondly, how the hospital meets the benchmark. It is realized that at the beginning many indictors given in these standards may not be gettingmeasured across all facilities, and therefore it would be difficult to set benchmark beforehand. However,with the passage of time, the state can set their benchmarks, and evaluate performance of health facilities against the set benchmarks. The standards include Productivity, Efficiency, Clinical Care and Service Quality Indicators and ensure compliance with State/National benchmarks.

S. no	Area of Concern: Outcome	DH	CHC	PHC	UPHC	HWC SC
1.	Standards	**4**	**4**	**4**	**2**	**4**
2.	**Measurable Elements**	**8**	**9**	**9**	**6**	**8**

Source: https://qps.nhsrcindia.org/

4

MusQan

India has made considerable progress in improving the survival of newborn and children. A major reason for this achievement is the massive scale-up of community and facility-based care that is being provided to newborn and children. A series of national level initiatives launched by the Government of India (GoI) under its flagship programmes, such as the National Health Mission and Ayushman Bharat have immensely contributed to these improved indicators.

Efforts over the past decade to minimize adverse outcomes for newborn and children have been directed for increasing access to institutional care. This has resulted in higher footfalls in health facilities in all regions. With increasing utilization of health services, poor quality of care (QoC) in many facilities has become a major bottleneck in the quest to end preventable mortality and morbidity.

The quality of newborn and pediatrics services delivered in public health facilities need to achieve standard benchmarks for accomplishing desired goals and improve the child health scenario in the country

For ensuring child-friendly services in public health facilities, the Ministry of Health & Family Welfare (MoHFW) is introducing a new quality improvement initiative "MusQan" for the paediatric age group (0- 12 years), within the existing National Quality Assurance Standards (NQAS) framework. MusQan aims to ensure timely, effective, efficient, safe, person- centred, equitable and integrated quality services in public health-care facilities, to reduce the preventable newborn and child morbidity and mortality.

OBJECTIVES OF MUSQAN

- To reduce preventable mortality and morbidity among children below 12 years of age
- To enhance Quality of Care (QoC) as per National Quality Assurance Standards (NQAS)
- To promote adherence to evidence-based practices and standard treatment guidelines & protocols
- To provide child-friendly services to newborn and children in humane and supportive environment

DEPARTMENTS INCLUDED IN MUSQAN

District Hospital	Sub Divisional Hospital	FRU/ CHC*	LaQshya Certified Medical Colleges
4 Departments • Paediatric OPD • Paediatric Ward • SNCU • Nutrition Rehabilitation Centre (NRC) (ifavailable)	3 Departments • Paediatric OPD • Paediatric Ward • SNCU/NBSU	2 Departments • Paediatric OPD • NBSU/ SNCU (If available)	4 Departments • Paediatric OPD • Paediatric Ward • SNCU • Nutrition RehabilitationCentre (NRC)

In the states, if NRCs are established at SDH and CHCs, same would be included in MusQan initiative ofsuch CHCs.

Besides ensuring the compliance to minimum criteria defined for MusQan, facility is supposed to attain the targets defined in **Annexure A** of MusQan guidelines. To achieve the targets and close the gaps departments are encouraged to undertake rapid improvement events (RIEs) and ensure long term sustainability of the efforts. Under MusQan the achievement of set target is checked by the assessor at the time of external assessment while under LaQshya, a brief period of 6 months is given to departments to achieve the targets. Verification of LaQshya targets is done by the SQAU along with state external assessor and maternal health division and a report is submitted to NHSRC. Incentives to LaQshya certified departments is not disbursed till targets are not achieved by the departments.

Source: https://qps.nhsrcindia.org/

5

NATIONAL QUALITY ASSURANCE STANDARDS FOR AEFI SURVEILLANCE PROGRAM

India is committed to achieve the target of Sustainable Development Goal (SDG) and National health policy is obliged to reduce the IMR to 25 per 1000 live births by 2030, through its various programmatic strategies. Universal Immunization program (UIP) is one of such programs with targets of almost 27 million newborns and 30 million pregnant women covered through 9 million sessions every year. It's an effective and evenly targeted programme and its ability to reduce the burden of Vaccine Preventable Diseases (VPDs) contribute in the wellbeing of children and mothers.

India is not only one of the largest consumers of the vaccines but also manufactures and export the vaccines to many countries thus it becomes imperative to have strong AEFI surveillance system in place.

