

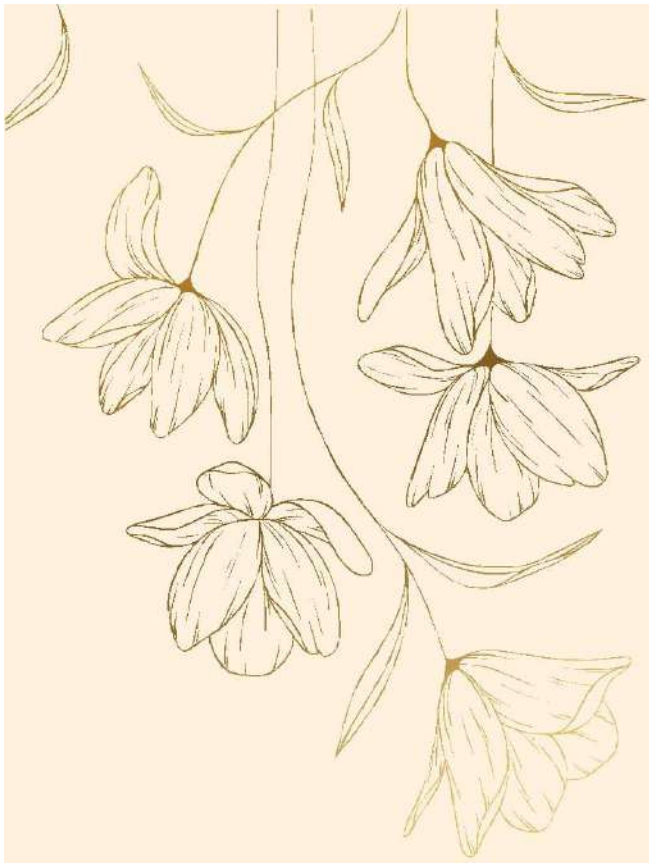


NHM Best Practices and Innovations

Good, Replicable and Innovative Practices



2020





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Good, **R**eplicable and **I**nnovative **P**ractices

2020





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Ministry of Health and Family Welfare
Government of India
Nirman Bhawan, New Delhi

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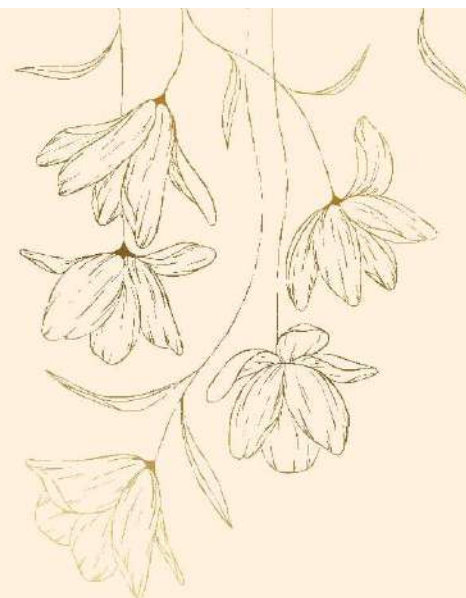
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Introduction



From the first summit held in 2013, the National Summit on Good and Replicable Practices and Innovations in Public Healthcare Systems in India, has, in a short span of time, become an institutional mechanism for sharing of innovations supported by the National Health Mission.

This is the seventh publication in this series and captures 47 best practices and innovations among health programmes. They span programmatic areas ranging from health systems, maternal and child health, family planning, tuberculosis and other communicable diseases, non-communicable diseases, mental health and e-health. They also include innovations that apply systems thinking to health problems such as the use of information technology to strengthen continuum of care and to addressing human resource shortages and challenges in capacity building, and innovations that address the needs of vulnerable populations in the National Urban Health Mission. The publication includes the presentations made at the seventh national summit held online in webinar mode due to conditions created by Covid-19 pandemic making it difficult to hold in person summit. In these webinars 23 oral and 24 poster presentations were made.

The National Health Innovation Portal (NHiNP), which was launched during the Shimla summit of 2015, represents the Ministry of Health and Family Welfare's unstinting effort towards identifying and nurturing good practices and innovations. Since 2015, over 1800 proposals have been received through this portal. In the last one year, more than 300 proposals have been uploaded on NHiNP. These have been subjected to criteria based reviews by various technical and programme divisions of the MOHFW, and the National Health System Resource Centre. The aim is to ensure that as we move towards realizing the aspirations of National Health Policy 2017, all sections of population, specially, those most disadvantaged, are benefited by new knowledge and new learning.

The portal has attracted interest from several policy think-tanks, the NITI Ayog and the Prime Minister's Office. This further supports and encourages future endeavours on enabling and fostering innovations at all levels, through public and private sector and addressing various dimensions of health systems challenges, both unfinished and emerging.

This publication includes Programme Innovations that are designed at various levels of health care delivery as a response to a specific problem to improve a health outcome or addressing a programmatic dimension required for improved performance. This may include (but are not limited to) innovations in service delivery, human resources for health, community processes, financing and governance. New vaccines and drugs are not included in this set of innovations since there are other mechanisms for identification, assessment and incorporation into large scale systems.

PRINCIPLES OF IDENTIFICATION AND ASSESSMENT OF INNOVATIONS

All innovations that are uploaded on the portal are assessed using certain guiding principles. They include:

Inclusion Criteria for Programme and Product Innovations

- + Innovations that are relevant to health care needs of the population, particularly those who are disadvantaged and marginalized.
- + Innovations that address locally endemic health problems or diseases.
- + Innovations that facilitate better health care reach to people in terms of accessibility (including reach to the rural areas, tier II and tier III urban settlements), affordability (including potential to reduce cost of care), quality (inclusive of safety of a health care product or process) and equity.
- + Innovations that bridge a crucial specialized skill gap required in delivery of health care services.
- + Innovations that apply a systems approach to health problems that are persistent and are common across states.
- + Innovations that address issues of convergence with Implication for social and environmental determinants.

Exclusion Criteria

- + Specific drugs, surgical, medical procedures or practices that need evaluation through Randomized Control Trials or Systematic Reviews.
- + Incomplete documentation of innovation: For any innovation to be reviewed the document should include adequate information on process, human resource requirements, and infrastructure need, capacity building strategies, outcomes, costs, and challenges.

Evaluation of Innovations

Criteria for evaluation of proposed innovations include- as per norms- i) Strength of Evidence; ii) Scale of Coverage; iii) Impact and iv) Potential for Replicability across varying contexts.

All stakeholders involved in health sector, centre and states, public sector, Non -Governmental Agencies, private sector organisations, academic and research agencies, and development partners must work in tandem utilizing each other's strengths to design innovative models of healthcare delivery.

The transition from the MDGs to SDGs, the realisation of the ambitious goals of Universal Health Coverage and of the National Health Policy 2017, require new ways of thinking, not in fragmented vertical programmes, but through a broader health systems approach. Launch of Ayushman Bharat and setting up Health and Wellness Centers across country are steps in this directions. Existing solutions need to be reworked and innovations that address current realities and people's aspirations need to be nurtured. The National Health Mission will continue to provide a platform for the engagement of stakeholders in creating innovations that can be scaled up for universal access to affordable and equitable health care.

Health Systems





CHATTISGARH

ZONE-WISE CATEGORIZATION OF ESSENTIAL SERVICES AT HWCS DURING COVID TIMES

PROBLEM STATEMENT

COVID-19 outbreak put extraordinary demands on public health system, compromising other essential health services for pregnant women, new-born & children and other vulnerable population groups. This was compounded by poor health seeking behaviour of the community due to social distancing and country wide lockdowns.

PROGRAMME DESCRIPTION

The uptake of essential health services in health facilities including HWCs were significantly decreased during COVID-19 pandemic. To address this, state with the support of Jhpiego/NISHTHA developed the operational framework for continuation of essential non-COVID services as per zone-wise categorization across all HWCs of the state.

Specific guidance was built for Red, Orange and Green zones as categorized by Government of India, according to COVID-19 scenario. The operational framework was designed to support the district officials and facility staff to provide quality non-COVID essential care to beneficiaries and understand priority of services in each zone, ensure preventive and infection control measures while service provision; enabling the District officials to monitor the priority activities and help the frontline workers to focus on essential services.

PROGRAMME OUTCOMES

The initiative resulted in ensuring availability of buffer stock of essential medicines and consumables at HWCs including PPE at HWCs as per the operational frame work. Home visits were initiated for ANC, PNC, HBNC,



NCD-follow up, TB treatment follow up and other vulnerable patients. Along with that, provision of RMNCH+A services, optimal utilization of HWC services for institutional delivery and RI sessions enhanced the utilization of resources at secondary / tertiary health facilities during crisis time. Other than this, tracking of co-morbidities of ILI among chronic patients was also initiated.

FINANCIAL IMPLICATIONS

This intervention did not incur additional fund.

SCALABILITY

The intervention can easily be scaled up at all HWCs across all the districts of the state as it does not incur any additional fund and staff are already trained in providing essential services.