As per the National Regulatory Assessment Conducted in 2012, AEFI surveillance in the country is needed to be improved. Of many activities undertaken to improve the AEFI surveillance in the country, development and establishing the QMS for AEFI surveillance was given the priority. NHSRC in collaboration with AEFI Secretariat within ITSU (Immunization Technical Support Unit) developed the QMS for AEFI Surveillance program in 2016.

Under this QMS, standards and indicators for processes at national, state, districts and session sites has been developed along with the checklists for each level to measure the performance and status against the standards.

This Quality Standards for AEFI Surveillance is path breaking in establishing the QMS in the public health program

AREA OF CONCERN 'A': NOTIFICATION AND REPORTING

AEFI surveillance is an important component of the Universal Immunization Programme. For strengthening AEFI surveillance, vigilance by health care providers is of utmost importance. Notification and reporting of an AEFI case is the first crucial step in the AEFI surveillance system. Thecompleteness and timeliness

of reporting are the major factors determining quality of the programme. It is essential that the health staff be able to identify and report all severe, serious and minor AEFIs

AREA OF CONCERN 'B': INVESTIGATION

The ultimate goal of a case investigation is to arrive at a clinical diagnosis based on the chronology ofmedical events, detailed medical history and other evidence such as laboratory investigations, etc. Oncea probable diagnosis is available, it will help in finding the cause of the AEFI and to undertake appropriate response for action. The investigations should identify any immunization error-related or

vaccine quality defect –related reactions because these are preventable. In case of co-incidental events, it is important to document and communicate because this maintains public confidence in theimmunization programme.

AREA OF CONCERN 'C': CAUSALITY ASSESSMENT

Causality assessment is the systematic review of the information obtained about an AEFI case, to determine the likelihood of the event having been caused by the vaccine(s) received. This does not necessarily establish whether or not a definite relationship exists between an event and immunization, but generally only ascertains a degree of association of the event with the vaccine/vaccination. It is a critical part of AEFI surveillance and enhances confidence in the national immunization programme.

Causality assessment may provide a more descriptive explanation of the event, which may help to understand what caused the event. If a manufacturing defect or a programme error is suspected to bethe cause of the event, specific steps can be taken to ensure prevention of further errors. If events arecoincidental, it reassures the community and stakeholders that the vaccines are safe. In essence, whether an AEFI might be attributable or not to the vaccine or vaccination determines what steps needto be taken to address the event.

AREA OF CONCERN 'D': OPERATIONAL MANAGEMENT

This area of concern is related to the overall operational management programme

of the AEFI surveillanceprogramme. This area of concern focuses basically on the constitution and functioning of the National AEFI Secretariat and AEFI Committees at National, State and district levels based on the established procedure for functioning.

It also addresses the roles and responsibilities of the stakeholders at different administrative levels, training and capacity building of personnel involved in AEFI Surveillance and preparation of the immunization sites for preventing and treating any adverse event following immunization

AREA OF CONCERN 'E': COMMUNICATION

Effective communication around vaccine safety, including management of public reactions, requires serious investment of resources and efforts towards strategic communication for immunization. In order to have a sustainable impact on the behavior of individual or groups on a larger scale, communication efforts need to be strategic, participatory, evidence-based, well-funded and a result-oriented process. Regular communication with the community and the media will improve relations between health providers and communities; it will encourage community involvement which will prevent the community from losing confidence in vaccinations and reduce the fear of AEFIs.

This area of concern measures the procedures for regular communication to maintain confidence in the immunization programme, procedures for communication in case of serious AEFI events, established strategy for media management at district, state and national level, defined procedures for management of information on social media and also for capacity building of key personnel responsiblefor communication at each level of administration.

AREA OF CONCERN 'F': CONVERGENCE

All stakeholders in AEFI surveillance are routinely communicating and coordinating with each other toavoid information gaps and take timely & appropriate action. Convergence among all stakeholders is maintained at such levels that any safe vaccine continues to be in use and any unsafe vaccine is withdrawn immediately, and action is taken for prevention of similar errors.

AREA OF CONCERN 'G': MONITORING AND FEEDBACK

This area of concern details about the defining, monitoring and analysis of the KPIs for AEFI Program,established procedures for identifying signals for AEFI cases and providing timely feedbacks on the reports that are submitted

Area of concern also address the procedures for providing feedback to the states regarding the causality assessment and trend analysis and follow up with non-reporting states and districts.

AREA OF CONCERN 'H': QUALITY MANAGEMENT SYSTEM

A quality management system consists of a set of interrelated activities that assure quality of servicesaccording to the standards set, and strive to improve upon it through systematic planning, implementation, checking and acting upon the compliances. The standards in this area of concern are opportunities for improvement to enhance quality of services and strengthening the AEFI programme.

Summary of Standards and Measurable Elements for AEFI

S. no	Area of Concern	Standards	Measurable Elements
A.	Notification and Reporting	5	**27**
B.	Investigation	5	**43**
C.	Causality Assessment	5	**37**
D.	Operational Management	5	**46**
E.	Communication	5	**24**
F.	Convergence	5	**12**
G.	Monitoring and Feedback	5	**19**
H.	Quality Management System	5	**22**
	Total	**40**	**230**

National Quality Assurance Programme is committed to build up a culture of quality in public health systems and revolves around finding the opportunities for

improvement through an explicit measurement system. Such opportunities could be structure related, process related, or outcome related. Facilities are expected to plan for systemic action for addressing such opportunities for improvement.

"Quality is all about having improved health outcomes with greater satisfaction of patients."

Source: https://qps.nhsrcindia.org/

6

LaQshya

Labour Room Quality Improvement Initiative – 'LaQshya'

After launch of the National Health Mission (NHM), there has been substantial increase in the number of institutional deliveries. However, this increase in the numbers has not resulted into commensurate improvements in the key maternal and new-born health indicators. It is estimated that approximately 46% maternal deaths, over 40% stillbirths and 40% newborn deaths take place on the day of the delivery.

A transformational change in the processes related to the care during the delivery, which essentially relates to intrapartum and immediate postpartum care, is required to achieve tangible results within short period of time.

'LaQshya' programme of the Ministry of Health and Family Welfare aims at improving quality of care in labour room and maternity Operation Theatre (OT).

Goal

Reduce preventable maternal and newborn mortality, morbidity and stillbirths associated with the care around delivery in Labour room and Maternity OT and ensure respectful maternity care.

Objectives

- To reduce maternal and newborn mortality & morbidity due to APH, PPH, retained placenta, preterm, preeclampsia & eclampsia, obstructed labour, puerperal sepsis, newborn asphyxia, and sepsis, etc.
- To improve Quality of care during the delivery and immediate post-partum care, stabilization of complications and ensure timely referrals, and enable an effective two-way follow-up system.
- To enhance satisfaction of beneficiaries visiting the health facilities and provide Respectful Maternity Care (RMC) to all pregnant women attending the public health facility.

Strategies

- Reorganizing/aligning Labour room & Maternity Operation Theatre layout and workflow as per 'Labour Room Standardization Guidelines' and 'Maternal & Newborn Health Toolkit' issued by the Ministry of Health & Family Welfare, Government of India.
- Ensuring that at least all government medical college hospitals and high case- load district hospitals have dedicated obstetric HDUs as per GoI MOHFW Guidelines, for managing complicated pregnancies that require life-saving critical care.
- Ensuring strict adherence to clinical protocols for management and stabilization of the complications before referral to higher centres.

Scope

Following facilities would be taken under LaQshya initiative on priority:

- All government medical college hospitals.
- All District Hospitals & equivalent healthy facilities.
- All designated FRUs and high case load CHCs with over 100 deliveries/60 (per month) in hills and desert areas.

Institutional Arrangement

Under the National Health Mission, the States have been supported in creating Institutional framework for the Quality Assurance - State Quality Assurance Committee (SQAC), District Quality Assurance Committee (DQAC), and Quality Team at the facility level. These committees will also support implementation of LaQshya interventions. For specific technical activities and program management, special purpose groups have been suggested, and these groups will be working towards achievement of specific targets and program milestones in close coordination with relevant structure.

Skill Development

- Ensuring availability of optimal and skilled human resources as per case-load and prevalent norms through rational deployment and skill upgradation.
- Ensuring skill assessment of all staff of LR & Maternal OT through OSCE (Objective Structured Clinical Examination) testing as per Dakshata guidelines for delivery of 'zero-defect' quality obstetric and newborn care. Enhance proficiency of labor room and operation theatre staff for management of the complications through skill-lab training, simulations and drills. Ensuring that staff working in the labour

room and maternity OT are not shifted from maternity duty to other departments/ wards frequently.