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TEAM HUDDLE MEETINGS ILC

PROBLEM STATEMENT

The HWC team comprises of a Community Health Officer (CHO) and MPW primarily. The CHOs are the designated team leaders at the HWCs, though they are younger in age than the other team members including ASHAs. The Female Health Workers are relatively most experienced and, in some cases, have higher pay scales as they belong to permanent cadre. These concerns end up in disrupting the team dynamics in most cases, causing a rift between the team members, eventually affecting the service delivery for the community.

PROGRAMME DESCRIPTION

The intervention promotes a positive team spirit among the HWC functionaries can help in alleviating the problem described above and thus improve the functioning of the center. The intervention should also be simple, cost effective and user friendly. Team Huddle" is commonly applied in sports for improving team spirit and boosting the morale of the players at the beginning and during the game and is used in different work settings as well.

PROGRAMME OUTCOMES

The preliminary outcomes reveal significant improvement in team bonding, communication and personal relations. Work duplication has also decreased as the work allocation, strategies, etc are discussed during the meetings beforehand. Also, the team members (ASHA, FHW) are more confident in discussing their work plan and field findings than before. The overall work culture has improved tremendously, thus fulfilling the objectives of this innovative strategy.



FINANCIAL IMPLICATIONS

The initiative is a zero-cost activity as no additional costs are required.

SCALABILITY

This innovation involves no financial costs and in terms of other resources, the time required per day is also less than an hour. The training required for the process is minimum and can be done through a team training approach where all members of the HWC participate together in the training.



PUNJAB

SCREENING, DETECTION AND MANAGEMENT OF DIABETIC RETINOPATHY THROUGH HEALTH & WELLNESS CENTRES

PROBLEM STATEMENT

Indian Council of Medical Research survey report reveals that every ninth person in rural Punjab is diabetic. The prevalence of diabetes in rural Punjab is highest among the fifteen major states surveyed in the study and Punjab has the second highest overall disease burden. Another recent study by AIIMS New Delhi (2015-19) conducted in district Kapurthala of Punjab found 22% prevalence of diabetes among people aged >50 years. Also, one in every forty sixth person loses eyesight and one in seventh person has some form of visual impairment due to the disease. Despite the fact that damage to the eye due to diabetes is preventable and curable, 90% of known diabetics do not ever go for fundus examination. There has been absence of focus on screening for Diabetic Retinopathy (DR) in NCD clinics. Most of the NCD clinics lack mechanism of eye check-up and there are no standard protocols regarding prevention and control of DR.

PROGRAMME DESCRIPTION

Department of Health & Family Welfare, Punjab started a project on Diabetic Retinopathy Screening through Health & Wellness Centers in 5 districts of the state on pilot basis (SAS Nagar, Kapurthala, Faridkot, Patiala and Amritsar). The initiative involves establishing a referral mechanism from HWCs to District Hospitals and Medical Colleges (for laser treatment) and installing portable non mydriatic fundus camera in the selected District Hospitals.

State level training for ophthalmologists and District level trainings were conducted to establish a multidisciplinary team of ophthalmologists,



Medical officers, Ophthalmic Officers, Community Health officers, ANMs & ASHAs. The initiative aims to identify diabetic patients with expected poorer health outcomes such as vision loss and improve quality of care for better health outcomes.

PROGRAMME OUTCOMES

Diabetes prevalence among the patients screened at HWCs was ~12%, out of which 13% diabetics had associated retinopathy. Out of total DR patient, 30% patients were referred to medical colleges for the laser treatment.

FINANCIAL IMPLICATIONS

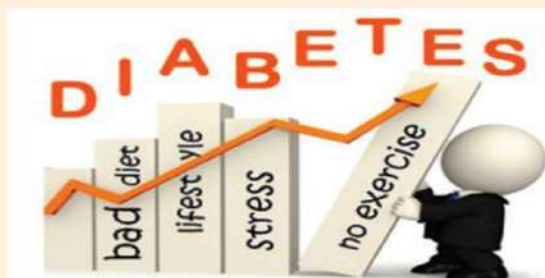
The approximate cost of the project was INR 6.50 lakhs per District, ~ INR 32 lakhs for the 5 project Districts. The major cost areas were procurement of portable non-mydratic fundus camera (6 lakhs/district), training at District & State level (0.25 lakhs/districts) and IEC/BCC activities (0.25 lakhs/district).

SCALABILITY

The initiative is a low-cost intervention, estimated to benefit around 10 lakh population of the state and will also contribute in reducing the out-of-pocket expenditure (OOPE) of the diabetics suffering from associated retinopathy.

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ਤੰਦਰੁਸਤ ਪੰਜਾਬ ਸਿਹਤ ਕੇਂਦਰ
ਆਯੁਸ਼ਮਾਨ ਭਾਰਤ ਅਧੀਨ
ਤੰਦਰੁਸਤ ਪੰਜਾਬ ਸਿਹਤ ਕੇਂਦਰ ਵਿਖੇ ਮਿਲਣ ਵਾਲੀਆਂ ਮੁਫ਼ਤ ਸਿਹਤ ਸਹੂਲਤਾਂ

ਤੰਦਰੁਸਤ ਪੰਜਾਬ ਸਿਹਤ ਕੇਂਦਰ

ਸਿਹਤ ਤੇ ਪਰਿਵਾਰ ਭਲਾਈ ਵਿਭਾਗ, ਪੰਜਾਬ

ਤੰਦਰੁਸਤ ਪੰਜਾਬ ਸਿਹਤ ਕੇਂਦਰ
ਆਯੁਸ਼ਮਾਨ ਭਾਰਤ ਅਧੀਨ
ਤੰਦਰੁਸਤ ਪੰਜਾਬ ਸਿਹਤ ਕੇਂਦਰ ਵਿਖੇ ਮਿਲਣ ਵਾਲੀਆਂ ਮੁਫ਼ਤ ਸਿਹਤ ਸਹੂਲਤਾਂ

ਗੈਰ-ਸੰਚਾਰੀ ਬਿਮਾਰੀਆਂ ਤੋਂ ਨਾ ਡਰੋ
ਬਚਾਅ ਅਤੇ ਤੁਰੰਤ ਇਲਾਜ ਦੇ ਉਪਰਾਲੇ ਕਰੋ।

ਗੈਰ-ਸੰਚਾਰੀ ਬਿਮਾਰੀਆਂ ਜਿਵੇਂ ਬਲੱਡ-ਪ੍ਰੈਸ਼ਰ, ਸ਼ੂਗਰ, ਕੈਂਸਰ, ਦਿਲ ਦੀਆਂ ਬਿਮਾਰੀਆਂ, ਗੁਰਦੇ ਦੀ ਬਿਮਾਰੀ, ਸਟ੍ਰੋਕ ।

ਬਚਾਅ :-

- ਆਪਣਾ ਭਾਰ ਘਟਾਓ।
- ਸਿਹਤਮੰਦ ਖੁਰਾਕ ਖਾਓ।
- ਤੰਬਕੂ, ਸਿਗਰੇਟ ਨਾ ਪੀਓ।
- ਰੋਜ਼ਾਨਾ ਸਰੀਰਕ ਕਸਰਤ ਕਰੋ।
- ਆਪਣੇ ਖਾਣੇ ਵਿੱਚ ਨੂਣ ਦੀ ਮਾਤਰਾ ਘਟਾਓ।
- ਸਰਾਬ ਦੀ ਵਰਤੋਂ ਨੂੰ ਘਟਾਓ।
- ਨਸ਼ਿਆਂ ਤੋਂ ਦੂਰ ਰਹੋ।

ਸਰੀਰਕ ਕਸਰਤ ਦੇ ਤਰੀਕੇ:-

- ਪੈਦੀਆਂ ਦਾ ਇਸਤੇਮਾਲ ਕਰੋ।
- ਪੈਦਲ ਚਲਣ ਦੀ ਆਦਤ ਬਣਾਓ।
- ਆਪਣੇ ਬੱਚਿਆਂ ਨਾਲ ਖੇਡੋ।
- ਰੋਜ਼ਾਨਾ ਯੋਗ ਅਭਿਆਸ ਕਰੋ।

ਸਿਹਤ ਤੇ ਪਰਿਵਾਰ ਭਲਾਈ ਵਿਭਾਗ, ਪੰਜਾਬ

TAMIL NADU

IMPLEMENTATION OF NATIONAL TELE-CONSULTATION SERVICES (E-SANJEEVANI OPD)

PROBLEM STATEMENT

The COVID-19 pandemic made it challenging for the public healthcare system to ensure equitable care to the general public without any disruption of regular services.

PROGRAMME DESCRIPTION

Govt. of Tamil Nadu undertook special initiatives including disbursing medication to chronic patients, shifting high priority patients to relevant health facility through state aided vehicles, forming Rapid Response Team, while ensuring follow up of chronic patients and maintaining social distancing as a key intervention in COVID-19 prevention.

Health care workers were involved for educating antenatal mothers and vulnerable people through home visits, general people coming to OPD were informed and e-Sanjeevani OPD application was installed in more than 13,000 tablets available with the field staff and Medical officers were provided tablets to provide teleconsultation. Frequent timely reviews were held at District/State level and regular monitoring was also ensured. Necessary instructions were issued to public institutions/private medicals to provide medicines to eSanjeevani OPD prescriptions. The technical support was provided by CDAC, Mohali. 20 master trainers were trained and 850 doctors were trained for providing online consultations. District officials were trained for monitoring mechanisms and field staff & officials from other departments were trained for necessary community awareness.