- Sensitizing care-providers for delivery of respectful maternity care and close monitoring of language, behavior and conduct of the labor room, OT & HDU Staff.
- Creating an enabling environment for natural birthing process.
- Implementation of Clinical Guidelines, Labour Room Clinical Pathways, Referral Protocols, safe birth checklist (in the labour room and Obstetric OT) and surgical safety check-list.
- Ensuring round-the-clock availability of Blood transfusion services, diagnostic services, drugs & consumables.
- Ensuring availability of triage area and functional newborn care area.
- Ensuring systematic facility-level audit of all cases of maternal/neonatal deaths, stillbirth, and maternal near miss etc. including with their mentor teams through clinical discussions, peer reviews in teaching institutes, Videoconference, or other distance mode mechanisms for continuous improvement and learning.
- Operationalization of 'C' Section audit and corrective & preventive actions for ensuring that 'C' Sections are undertaken judiciously in those cases having robust clinical indications.
- Instituting an ongoing system of capturing of beneficiaries' independent feedback through mechanism 'Mera- Aspataal' or manual recording, or Grievance Redressal Help Desk and take action to address concerns, for continual enhancement in their satisfaction.
- Ensuring availability of essential support services such as 24x7 running water, electricity, housekeeping, linen and laundry, security, equipment maintenance, laboratory services, dietary services, BMW management, etc.
- Use of digital technology for record keeping & monitoring for maternity wing (MIS), including use of E partograph. Piloting of technology for managing care, such as Computer on Wheel, Computerized Physician Order Entry.
- Use aggressive IEC, user friendly training material and IT-enabled tools. Facilitating branding of all high case load facilities meeting quality standards to improve visibility and awareness.
- Using Quality tools for prioritization, and gap closure such as Plan Do Check Act (PDCA), Root Cause Analysis, Run Charts, Pareto chart and Mistake Proofing for achieving desired targets.

Rapid Improvement Events

Six cycles of two months each as defined below will need to be rigorously supervised and ensured. This will enable competency in all critical skills needed. For each area, a targeted campaign would be launched for a two-month duration, with the first month for the roll-out, followed by sustaining such efforts during the subsequent month (Period for one event – 2 months).

Suggested list of the themes

Cycle 1: Real-time Partograph generation including shift to electronic partograph & usage of safe birth check-list & surgical safety check-list and strengthening documentation practices for generating robust data for driving improvement.

Cycle 2: Presence of Birth companion during delivery, respectful maternity care and enhancement of patients' satisfaction.

Cycle 3: Assessment, Triage and timely management of complications including strengthening of referral protocols.

Cycle 4: Management of Labour as per protocols including AMTSL & rational use of Oxytocin.

Cycle 5: Essential and emergency care of Newborn & Pre-term babies including management of birth asphyxia and timely initiation of breast feeding as well as KMC for preterm newborn.

Cycle 6: Infection Prevention including Biomedical Waste Management.

Incentives

The Quality Improvement in labour room and maternity OT will be assessed through NQAS (National Quality Assurance Standards). Every facility achieving 70% score on NQAS will be certified as LaQshya certified facility. Furthermore, branding of LaQshya certified facilities will be done as per the NQAS score. Facilities scoring more than 90%, 80% and 70% will be given Platinum, Gold and Silver badge accordingly. Facilities achieving NQAS certification, defined quality indicators and 80% satisfied beneficiaries will be provided incentive of Rs 6 lakh, Rs 3 lakh and Rs 2 lakh for Medical College Hospital, District Hospital and FRUs respectively.

Source: LaQshya / NHM, www.qps.nhsrcindia.org

7

NQAS for Comprehensive Lactation

Improving breastfeeding practices for quality survival of newborn is one of the important interventions under the National Health Mission (NHM) of the Ministry of Health and Family Welfare, Government of India.

Availability of safe donor human milk (DHM) at NICU/SNCU is critical to ensure that every sick and pre- term baby receives human milk within the first hour. DHM plays a lifesaving role by helping these babies receive the benefits of early initiation and exclusive feeding of human milk. Therefore, a mechanism to collect, pasteurize, test, and store safe DHM from lactating mothers and provide it to infants in need, ensures that even if babies cannot breastfeed, they still receive human milk as soon as possible. National Health Mission has taken the initiative to establish lactation management centers at secondary and tertiary level public health facilities to provide lactation support for mothers who can, or can eventually, breastfeed.

This facility-based lactation management strategy adopting the procedures of collection, processing, storage and dispensing of donor human milk and mother's own milk along with provision of lactation support to the mothers is a key component for protecting, promoting, and supporting breastfeeding.

This initiative is operationalized in the form of the establishment of:

- Comprehensive Lactation Management Centres (CLMCs) for donor human milk collection, storage, processing and dispensing for babies admitted in health facilities.
- Lactation Management Units (LMUs) for collecting, storing and dispensing of mother's breast milk, expressed and stored for consumption by her own baby.
- Lactation Support Units (LSUs) for providing lactation support to mothers at all delivery points.

The objective of initiatives is to protect, promote and support breastfeeding, to promote early initiation and exclusive feeding of human milk among sick and vulnerable newborns admitted in SNCUs/NICU and to save babies from the

adverse events of formula feed.

Under the ambit of Ministry of Health & family welfare, 'National Quality Assurance Standards for Public Health facilities that are already implemented across States/ UTs. NQAS for CLMC would be measuring Quality of services as well as functionality of its processes as per defined quality standards. It is the first step in assessing the existing system and moving towards dwelling a Quality Management System in human milk banks.

1. AREA OF CONCERN 'A': SERVICE PROVISION

This area of concern implies that the milk bank provides service delivery as per the scope, including the availability of mothers for voluntary donation of milk and the availability of adequate, safe, pasteurized, donated milk for ready use following standard practices to provide human milk to sick and vulnerable newborns.

2. AREA OF CONCERN 'B': PATIENT RIGHTS

This area of concern pertains to accessibility, affordability, and quality of service delivery to the Users, which is provided with dignity and confidentiality without any physical barriers, informational and financial barriers. Patients' rights also include consideration to users' social, cultural, and religious preferences.

3. AREA OF CONCERN 'C': INPUTS

This area of concern focuses on the physical and fire safety measures, adequate qualified and trained staff for rendering the services and equipment and consumables for collection, processing and storage of Human Milk are available as per the defined norms and case load.

4. AREA OF CONCERN 'D': SUPPORT SERVICES

This area of concern includes establishing the demand of human donor milk and maintaining the buffer stock to avoid stock out along with compliance to prevalent legal and regulatory requirements.

5. AREA OF CONCERN 'E': CLINICAL SERVICES

This area of concern describes about the technical component of milk bank that includes recruitment and screening of donors, methodology followed for milk

collection, labeling and pre-pasteurization, storage, pooling and aliquoting of milk, pasteurization, maintenance of temperature and dispensing of donated human milk and mother's own milk and optimal feeding practices in attached NICU/ SNCU.

6. AREA OF CONCERN 'F': INFECTION CONTROL

This area of concern only covers the adherence to infection control practices among milk bank staff but also among mothers visiting the milk bank for donation. Area of concern also persists on compliance with hand-hygiene, antisepsis, and personal protection during handling of Human Milk. Sterility of processing and storage equipment along with microbiological testing for improving the infection control practices.

7. AREA OF CONCERN 'G': QUALITY MANAGEMENT

This area of concern addresses the quality policies and objectives and communication of the same to the users and staff deployed. It also ensures that CLMC is operated as per defined and documented SOPs and quality improvement processes are reviewed periodically to enhance quality of services and customer satisfaction. It also addresses the implementation of Hazard Analysis and Critical Control Point (HACCP) protocols as per the guidelines.

8. AREA OF CONCERN 'H': OUTCOME

Measurement of the quality is critical to improvement of processes and outcomes. This area of concern has standard to measures the Key Performance Indicators and understand the utilization of services for undertaking improvements.

Standards and Measurable Elements for CLMC

S. no	Area of Concern	Standards	Measurable Elements
A.	Service Provision	2	6
B.	Patient Rights	2	6
C.	Inputs	4	12
D.	Support Services	4	12
E.	Clinical Services	10	30

F.	Infection Control	3	9
G.	Quality Management	4	12
H.	Outcome	1	3
Total		30	90

Source: LaQshya / NHM, www.qps.nhsrcindia.org

Ayushman Bharat Digital Mission

About

The Ayushman Bharat Digital Mission (ABDM) aims to develop the backbone necessary to support the integrated digital health infrastructure of the country. It will bridge the existing gap amongst different stakeholders of healthcare ecosystem through digital highways.

Background

To strengthen the accessibility and equity of health services, including continuum of care with citizen as the owner of data, in a holistic healthcare programme approach leveraging IT & associated technologies and support the existing health systems in a 'citizen-centric' approach, the ABDM envisages the following specific objectives:

The National Health Policy (NHP) 2017 has the following goal:

- "The attainment of the highest possible level of health and wellbeing for all at all ages, through a preventive and promotive health care orientation in all

developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence."