PROGRAMME OUTCOMES

More than 2 lakh online consultations were provided on general medicine, AYUSH, Yoga & naturopathy, OBGYN services, TB and ART services. Only the patients who needed clinical examination were advised to attend nearby/higher health facilities for further evaluation and management.

FINANCIAL IMPLICATIONS

No additional costs were involved. Additional funds to strengthen telemedicine in the State were approved in FY 2020-21, from which procurement has been completed.

SCALABILITY

The telemedicine model is easily replicable as national level platform is readily available, and no special efforts are required for developing separate telemedicine module for each state.

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TELANGANA



FREE DIAGNOSTICS

PROBLEM STATEMENT

A detailed analysis of existing diagnostic services exposed challenges such as vacant positions, inadequate lab equipment, irregular supply of reagents, poor standardization in quality & quantity and poor monitoring, all causing high OOPE to the end user.

PROGRAMME DESCRIPTION

Telangana Free Diagnostics program aims to provide diagnostic services to all the patients attending the health facilities in GHMC area of Hyderabad initially and expand to the remaining Districts as a complete in house, Hub and Spoke Model.

A state of art central lab was created as Hub in the IPM premises, for which the technical support for finalising the devices, number of investigations, IT interface, infrastructure and HR was provided by the Tata Trust initially. All the LTs from the facilities were trained on blood collection procedures and on using the Lab Information Management System. Sample transferring mechanism is outsourced and samples are processed within 24 hours as the lab functions 24 hours in three shifts.

The central lab has been designed to accommodate the fully automated devices which generate sample barcodes, pasted on the sample collection tubes. The sample process through bi-directional interfacing where in the lab technician simply needs to expose the samples to the automated device. The device itself will query for the investigations to be performed and results are sent back to the application/software updating corresponding patient records after processing. The results are verified by Department Heads from Pathology, Microbiology and Biochemistry and are then published online, which can be downloaded by the facilities in OPD hours.

PROGRAMME OUTCOMES

The central lab at Hyderabad caters to ~250 facilities including the 152 Basthi Dawakhanas in GHMC Limit and receives approximately 3000 samples per day from 277 centers. Currently 60 investigations are being processed including 39 Clinical Biochemistry, 8 Microbiology and 13 Pathological Tests.

More than 11 lakh samples have been collected from January 2018 to February 2020, on which more than 16 lakh tests have been done on around 80 lakh parameters, benefitting approximately 6.5 lakh patients.

FINANCIAL IMPLICATIONS

The establishment cost of the central lab, and other fixed assets was approximately 2 cr. and the recurrent cost is approximately 58 cr annually. Compared to these costs, the market worth of these tests is roughly 62 cr, which is the revenue saved for the beneficiaries.

SCALABILITY

The pilot of Telangana Diagnostics was initiated in January 2018, in which 50 centres were identified and included in a phased manner. 37 hubs are planned across the Districts to cater all health facilities in the State gradually.

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DCP





PROBLEM STATEMENT

Malaria is the main cause of Anaemia and Malnutrition in Pregnant Women & children, contributing to high IMR and MMR. High Malaria Prevalence also leads to poor socio-economic condition of the tribal community - as it causes high expenditure on morbidity.

PROGRAM DESCRIPTION

Under "Malaria Mukht Bastar Campaign" Chhattisgarh is conducting Community based active Screening and treatment in seven districts of Bastar division to reduce Malaria parasite load in the community. The survey team conducted door to door visits applying the Test, Treat and Track procedure. The team also provided local food to the Malaria positive cases to avoid drug intake in empty stomach and also collected empty blister packs to ensure complete treatment. Treatment card was issued to all Malaria Positive cases for ensuring complete treatment and verified during case follow up. Wall sticker/stencil were pasted outside the surveyed house for identification. The severe or complicated positive cases were also given referral slips. All these cases were then followed up after one month of treatment completion to ensure parasite elimination.

Surveillance activities were carried out in haat bazars through health camps. Use of LLINs were monitored during door-to-door visits and Mitanins were roped in to Whistling/ ringing of bell in the evening by Mitanin for community awareness for use of LLIN. The initiative required inter sectoral coordination with different departments like CGMSC, WCD, NCDC, Paramilitary Education, Forest etc and carried out entomological surveillance in coordination with NCDC. Total 8749 person were engaged in 1562 survey teams in 1st Round and 5608 persons were deployed in 2804 survey teams during 2nd round of Abhiyan.

All Chief Medical and Health officers, District Malaria Officers, District Training officers, Block Medical Officers, District Programme Managers,





Block Extension Educator, VBD Consultants, Block Programme Manager, all survey team members, Supervisor, Medical Officers, RMA and Lab Technicians of Bastar divisions were trained before Abhiyan.

PROGRAM OUTCOMES

14.06 lakhs individuals in 1st round and 23.75 lakhs individuals in 2nd round were tested for Malaria by Rapid Diagnostic test. 64,646 malaria cases in 1st round and 30,076 cases in 2nd round were identified and given complete treatment. Out of total Malaria cases found- 57.03% cases in 1st round and 59.75% cases in 2nd round were asymptomatic. In 1st round Total 13355 Pregnant Women were tested, out of which 870 were found malaria positive. Similarly, 16181 Pregnant Women were tested, out of which 308 were found malaria positive during 2nd round of Abhiyan. In the 1st round 4.6% of the population found positive wherein 1.27% of the population found positive in 2nd round. Around 65% of malaria positive cases have been reduced in the month of September 2020 in comparison with September 2019.

FINANCIAL IMPLICATIONS

In the first phase - Apart from drugs & consumables - total 134.07 lakhs were spent and in 2nd phase total 236.82 lakhs was spent in the campaign. Majority expenditure was on incentives to health teams & community mobilization.

SCALABILITY

Two rounds of Malaria Mukta Bastar Abhiyan were completed successfully which is the best initiative step to eliminate malaria from the state and decrease the malnutrition, anaemia and IMR and MMR.

Contact

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CHHATISSGARH

SPECIAL LEPROSY ERADICATION PROGRAM NATIONAL LEPROSY ERADICATION PROGRAM LEPTRACK

PROBLEM STATEMENT

Surveillance in Public Health is collection and analysis of health-related data for action. Chhattisgarh has highest burden of Leprosy cases in the country and special action is required to lead to the GOAL of ELIMINATION of Leprosy. The number of NMA/NMS staff of NLEP are gradually decreasing in the field, the surveillance and NLEP field activities faces implementational challenges due to lack of trained staff.

PROGRAM DESCRIPTION

LEPTRACK is a web based mobile application for Leprosy Disease Surveillance and patient follow up in State of Chhattisgarh. This software enables the program managers at State, District and Block level to take informed, prioritized and timely action to plan effective and efficient interventions. All data contained in this application has the public health surveillance attributes: Person, Place, Time and all data has village level information for geographic reference by click of a button. The design and development of this application are intended to the strengthening of Leprosy Surveillance for planning public health interventions. This application provides real-time information on Leprosy surveillance from anywhere on any electronic device, this facilitates point entry of data through hand held smartphones and with ease. The MPW/NMA/RMA input screening data and follow up data, Medical Officer confirms diagnosis and prescribe diagnosis. All login is password protected and linked to HRMIS-CG. District Level trainings were organized for pilot districts involving MO, RMA, NMA, NMS, MPW with installation of application in the personal smartphones.



PROGRAM OUTCOMES

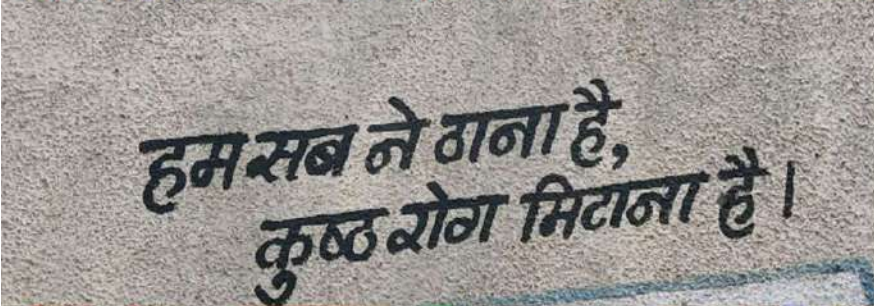
The State Level Dashboard is functional with more than 1000 suspects being entered and around 700 confirmed cases with all epidemiological data available. The 430 suspects not confirmed can be tracked. Village level action plan can be prepared as per the new GOI guideline of 'Active Case Detection and Routine Surveillance'. Presently, 7 districts are harboring 60% of total state case load, so the implementation of LEPTRACK has been prioritized in these 7 districts

FINANCIAL IMPLICATIONS

No separate cost to the program for development of this application. Approximately INR 2,00,000 has been allocated by NHM for incentive to the staff entering data based on number of entries they have done.