- In a follow-up of the NHP's specific goals for adopting digital technologies, the Ministry of Health and Family Welfare constituted a committee headed by Shri J. Satyanarayana to develop an implementation framework for the National Health Stack. This committee produced the National Digital Health Blueprint (NDHB), laying out the building blocks and an action plan to comprehensively and holistically implement digital health.
- Taking forward the NDHB, this document describes the broad context, rationale, scope, and implementation arrangements for a digital ecosystem for healthcare services across the country. Since the implementation is envisioned to be in a mission mode, the initiative is referred to as the Ayushman Bharat Digital Mission (ABDM).

Vision

To create a national digital health ecosystem that supports universal health coverage in an efficient, accessible, inclusive, affordable, timely and safe manner, that provides a wide-range of data, information and infrastructure services, duly leveraging open, interoperable, standards-based digital systems, and ensures the security, confidentiality and privacy of health-related personal information.

Objectives

To strengthen the accessibility and equity of health services, including continuum of care with citizen as the owner of data, in a holistic healthcare programme approach leveraging IT & associated technologies and support the existing health systems in a 'citizen-centric' approach, the ABDM envisages the following specific objectives:

- To establish state-of-the-art digital health systems, to manage the core digital health data, and the infrastructure required for its seamless exchange;
- To establish registries at appropriate level to create single source of truth in respect of clinical establishments, healthcare professionals, health workers, drugs and pharmacies;
- To enforce adoption of open standards by all national digital health stakeholders;

- To create a system of personal health records, based on international standards, easily accessible to individuals and healthcare professionals and services providers, based on individual's informed consent;
- To promote development of enterprise-class health application systems with a special focus on achieving the Sustainable Development Goals for health;
- To adopt the best principles of cooperative federalism while working with the States and Union Territories for the realization of the vision;
- To ensure that the healthcare institutions and professionals in the private sector participate actively with public health authorities in the building of the ABDM, through a combination of prescription and promotion;
- To ensure national portability in the provision of health services;
- To promote the use of clinical decision support (CDS) systems by health professionals and practitioners;
- To promote a better management of the health sector leveraging health data analytics and medical research;
- To provide for enhancing the efficiency and effectiveness of governance at all levels;
- To support effective steps being taken for ensuring quality of healthcare; and
- To strengthen existing health information systems, by ensuring their conformity with the defined standards and integration with the proposed ABDM.

The current strong public digital infrastructure—including that related to Aadhaar, Unified Payments Interface and wide reach of the Internet and mobile phones (JAM trinity) — provides a strong platform for establishing the building blocks of ABDM. The existing ability to digitally identify people, doctors, and health facilities, facilitate electronic signatures, ensure non-repudiable contracts, make paperless payments, securely store digital records, and contact people provide opportunities to streamline healthcare information through digital management.

Opportunities

- The current strong public digital infrastructure—including that related to Aadhaar, Unified Payments Interface and wide reach of the Internet and mobile phones (JAM trinity) —provides a strong platform for establishing the building blocks of ABDM. The existing ability to digitally identify people, doctors, and health facilities, facilitate electronic signatures, ensure non-repudiable contracts, make paperless payments,

securely store digital records, and contact people provide opportunities to streamline healthcare information through digital management.

- Ayushman Bharat—Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) has successfully used the available public digital infrastructure to provide end-to-end services through an information technology (IT) platform from identification of beneficiaries to their admission and treatment in hospitals to their discharge and paperless payment to hospitals. The experience of AB-PMJAY can be leveraged to expand the reach of digital health to all residents and develop an open and inter-operable health management system that empowers residents, healthcare providers, the Government and researchers.
- Emerging technologies such as artificial intelligence, the internet of things (IoT), Blockchain and cloud computing provide additional opportunities for facilitating a more holistic digital health ecosystem, that can increase the equitable access to health services, improve health outcomes and reduce costs.

Benefits

- The implementation of ABDM is expected to significantly improve the efficiency, effectiveness, and transparency of health service delivery overall. Patients will be able to securely store and access their medical records (such as prescriptions, diagnostic reports and discharge summaries), and share them with health care providers to ensure appropriate treatment and follow-up. They will also have access to more accurate information on health facilities and service providers. Further, they will have the option to access health services remotely through tele-consultation and e-pharmacy. ABDM will empower individuals with accurate information to enable informed decision making and increase accountability of healthcare providers.
- ABDM will provide choice to individuals to access both public and private health services, facilitate compliance with laid down guidelines and protocols, and ensure transparency in pricing of services and accountability for the health services being rendered.
- Similarly, health care professionals across disciplines will have better access to patient's medical history (with the necessary informed consent) for prescribing more appropriate and effective health interventions. The integrated ecosystem will also enable better continuum of care. ABDM will help digitize the claims process and enable faster reimbursement. This will enhance the overall ease of providing services amongst the health care providers.

- At the same time, policy makers and programme managers will have better access to data, enabling more informed decision making by the Government. Better quality of macro and micro-level data will enable advanced analytics, usage of health-biomarkers and better preventive healthcare. It will also enable geography and demography-based monitoring and appropriate decision making to inform design and strengthen implementation of health programmes and policies.
- Finally, researchers will greatly benefit from the availability of such aggregated information as they will be able to study and evaluate the effectiveness of various programmes and interventions. ABDM would facilitate a comprehensive feedback loop between researchers, policymakers, and providers.

Source: https://nha.gov.in/NDHM

Pradhan Mantri Jan Arogya Yojna (PM-JAY)

Ayushman Bharat is the Pradhan Mantri Jan Arogya Yojna or PM-JAY as it is popularly known. This scheme was launched on 23rd September, 2018 in Ranchi, Jharkhand by the Hon'ble Prime Minister of India, Shri Narendra Modi.

Ayushman Bharat PM-JAY is the largest health assurance scheme in the world which aims at providing a health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalization to over 12 crores poor and vulnerable families (approximately 55 crore beneficiaries) that form the bottom 40% of the Indian population. The households included are based on the deprivation and occupational criteria of Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas respectively. PM-JAY was earlier known as the National Health Protection Scheme (NHPS) before being rechristened. It subsumed the then existing Rashtriya Swasthya Bima Yojana (RSBY) which had been launched in 2008. The coverage mentioned under PM-JAY, therefore, also includes families that were covered in RSBY but are not present in the SECC 2011 database. PM-JAY is fully funded by the Government and cost of implementation is shared between the Central and State Governments.

Key Features of PM-JAY

- PM-JAY is the world's largest health insurance/ assurance scheme fully financed by the government.
- It provides a cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalization across public and private empanelled hospitals in India.
- Over 12 crore poor and vulnerable entitled families (approximately 55 crore beneficiaries) are eligible for these benefits.
- PM-JAY provides cashless access to health care services for the beneficiary at the point of service, that is, the hospital.
- PM-JAY envisions to help mitigate catastrophic expenditure on medical treatment which pushes nearly 6 crore Indians into poverty each year.
- It covers up to 3 days of pre-hospitalization and 15 days post-hospitalization expenses such as diagnostics and medicines.

- There is no restriction on the family size, age or gender.
- All pre–existing conditions are covered from day one.
- Benefits of the scheme are portable across the country i.e. a beneficiary can visit any empanelled public or private hospital in India to avail cashless treatment.
- Services include approximately 1,929 procedures covering all the costs related to treatment, including but not limited to drugs, supplies, diagnostic services, physician's fees, room charges, surgeon charges, OT and ICU charges etc.
- Public hospitals are reimbursed for the healthcare services at par with the private hospitals.

Benefit Cover Under PM-JAY

Benefit cover under various Government-funded health insurance schemes in India have always been structured on an upper ceiling limit ranging from an annual cover of INR30,000 to INR3,00,000 per family across various States which created a fragmented system. PM-JAY provides cashless cover of up to INR5,00,000 to each eligible family per annum for listed secondary and tertiary care conditions. The cover under the scheme includes all expenses incurred on the following components of the treatment.

- Medical examination, treatment and consultation
- Pre-hospitalization
- Medicine and medical consumables
- Non-intensive and intensive care services
- Diagnostic and laboratory investigations
- Medical implantation services (where necessary)
- Accommodation benefits
- Food services
- Complications arising during treatment
- Post-hospitalization follow-up care up to 15 days

The benefits of INR 5,00,000 are on a family floater basis which means that it can be used by one or all members of the family. The RSBY had a family cap of five members. However, based on learnings from those schemes, PM-JAY has been designed in such a way that

there is no cap on family size or age of members. In addition, pre-existing diseases are covered from the very first day. This means that any eligible person suffering from any medical condition before being covered by PM-JAY will now be able to get treatment for all those medical conditions as well under this scheme right from the day they are enrolled.

Coverage under PM-JAY

Including the poorest and most vulnerable population of any country in the health insurance programme is often the most challenging because they cannot pay any premium and are the hardest to reach. Many times, they are also not literate and, therefore, require a very different approach for awareness generation. This is true for most Lower and Middle-Income Countries (LMIC) and India is not an exception.