SCALABILITY

The State plans to implement this application in all the districts with 148 Block User for specific Block Report, 27 District User for Block Reports of respective district and State User- all Districts Reports.



Dadra and Nagar Haveli

ACTION AT DUSK – ACTIVE CASE FINDING FOR LEPROSY IN EVENING HOURS

PROBLEM STATEMENT

The Prevalence Rate of Leprosy in the UT of Dadra & Nagar Haveli has been highest in the country continuously for many years. Now, after merger of Dadra & Nagar Haveli and Daman & Diu, the district of Dadra & Nagar Haveli still has high prevalence of Leprosy. Although due to integrated efforts and innovative approaches, it succeeded not only in bringing down the Prevalence Rate of Leprosy from 6.77 in 2016 to 2.7 in 2020 but also in reducing and maintaining the Grade 2 Disability to 'Zero' when most of states are struggling to reduce Grade II Disability to less than '1' per million population.

It was observed that the UT of Dadra & Nagar Haveli had higher female proportion among new Leprosy cases continuously from 2009 – 2015 in comparison to the national level.

PROGRAM DESCRIPTION

In 2016, the Data analysis of new Leprosy cases of D&NH indicated a clear and significant trend of more cases among females. The UT of DNH had been conducting Active Case Finding Drives since 2009 but that had not been helpful to curb the rising PR as well as the G2D. The Data of new cases and G2D indicated that a fair proportion of males were being missed during the active case finding surveys. The issue was reviewed by the NLEP unit of D&NH and it was decided to trace the missing males (those who are on job during the day time) during active case finding drives by modifying the timing of these surveys.

As an intervention, the survey timing was modified (from the erstwhile 9:00 am – 5:00pm) to 9:00am to 01:00 pm in the first half and 5:00 pm to 8:00 pm in the second half. During the first half, the team comprising of one male & one female visited the houses to screen households. The houses with unavailable males/females were noted and their probable time of availability was recoded. The male volunteer/MPW started visiting those houses in evening hours after 5 pm to screen the missing males/females. The female accompanied the team till 6 pm only to screen females missed during first half. The objective of this modified timing was to cover the majority of males and some working females who are not available at home during day time.



PROGRAM OUTCOMES

This innovative approach was started for the first time in May 2016. In the Active Case Finding Survey done in May 2016, the number of males among new cases outnumbered the females. The proportion of males increased from 45% (in ACF surveys prior to 2016) to 56%. That indicated the presence of hidden male cases in the community. This conclusion was further reinforced by the fact that 62.5% of G2D cases at diagnosis were males. In the year 2016 -17, the female proportion of new cases decreased from 57.89% in 2015-16 to 51.50%.

After implementing the strategy of targeted flexible timing for screening of working population, the gap between males and females in new cases reduced and finally in the year 2019-20, equal number of males and females were diagnosed as Leprosy

The proportion of males in cases confirmed out of suspects identified between 5-8 pm was 33/45 (73.33%), indicating our objective was met. The female proportion among new cases got balanced and approaching to 50% which is a desired level. The number of G2D which was predominantly in males, got drastically reduced and reached 'Zero'

FINANCIAL IMPLICATIONS

No direct additional cost was incurred due the novel approach of modified timing for Active Case Finding Surveys. The only thing needed to materialize this approach was motivation of field staff for survey in evening hours. But the benefits due to this are significant and perceivable.

SCALABILITY

The approach adopted in the UT is easily replicable and applied to anywhere else in the country. Although the approach of suitable timing for more and early case detection was applied for Leprosy, it can be equally adopted for screening of other communicable as well as non-communicable diseases.

Contact

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JHARKHAND

NIKSHAY MITRA

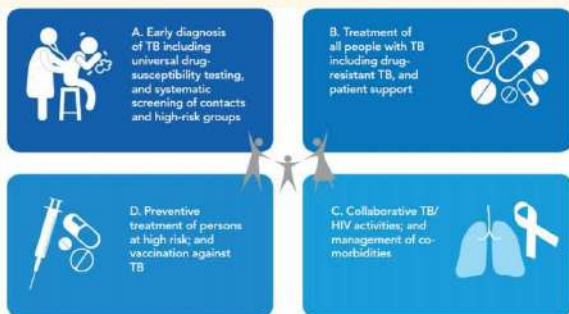
PROBLEM STATEMENT

There are significant gaps across the patient care cascade in the private sector such as under reporting, diagnostic delays, irrational and non-standardized regimens along with catastrophic out of pocket expense to patients.

To strengthen private sector engagement and provide quality health care to TB patients managed by them, the Government of Jharkhand has engaged ALERT INDIA as PPSA. The overall strategy is to provide an ecosystem with an explicit framework that outlines interventions for collaborating with the private sector and earmark resources to support its execution.

PROGRAM DESCRIPTION

Nikshay Mitra cum Treatment Supporter: (Nikshay means Elimination of TB & Mitra means Friend; "Nikshay Mitra" means "Friend to help in Elimination of TB"). A nodal person is identified by every private provider to do TB work, for which they are provided incentive for set of activities done by him. The tasks include: Representation and coordination with PPSA for Private Health Establishment, Case Notification in Nikshay Portal and TB Notification Register, Creating a TB Treatment Card (supplied by PPSA), Health education and counselling of patients and their family members, Collection of sputum specimens for Drug Sensitivity Testing (DST) from patients and data entry, HIV and Diabetes testing and/or referral and update the reports in Nikshay portal, Contact screening and testing with prophylactic treatment to children below 5 years with entries in the portal, Follow-up visits/ calls to the patients for tracking and adherence on regular intervals after treatment initiation, Record treatment adherence on a monthly basis and outcome reporting at the end of the treatment in treatment card, TB Notification register and Nikshay portal, Bank account details collection and entry in Nikshay portal for Direct Benefit Transfer



(DBT) under Nikshay Poshan Yojana, Ensures Fixed Drug Combination (FDC) offer/supply to the patients.

PROGRAM OUTCOMES

PPSA started its operation in the state from 27th September 2019. PPSA has been able to support NTEP Jharkhand in improving the service delivery to TB patients managed in private sector in Jharkhand substantially. The DST of private sector TB patients substantially increased to 46% in 3Q2020 compared to 3% in 4Q2018 i.e. before PPSA implementation. Similar trend has been observed in DBT, HIV and Diabetes testing among TB patients of private sector. Almost 60% patients in private sector are on NTEP supplied FDC. Even though there was setback due to Covid-19 pandemic, PPSA put in all efforts to further improve the performance.

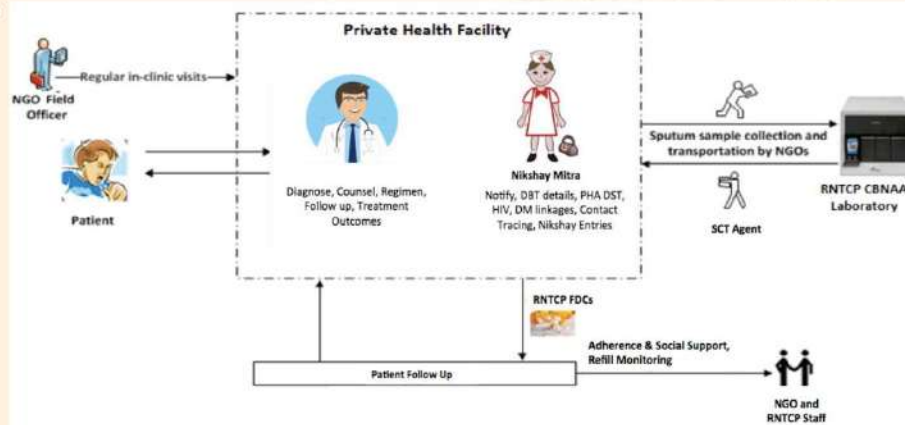
FINANCIAL IMPLICATIONS

All costs borne through State NHM funds. Both clusters have different rates/per patient which is paid to PPSA by NTEP for their work. The approved amount is further sub-divided into different components i.e. 30% for notification, 15% for DST, 10% for validated accounts, 5% for DM & HIV testing, 30% for treatment outcome and 10% of the amount is kept for target achievement. The salary of the project staff and incentives of Nikshay Mitra are borne by PPSA.

SCALABILITY: The learnings during the course of implementation and the encouraging trend so far, provides an opportunity for other states of the country to provide universal TB care.

Contact

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KERALA

AKSHAYA KERALAM – TB SERVICES AT DOOR STEPS DURING COVID PANDEMIC

PROBLEM STATEMENT

COVID -19 pandemic has posed great challenges to TB Elimination efforts, especially to early case finding. Difficult access, stigma to respiratory symptoms and competing priorities has led to a reduction in TB case detection around the globe.

PROGRAMME DESCRIPTION

Causal analysis revealed difficult access and fear among health care workers in processing sputum samples as the reason for dip in TB examination. The Government established a tele health help line at all districts for contacting all TB patients and ensuring continuity of care during lock down period. Services such as delivering medicines at door step for all diagnosed patients was also ensured through the primary health care systems and community health volunteers.

Additionally, 75 Truenat & 12 additional CB NAAT machines were deployed in public sector and 36 Truenat and 12 additional CB NAAT were equipped in private sector for diagnosing both TB and COVID. Special catch-up campaign was also designed to identify missed TB cases with focus on vulnerable individuals including elderly, old age homes, palliative care and individuals identified through vulnerability mapping exercise previously.

Screening mechanism for all ILI/SARI cases for TB along with COVID sample collection was established and specimen collection transportation system was established from home to NAAT site, ensuring robust biosafety precautions.



PROGRAMME OUTCOMES

Presumptive TB Examination and Notification for the month of October 2020 reached the same level as compared to October 2019. No TB treatment interruption occurred beyond usual, during COVID period. All public health actions remain uninterrupted as normal, during COVID period.

FINANCIAL IMPLICATIONS

NA

SCALABILITY

The concept of identifying and availing the services of "Cough Supervisors" in the community during unforeseen emergency situation such as the current Covid-19 pandemic, outbreaks, floods, earthquakes etc can be helpful in a long way in early identification and treatment of TB patients

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ROLE OF PEER SUPPORT STAFF IN IMPLEMENTATION AND EXPANSION OF NVHCP DURING COVID

PROBLEM STATEMENT

The Mukh Mantri Punjab Hepatitis C Relief Fund (MMPHCRF) Programme was launched in June 2016 to provide free treatment of Hepatitis-C at 25 treatment centres under guidance of 1 Model treatment centre.

PROGRAM DESCRIPTION

Punjab Government started utilizing the infrastructure of 22 District hospitals and 3 Medical colleges and, the existing staff of medical specialists, lab technicians, pharmacists, and data entry operators to provide free screening and treatment for Hepatitis C patients.

Under NVHCP Peer support staff was provided by NHM at each Treatment centre for effective and dedicated outreach to patients. The hired Peer supports are either old Hepatitis-C patients or someone from their own family have been a Hepatitis-C patient as they better understand the challenges related to the disease.

The peer support is working under the guidance & supervision of Distt. Programme Officer (Distt. Epidemiologist) and is responsible for ensuring the patient management in the phased manner (from preparation of treatment card till dispensation of medicines).

The peer supports share screening report of Hepatitis C on daily basis and Hepatitis B on monthly basis, for which the daily report format has been shared with districts. They are provided lists of patients with gap in their treatment, eligible for SVR, lost to follow up, defaulted on treatment and due on follow up so that these could be called by peer supports for



uninterrupted flow of treatment. They were also involved in the Loss to Follow up) Study for the year 2018-2019.

During COVID-19, all the 26 peer supports and data entry operator of MTC were given the task of ensuring patient follow up. Peer supports and DEO at MTC followed up the cirrhotic patients on daily basis for treatment adherence and co-morbid patients were also counselled for COVID-19 precautions. The patients, who have missed their follow ups (or defaulted) due to COVID 19 pandemic, were counselled for further follow ups after lockdown.

PROGRAM OUTCOMES

Approximately 6,000 patients were followed up across the state. Patients due for initiating treatment initiation were also motivated for treatment, thus increasing the treatment initiation rates.

Average 1,200 patients were initiated on treatment per month before COVID situation. Due to lockdown the count declined to only 250. After active calling and counselling of Viral load positive patients the count gradually started increasing to an average of around 800 patients per month.

FINANCIAL IMPLICATIONS

NA

SCALABILITY

The model is easily scalable in similar settings across the country.

Contact

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NCDs





Himachal Pradesh

GERIATRIC DAY CARE CENTER



PROBLEM STATEMENT

A total of 7 Lakh (10%) people in state of Himachal Pradesh are senior citizen and have restricted mobility due to extreme geographical conditions, weather conditions and onset of different musculoskeletal disorders. Due to the rapid urbanization these elderly people are forced to stay alone, depriving them of an environment to interact and care for their overall health.

PROGRAMME DESCRIPTION

In order to provide comprehensive services to the elderly persons, State National Health Mission in collaboration with Help Age India has taken an initiative to develop 'Model Multipurpose Day Care Centre for the Elderly' at three locations- Shimla, Mandi and Dharamshala in Himachal Pradesh. The center provides active ageing services like weekly health check-ups with provision of free medicine, physiotherapy sessions, health awareness programs, digital literacy classes to help them use social media platforms, use technology for convenience in daily life, legal and counselling services to elderly who are victim of domestic abuse, yoga, exercises, laughing sessions, outing with friends, watching news on TV, play indoor games help the senior citizens to keep themselves engaged, etc. This shall ensure improved physical, mental and emotional health of senior citizens.



PROGRAMME OUTCOMES

More than 17 thousand elderly have benefited under the initiative. Approximately 10 thousand elderly availed physiotherapy services and 1700 received health check-ups.

FINANCIAL IMPLICATIONS

NA

SCALABILITY

The model can be scaled-up in Districts/States with similar proportions of elderly population.

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KARNATAKA

NAMMA KANNU NAMMA DODDABALLAPURA - FREE VISION SCREENING TO EVERY RESIDENT

PROBLEM STATEMENT

Approximately 67% of population of Doddaballapur is in rural areas spread across 376 villages, which is famous for silk sarees and weaver's community and has one of the largest apparel parks. Screening of around 1,50,000 people in the region revealed that almost 25% of the population has refractive error and needs correction.

PROGRAMME DESCRIPTION

An MoU was signed in September 2020 between District Health Officer, Bangalore Rural District and Essilor Vision foundation with project implementation partner of Drishti Eye Hospital. Teams comprising ASHAs, MO and optometrists were trained for primary eye screening at PHC level.

The trained ASHAs and Essilor Nethra Sahayakas conducted door to door screening for vision defects and colored stickers were posted outside homes; red indicating persons identified with refractive error and yellow indicating no problems in vision. If a house is found to be locked then stickers were posted to inform about the mobile eye screening camp as per the schedule. People detected with refractive error or any other eye diseases are referred to the mobile van fully equipped with sophisticated equipment and qualified team. Based on the screening outcome, presbyopia spectacles are delivered to people on the spot. For prescription cases (Rx lens), fitting is done at Essilor facility and delivered to end user at their door step.



Other activities such as referring people detected with other eye diseases to partner NGO eye hospital (Drishti Eye Hospital, Bangalore), screening for school children & free distribution of spectacles, etc were done under supportive supervision of District Blindness Control Officer.

PROGRAMME OUTCOMES

Door step comprehensive eye screening services have been provided in 279 villages and 31 urban wards. More than one lakh had their vision checked, out of which 31,890(18%) people had refractive error and received free spectacles. Similar activity has been initiated at south Bidar constituency as CSR initiative.

FINANCIAL IMPLICATIONS

Taken up as CSR activity from Essilor Vision Foundation with permission being granted from Health & Family Welfare Services, Govt. of Karnataka.

SCALABILITY

Can be scaled up in as a CSR initiative.

Contact

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KARNATAKA

MENTAL HEALTHCARE MANAGEMENT SYSTEM

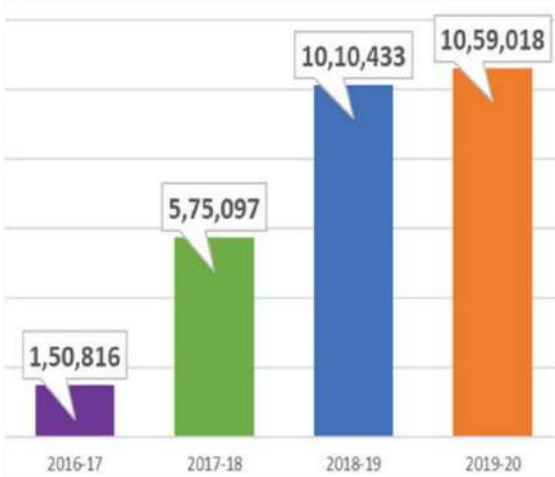
PROBLEM STATEMENT

The footfall for mental health services increased from 23,000 in 2014-15 to more than 10 lakh in 2018-2020 in Karnataka. The Mental health Division of Directorate of Health Services felt there is no software solution to maintain individual patient electronic health records, after the promulgation of the Mental Health Care Act 2017 and the Rules and regulations thereof in 2018.

PROGRAMME DESCRIPTION

e-Manas Karnataka, also known as Karnataka Mental Healthcare Management Systems is an internet-based Karnataka state-wide registry of Mental Health Establishments (MHEs), Mental Health Professionals (MHPs), People with Mental Illnesses (PwMIs) and their treatment records (including Advance Directives (AD) & Nominated Representatives (NR).

The platform aims to digitise mental healthcare in Karnataka and facilitate compliance with the Mental Healthcare Act, 2017, in alignment with the State Mental health rules formulated from the Central Mental Health Rules. It facilitates replacing the manual registers / formats with public authorities, health institutions and functionaries and can be leveraged by Government as well as Private medical health care establishments and service providers. It helps in data portability and accessibility leveraging a centralized database for demographic and clinical data of patients. It integrates with other public healthcare, IT and e-Governance systems of the state.



PROGRAMME OUTCOMES

e-Manas has been developed to ensure better compliance to the Mental Health Care Act. There is increase in number of registered patients from approximately 1 lakh in 2016-17 to more than 10 lakhs in 2019-20.