Thus, PM-JAY has been rolled out for the bottom 40 per cent of poor and vulnerable population. In absolute numbers, this is close to 12 crore households. The inclusion of households is based on the deprivation and occupational criteria of the Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas, respectively. This number also includes families that were covered in the RSBY but were not present in the SECC 2011 database.

The SECC involves ranking of the households based on their socio-economic status. It uses exclusion and inclusion criteria and accordingly decides on the automatically included and automatically excluded households. Rural households which are included (not excluded) are then ranked based on their status of seven deprivation criteria (D1 to D7). Urban households are categorised based on occupation categories.

In line with the approach of the Government to use the SECC database for social welfare schemes, PM-JAY also identifies targeted beneficiary families through this data.

Rural Beneficiaries

Out of the total seven deprivation criteria for rural areas, PM-JAY covered all such families who fall into at least one of the following six deprivation criteria (D1 to D5 and D7) and automatic inclusion (Destitute/ living on alms, manual scavenger households, primitive tribal group, legally released bonded labour) criteria:

- D1- Only one room with kucha walls and kucha roof
- D2- No adult member between ages 16 to 59
- D3- Households with no adult male member between ages 16 to 59

- D4- Disabled member and no able-bodied adult member
- D5- SC/ST households
- D7- Landless households deriving a major part of their income from manual casual labour

Urban Beneficiaries

For urban areas, the following 11 occupational categories of workers are eligible for the scheme:

- Ragpicker
- Beggar
- Domestic worker
- Street vendor/ Cobbler/hawker / other service provider working on streets
- Construction worker/ Plumber/ Mason/ Labour/ Painter/ Welder/ Security guard/ Coolie and other head-load worker
- Sweeper/ Sanitation worker/ Mali
- Home-based worker/ Artisan/ Handicrafts worker/ Tailor
- Transport worker/ Driver/ Conductor/ Helper to drivers and conductors/ Cart puller/ Rickshaw puller
- Shop worker/ Assistant/ Peon in small establishment/ Helper/Delivery assistant / Attendant/ Waiter
- Electrician/ Mechanic/ Assembler/ Repair worker
- Washer-man/ Chowkidar

Even though PM-JAY uses the SECC as the basis of eligibility of households, many States are already implementing their own health insurance schemes with a set of beneficiaries already identified. Thus, States have been provided the flexibility to use their own database for PM-JAY. However, they will need to ensure that all the families eligible based on the SECC database are also covered.

Expansion of coverage by States under PM-JAY and convergence

Various States have been implementing their own health insurance/assurance schemes over the past couple of decades. Most of these schemes provide cover for tertiary care conditions only. The benefit cover of these schemes is mostly available within the State boundaries except some smaller States have empanelled a few hospitals outside the State boundaries. Very few States had converged their schemes with the erstwhile RSBY scheme and many of them were operating independently. This was due to the lack of flexibility in the design of the RSBY, which although initially helped in quick scale-up but became a challenge over a period of time and offered limited flexibility to the States.

Even though these schemes were targeting the poor and vulnerable, there were large variations across States in terms of eligibility criteria and databases. Few States were using the food subsidy database while some others had created a separate database for their welfare schemes.

The primary objectives for launching PM-JAY were to ensure comprehensive coverage for catastrophic illnesses, reduce catastrophic out-of-pocket expenditure, improve access to hospitalisation care, reduce unmet needs, and to converge various health insurance schemes across the States. PM-JAY will also establish national standards for a health assurance system and provide national portability of care. At the implementation level, the States are given the flexibility to use their database if they were already implementing a health insurance/ assurance scheme and were covering more families than those eligible as per the SECC 2011 database. However, such States shall ensure that all families eligible as per the SECC data are covered and not denied benefits.

Source: https://nha.gov.in/PM-JAY and https://pmjay.gov.in/

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- https://pmjay.gov.in/
- https://bhs.org.in/a-gentle-introduction-to-vhsnc/
- https://nhm.gov.in/images/pdf/communitisation/vhsnc/order-guidelines/vhsnc_guidelines.pdf

DISCLAIMER

This “Sankalan – National Health Programmes Handbook” is intended for reference purposes only. While every effort has been made to ensure the accuracy and relevance of the information provided, it should not be considered a substitute for the official operational guidelines.

For comprehensive details, clarifications, and context, readers are encouraged to refer to the official operational guidelines or consult the relevant authorities. The author is not liable for any discrepancies or actions taken based on the information in this document.