FINANCIAL IMPLICATIONS

Rs. 100 lakhs were utilized for phase 1 of the development and deployment of the software and now it has low manpower requirements for maintenance and support.

SCALABILITY

The e-Manas platform can be scaled up to support other states of the country and has provision of vertical & horizontal scaling up of the solution based on counts of users or higher volumes of transactions.

Contact

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C. MHP Getting Access to Clinical Module



HUMAN PAPILLOMA VIRUS VACCINE, GARDASIL, INTRODUCTION IN THE STATE OF SIKKIM AND SUBSEQUENT INCLUSION IN ROUTINE IMMUNIZATION PROGRAMME

PROBLEM STATEMENT

In India, cervical cancer contributes to approximately 6–29% of all cancers in women (Saurabh Bobdey, Jignasa Sathwara, Aanchal Jain, and Ganesh Balasubramaniam. Burden of cervical cancer and role of screening in India. Indian J Med Paediatr Oncol. 2016 Oct-Dec; 37(4): 278–285). An estimated 132,000 new cases and 74,000 deaths occur annually in India accounting to nearly 1/3rd of the global cervical cancer deaths. Indian women face a 2.5% cumulative lifetime risk and 1.4% cumulative death risk from cervical cancer (WHO/ICO Information Centre on HPV and Cervical Cancer (HPV Information Centre). Summary report on HPV and cervical cancer statistics in India 2007. Available from: <http://www.who.int/hpvcentre>).

Sexually transmitted human papilloma virus (HPV) infection is a critical risk factor for cervical intraepithelial neoplasia and invasive cervical cancer. At any given time, about 6.6% of women in the general population are estimated to harbour cervical HPV infection. In Sikkim, Ca Cervix is the 2nd leading cancer among all cancer in women accounting for approximately 10% of all female cancer cases. Major hurdles are encountered often in early diagnosis and effective treatment such as unavailability of reliable and comprehensive cancer care facilities and specialists, poor compliance with cervical pap smear screening and exorbitant treatment costs.

PROGRAMME DESCRIPTION

State Department of Health and Family Welfare started a State wide free of cost immunization drive; initially to vaccinate adolescent girls (9-14 years) and subsequently incorporate HPV Vaccine in Routine Immunization programme. Procurement was done through UNICEF after an MOU between UNICEF and Department of Health & Family Welfare, Govt. of Sikkim, finances for which were met from State budget. First dose

of the vaccine was given to 9-14 years old girls of all Govt, Govt-aided and Private schools, including out-of-school girls. The 1st round activities started from July to August 2018 and second dose was administered from April to May 2019.

Existing HCWs and CHVs like ASHAs and AWWs were involved in the programme after providing sufficient training of the health care workers and vaccination teams. Sensitization workshops for Principals and Nodal Teachers and Parent Teacher Meetings were held to resolve any issues and apprehensions related to the vaccine. IEC activities such as press conference for media sensitization, display of banners, leaflet distribution, newspaper advertisements, radio spots, etc were done to garner sufficient public awareness.

PROGRAMME OUTCOMES

A total of 1123 schools were covered during HPV vaccination drive. 97.85% of the beneficiaries were vaccinated in the 1st round and 97.81% in the 2nd round. Total 59,443 doses were administered.

FINANCIAL IMPLICATIONS

A total of 1123 schools were covered during HPV vaccination drive. 97.85% of the beneficiaries were vaccinated in the 1st round and 97.81% in the 2nd round. The total number of doses administered were 59,443 at an incurred expenditure of Rs.3.92 Crore. The major cost areas were of meetings, trainings, IEC, monitoring & supervision, printing, vaccine delivery, etc.

SCALABILITY

The model can be scaled up in similar settings with huge burden of Ca Cervix in female population.

Contact

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TAMIL NADU

DELIVERY OF NCD DRUGS TO PATIENTS DURING COVID-19 PANDEMIC



PROBLEM STATEMENT

Covid19 is a communicable disease associated with morbidity and mortality all over the world. According to the WHO report, mortality is high among those with multiple comorbidities like Diabetes Mellitus, Hypertension, Chronic kidney disease and Cancer. During Covid19 pandemic services for providing Non-communicable disease, drugs are hindered due to complete lockdown. During the complete lockdown, there was no transport service for the people to reach health care facilities. This may result in poor drug compliance and worsening of the disease condition.

PROGRAMME DESCRIPTION

In Tamil Nadu, NCD drugs were delivered for two months for all patients registered at Primary, Secondary and Tertiary Health care facilities. The patients whose contact numbers were unavailable in the registration details were traced and identified and drugs were being distributed to them at the doorsteps through Village Health Nurses, Mobile Medical Unit, RBSK teams, WHVs and other volunteers identified in the community. Appropriate personal protective measures and social distancing were observed while distributing the drugs at the doorstep.



PROGRAMME OUTCOMES

More than 17 lakhs patients received their medicines for two months. 72.2% of registered NCD patients received drugs through volunteers or field staffs at their doorstep during COVID 19 lockdown. Around 3.5 lakh patients of diabetes mellitus and hypertension were provided medicines at their doorstep.

FINANCIAL IMPLICATIONS

Existing human resource like VHNs, MMUS, RBSK team, WHVs and other volunteers were utilized without any financial implications.

SCALABILITY

The model can be implemented in similar settings by optimally utilising the existing resources.

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NUHM



PROBLEM STATEMENT

Unlike in rural health where the public healthcare mechanism is well-developed, the urban areas, especially the slums lack structured preventive, promotive and curative health delivery mechanism. Poor availability coupled with poor affordability increased the morbidity and mortality among the urban poor and other urban marginalised community.

PROGRAMME DESCRIPTION

The initiative included upgradation of selected UPHCs in terms of infrastructure, human resources, etc. The entire initiative is expected to benefit more than 13 lakh individuals residing in and around Raipur. The upgradation included providing necessary training to the staff, deployment of additional human resources wherever required, establishing quality control parameters, ensuring availability of adequate equipment at the facility, etc. Necessary steps were taken to integrate existing technology platform with supply chain and automated process, a set of minimum assured services was developed to also monitor the availability of services, procurement of appliances, basic infrastructure was made and an incentive mechanism was also designed for the existing & new staff.

PROGRAMME OUTCOMES

The efforts resulted in increase of OPD footfall at all facilities after upgradation. Diagnostic services such as X-ray and dental care services were started for the first time at few of these facilities.



FINANCIAL IMPLICATIONS

The major cost areas in the initiative were- infrastructure upgradation, human resources (new hiring and incentives), diagnostics (new equipment) and drugs. Total estimated funds required for infrastructure upgradation of 4 UPHCs was approximately INR 1.27 Cr, for hiring new human resource and incentives the cost was around INR 88 Lakhs, procurement of new diagnostics equipment was made for around INR 47 lakhs, and INR 2 lakh per facility was for local purchase in emergency/shortage of drugs supply drugs amounting to INR 8 lakhs.

SCALABILITY

Upgradation of urban health facilities to provide affordable care to the urban poor and vulnerable population can be made after selection of facilities on criteria such as population to be benefitted, total costs involved, existing footfall, etc.

Contact

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TELENGANA

SPECIALISTS EVENING CLINICS UNDER NUHM

PROBLEM STATEMENT

In Telangana, 132 UPHCs are functional in the Greater Hyderabad Municipal Corporation limits. Since the specialist's services are limited and are financially inaccessible for these population groups, a committee comprising of the District Medical & Health Officers (DM&HOs) of the GHMC limits and the NUHM officials in the State Head Office came up with concept of Evening Clinics with Specialist clinic service on 5 fixed days in week in selected 30 UPHCs on pilot basis.

PROGRAMME DESCRIPTION

State decided to provide Specialist Evening Clinics in UPHCs during extended hours of working i.e., 5 PM to 8 PM (5 days a week) for providing specialist services such as General Medicine, Paediatrics, OBGYN & Orthopaedics within the premises of UPHCs.

The norms of specialist outreach programme laid out by Government of India were followed to hire specialists and other required paramedical from open market or regular paramedical staff with incentive. Biometric attendance is followed for all clinic days and honorarium/incentive payments are made according to the norms on certification by the concerned Medical Officer, DM&HO. Diagnostic services are provided by the Telangana Diagnostics and drugs/consumables are utilised from the funds provided to the UPHC.



PROGRAMME OUTCOMES

The evening OPD footfalls increased gradually and the average OPD was around 30 per day. The clinics were discontinued during peak of COVID-19 pandemic and services have been resumed with necessary precautions and norms.

FINANCIAL IMPLICATIONS

The initial budgetary requirements for the initiative for a period of three months was approximately INR 43 lakhs including costs for IEC, remuneration and contingency. Funds were approved under the NHM for FY 2019-20 for 100 UPHCs, and increase in remuneration for specialists and paramedical staff was also approved in FY 2020-21. The facilities which had adequate unfractured were permitted to start the program from their unspent budget for providing specialist services within the premises of UPHCs under NUHM.

SCALABILITY

It is planned to extend the programme to other Districts to cover more areas of vulnerable population by providing Specialist services at their nearest health facilities.

Contact

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Govt of Telangana
Health, Medical & Family Welfare Department
Dist Medical & Health Office, Hyderabad Dist

**Free Evening Specialist Clinics at UPHC
Services Rendered**

- Free Pediatrician Consultation
- Free Diagnostic Test & Reports in time
- Free Drugs Distribution
- Free Immunization

Eligibility: All Childrens From 0-18 Years of Age

Place : Urban Primary Health Center
16-7-745, Opp: Ward Office, Near Kanta,
Azampura, Hyderabad.

Timings : 4:00pm to 8:00pm, Monday to Thursday
(Open Even on Public Holidays)

**UPHC
Azampura
Route Map**

Dist Medical & Health Officer Hyderabad Dist **Collector & Dist. Magistr** Hyderabad Dist

RMNCHA+N





Himachal Pradesh

NAYI DISHA KENDRA UNDER RASHTRIYA KISHOR SWASTHYA KARYAKRAM

PROBLEM STATEMENT

According to the Youth Health Survey Report 2015 (NIMHANS), 7.36% of the youth in Himachal Pradesh had a history of smoking at least once in their lifetime with almost 94% being boys. Among those who ever smoked about 61.03% started smoking between the years 15-18 and 16.43% started before the age of 15 years. In Himachal, 3.2 per cent of the population used charas and ganja — derivatives of cannabis — much above the national average (1.2%). It was the sixth-highest user along with Uttar Pradesh and Mizoram as per a report on Magnitude of Substance Abuse in India.

The State Health Department included the De-addiction Programme, as one of the major components of Rashtriya Kishor Swasthya Karyakaram (RKSK) in order to address this issue of growing substance abuse among adolescents.

PROGRAMME DESCRIPTION

Under RKSK, Adolescent Friendly Health Centers entail a whole gamut of clinical, counseling and referral services on diverse adolescent health issues ranging from sexual and reproductive health to nutrition, substance abuse, injuries, violence, non-communicable diseases and mental health issues at various level of health care facilities. These facilities are also providing De-addiction services; hence State proposed the name of these facilities as Nayi Disha Kendra.

A total of 99 facilities are notified as Nayi Disha Kendras in the state. These are established at Medical College/ Zonal Hospital/ District Hospital/ Community Health Centre. The centres are designed appropriately with adequate facilities for the adolescents. Only 22 NDKs out of 99 had dedicated Adolescent Health Counsellors, for which a team including paramedic staff has been trained to provide various services at NDK. Outreach activities have also increased as the team trained at Nayi Disha Kendra participate in Adolescent Health Days and provide counselling services.



In order to minimize the human errors in reporting; online reporting on monthly basis in DHIS-2 portal is in place. State has also prepared the RKSK Key Performance Indicators (KPI) to get better outcome and review on the basis of these indicators is being done regularly.

PROGRAMME OUTCOMES

Capacity building of various staff category was done in the month of December 2019 and services on de-addiction started in the month of January 2020. Starting from January 2020 till September 2020, 16,633 adolescents have availed various services at Nayi Disha Kendras in the state. Out of which 523 have exclusively availed the services on Substance abuse. Counselling on Substance abuse was done for these adolescents either by Medical Officer or counsellor/ Paramedic staff. The OPD footfalls decreased during the COVID-19 but have resumed to increase after the lock-down is lifted.

FINANCIAL IMPLICATIONS

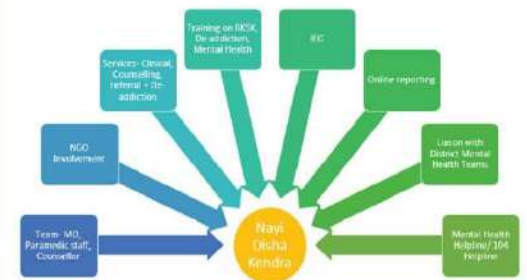
The budget approved in NHM RoP for maintenance and establishment of Adolescent Friendly Health Clinics was utilized for Nayi Disha Kendras. No additional budget was required to give de-addiction services.

SCALABILITY

Initially Nayi Disha Kendras were started at the tertiary and secondary level of facility i.e. Medical colleges, DH/ CH and CHC having adequate infrastructure. State plans to increase the number of these facilities by replicating the model to cover the Health and Wellness Centers in next phase.

Contact

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BRINGING TO FOREFRONT MATERNAL DEATH SURVEILLANCE DURING COVID-19

PROBLEM STATEMENT

Madhya Pradesh has a high maternal mortality ratio (MMR) of 173 per 1,00,000 live births (SRS 2018). The rate of decline is not as expected, considering which, the State started the Maternal Death and Surveillance Review (MDSR) program in 2018-19, to ensure identification of causes for maternal deaths and decide on appropriate action. Though State has completed the state and district level orientation and training programs of MDSR, the Districts did not show satisfactory compliance to the program. The program was expected to take a hit during the COVID-19 pandemic as most of the District officials were occupied in filed activities relate to COVID-19 pandemic. The State team thus decided to start the Maternal death reviews from state level under chairpersonship of Additional Chief Secretary, Commissioner Health and Mission director to keep focus on MDSR.

PROGRAMME DESCRIPTION

More than 50 maternal deaths were reviewed at state level till September 2020, where both District and Divisional level MDR are conducted. Two preventable maternal deaths are identified per division and the list of maternal deaths is shared with District Health Officer (DHO-1) and District Program Managers (DPM). The District officials collect all the required documents such as ANC records, OPD and IPD records, etc, after which the details are presented in a template shared by the State team. The Regional Directors present analysis of the maternal death review in their respective districts and the team deliberates on necessary actions to be taken to prevent similar deaths in future.

PROGRAMME OUTCOMES

The initiative has led to an increase in maternal death reporting by the districts, increase in numbers and quality of reviews by District Officials. As follow up actions, service delivery gaps have been identified and adequate efforts such as State level licensing for blood storage units, involvement of CHOs in IV sucrose administration, procurement of digital hemoglobinometers, customisation of ANMOL application to MPANMOL to improve ANC services, rational deployment of specialist staff, technical and operational research studies to resolve challenges found during MDSR have been made accordingly.

FINANCIAL IMPLICATIONS

No additional costs have been incurred in this initiative.

SCALABILITY

State level review of maternal deaths demonstrate the commitment towards this issue and is easily replicable without any additional financial costs.

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RAJASTHAN

INCREASING ACCESS AND AVAILABILITY OF INJECTABLE CONTRACEPTIVES TO NEW BENEFICIARY THROUGH TELEPHONIC SCREENING AND COUNSELLING

PROBLEM STATEMENT

An unavoidable decline in contraceptive services at the health facilities was observed during lockdown due to COVID-19. Sterilization services were almost on halt and only temporary contraceptive services were provided during this period. New clients could not go to the higher health facilities for receiving injectable contraceptive services and some wanted to avoid unnecessary exposure to COVID-19. This adversely affected the service delivery on injectable contraceptives to new clients, though clients were able to receive due dose from their nearby facility.

PROGRAMME DESCRIPTION

Since the sterilization services were almost on halt due to COVID-19, the state decided to focus on temporary methods of contractions during this period to address unmet need for family planning. In this regard major focus was given on injectable contraceptive services as this is a long term (3 months) and very effective contraceptive. Trained ANMs were allowed by state to provide injectable contraceptive services to the new clients during COVID-19 to reduce unnecessary exposure to client from coming to the higher health centers and also increasing the access and availability of contraceptive services. Telephonic counselling and screening (through checklist) by a trained MBBS doctor were made mandatory and ANMs were allowed to only provide first dose after receiving confirmation from medical officer. New guidelines were disseminated through official circulars and virtual meeting. (Detailed instructions were about this were issued by the state through letter no 10 dated 4.5.2020), a Zoom VC was also organized on 27th May 2020 for dissemination of service delivery guidelines.



PROGRAMME OUTCOMES

There are 13581 sub centers in the state out of which 3727 (27.44%) have provided injectable services during April to Aug 2020 and out of these 1300 (35%) have provided services to 10083 new clients. This innovation led to overall increase of 4193 new injectable clients in the state during June-July 2020 compared to same period last year and also helped in ensuring the coverage of subsequent doses.

FINANCIAL IMPLICATIONS

No additional cost is required for scaling of this innovation. Screening checklists for injectable contraceptives can be budgeted in NHM PIP.

SCALABILITY

The initiative can be easily scaled up in other states/districts.

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अंतरा (DMPA) की स्क्रीनिंग के लिए पात्रता चेकलिस्ट

नाम: _____ पता: _____

अंतरा (DMPA) का उपयोग गर्भवती के लिए सुरक्षित है। अंतरा (DMPA) का उपयोग करने से पहले स्क्रीनिंग करना आवश्यक है। निम्न प्रश्नों का उत्तर देना आवश्यक है, जो कर्मचारी द्वारा पूरे किए गए निर्देशों का पालन करें।

1. क्या आपको कोई बुखार, बुखार, कंठ में सूजन या आँसु आना हुआ है, फिर भी ठीक है ?	हाँ	हाँ	हाँ
2. क्या आपको कोई रक्तस्राव हुआ है या फिर अत्यधिक रक्तस्राव ?	हाँ	हाँ	हाँ
3. क्या आपको कोई चक्कर (Lightheadedness) हुआ है, चक्कर आना हुआ है, चक्कर आना हुआ है ?	हाँ	हाँ	हाँ
4. क्या आपको कोई रक्तस्राव हुआ है या फिर अत्यधिक रक्तस्राव ?	हाँ	हाँ	हाँ
5. क्या आपको कोई रक्तस्राव हुआ है या फिर अत्यधिक रक्तस्राव ?	हाँ	हाँ	हाँ
6. क्या आपको कोई रक्तस्राव हुआ है या फिर अत्यधिक रक्तस्राव ?	हाँ	हाँ	हाँ
7. क्या आपको कोई रक्तस्राव हुआ है या फिर अत्यधिक रक्तस्राव ?	हाँ	हाँ	हाँ

अंतरा (DMPA) का उपयोग करने से पहले स्क्रीनिंग करना आवश्यक है। अंतरा (DMPA) का उपयोग करने से पहले स्क्रीनिंग करना आवश्यक है। अंतरा (DMPA) का उपयोग करने से पहले स्क्रीनिंग करना आवश्यक है।

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9. क्या आपको रक्तस्राव हुआ है या फिर अत्यधिक रक्तस्राव ?	हाँ	हाँ	हाँ
10. क्या आपको रक्तस्राव हुआ है या फिर अत्यधिक रक्तस्राव ?	हाँ	हाँ	हाँ
11. क्या आपको रक्तस्राव हुआ है या फिर अत्यधिक रक्तस्राव ?	हाँ	हाँ	हाँ
12. क्या आपको रक्तस्राव हुआ है या फिर अत्यधिक रक्तस्राव ?	हाँ	हाँ	हाँ
13. क्या आपको रक्तस्राव हुआ है या फिर अत्यधिक रक्तस्राव ?	हाँ	हाँ	हाँ

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TAMIL NADU

MANAGEMENT OF HIGH-RISK ANTENATAL MOTHERS DURING COVID 19

PROBLEM STATEMENT

The COVID 19 outbreak has placed unprecedented demands on our health system. The State identified all pregnant women as High Risk and made special reference to provide emergency services to them. The goal during the pandemic was to maintain equitable access to Essential Health Service delivery throughout the emergency, limiting direct mortality and avoiding increased indirect mortality, since the pregnant women come under the vulnerable group.

PROGRAMME DESCRIPTION

Line list for all ANC women were obtained from PICME / RCH portal for categorization for High-Risk Mothers as Green for safe, Yellow for moderately risked and Red for high-risk pregnancies.

Women with history of PIH Anaemia, GDM, HOB, previous LSCS, any heart disease complicating pregnancy, BOH, teenage/elderly/primi/breech, twins, triples, previous APH/PPH preterm delivery any medical disorders etc are identified as High-Risk Mothers.

The line list of High-Risk mothers is shared between the Mentor Obstetrician, who looks after a block in each district, the Chief District Obstetrician who is in charge of the whole district and the State Maternal Health Division with virtual and real time monitoring.

To ensure early registration, the already existing software PICME was revamped as PICME 2.0 and linked to Conditional Cash Transfer, besides linking it to issuance of birth certificates. The High-Risk mothers are mobilised to the nearest CEmONC centre for ANC and delivery via 108



Ambulance and women with known cardiac disease are registered in the Cardiac Registry and managed in MCH by multidisciplinary team including Cardiologist, Obstetrician, Anaesthesiologist and Neonatologist. Uninterrupted supply of Blood, Oxygen Drugs Reagents and Consumables including PPE were ensured for nil stock outs.

All secondary care and tertiary care hospitals were COVID Designated Hospital, where designated areas were created for suspected and confirmed COVID positive pregnant mothers. These hospitals had necessary services such as triage, AN ward, labour room, maternity OT, postnatal, post-operative wards, NICUs and holding area for mothers whose reports were awaited. Other than this, family planning services including PPIUCD (concurrent with delivery), PAIUCD (concurrent with abortion) and Injectable Contraceptives were provided at all delivery points. Obstetricians were pooled into the Telemedicine e sanjeevani OPD and public awareness was promoted to prevent unnecessary travel and exposure of the pregnant women. The private nursing homes were also instructed to manage COVID suspected positive patients and periodically monitored for their preparedness.

PROGRAMME OUTCOMES

Improvements were seen in early ANC registration, uptake of PPIUCD, IUCD, Antara and Chhaya due to this initiative between April-September 2019 and 2020. During April to October 2020, more than 5000 COVID positive pregnant women were admitted and registered. The registration, categorisation and tracking of all ANC women including the high-risk pregnancies improved with this initiative.

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EMERGING INITIATIVES

Health Systems Strengthening



CHHATTISGARH

MITANIN ONLINE INCENTIVE PAYMENT SYSTEM

Problem statement

Ensuring timely payments and performance review of Mitanins' incentive was a constant challenge for the department from inception. There was no IT platform for the same to fasten and simplify the process.

Programme description

The existing on field model has been converted in the Mitanin Online Incentive Payment system, through following steps

- + Filling of incentive form by Minanints in the "Dawa Patrak form"
- + Verification of form by ANMs from registers
- + Entry of forms into software from PHCs and submit to Block/ district
- + Verification at Block/ district level and submission of data into PFMS for payment
- + Import payment details from PFMS to MIPS

All concerned staff including District RCHO, District Accounts Manager, District Accounts Assistant, District data manager, Block & PHC accounts and data managers and Mitanin programme coordinators were trained in using the software.

Programme outcomes

Mitanin Online payment system (MIPS) facilitates the department to ensure timely and seamless online payment incentive payment to Mitanins and capture Mitanin wise details of services given to the community. The payments are made directly to the bank account of the Mitanin. The software also has the provision to generate different reports if required. On average, 93% Mitanins are benefitted and receive their incentives timely.

Financial implications

No additional costs were incurred as the software was developed by NIC and State team.

Scalability

This software is free to adopt by any state as its developed by NIC and thus easily scalable. Only variables required are details of Mitanins, type of incentives, health facilities hierarchy and PFMS which are available in any state.

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KERALA

HUB AND SPOKE MODEL- INTEGRATED SAMPLE TRANSPORT SYSTEM

Problem statement

Sepsis is major cause of neonatal mortality and irrational use of antibiotics leading to Anti-Microbial Resistance makes it more difficult to treat sepsis. Further, peripheral health facilities do not have in-house advance lab services, thus making AMR surveillance a tough job.

Programme description

Early identification and management of neonatal sepsis may help to reduce the neonatal mortality and thereby help to further reduce the IMR.

As part of widening of diagnostic facilities through government and private hospitals, the Hub and spoke model of diagnostic facility was introduced in District Ernakulam. 65 trainees comprising of clinicians, nurses and lab technicians (LTs) were trained through a 4-hour training session, spread over two batches on 18 and 19 November 2019 at GH, Ernakulam. Five vehicles have been allotted to GH for sample collection from the laboratory where samples from different spokes are tested.

For the sepsis management programme, GH is the hub with advanced facility, while all the six peripheral hospitals – Perumbavoor, Tripunithura and Karuvelipady taluk hospitals, Women and Child Hospital, Mattanchery; District hospital, Aluva; and General hospital, Muvattupuzha are the spokes. Lab is the collection point in every hub and spokes and necessary documentation/ register is being maintained by the concerned programs and departments. The service is available on all days except Sundays.

Samples for Histopathology (Biopsy, FNAC and Pap smear samples under Comprehensive cancer control programme), 4. Cartridge Based Nucleic Acid Amplification test (CBNAAT) under RNTCP, Covid 19 tests samples, metabolic samples from new-borns and other specimens of suspected, Leptospirosis, Dengue, Hepatitis etc are collected from the spokes and transported to the hub for testing.

Programme outcomes

Within 3 months of establishment, GH has received around 50 blood culture samples from peripheral hospitals. GH Ernakulam is the regional centre to coordinate AMR surveillance in health service dept, getting 30 -40 microbiology samples (blood, CSF, body fluid, pus, sputum, urine, respiratory specimens) that includes 8-10 blood culture per day with positivity of 10-12%.

Financial implications: Training, operational cost of transport vehicles.

Scalability: This model is easily scalable by any state.

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Madhya Pradesh

AN INNOVATION FOSTERING HEALTH SERVICE DELIVERY AND STRENGTHENING ASHA MONITORING SYSTEM

Problem statement

Despite laborious efforts by ASHA workers in difficult geographies, the maternal and child health indicators do not progress in the way it should. One of the prime reasons for this is the health behaviour of the beneficiaries which needs to be tracked and supervised. Similarly, at supervisory level, the data of the beneficiaries needs to be reviewed for critical decision-making during sector meetings. The need for supportive supervision at all levels was felt by the leadership team in Betul. There is a need of a tool which capacitates ASHA Sahyogi to easily visualize the picture of her villages and its status of critical indicators. In current situation, ASHA Sahyogi can check the ASHA dairy record, but the information cannot be validated for all beneficiaries. Similarly, there is no tool through which beneficiaries themselves can track their health status.

Programme description

This innovation aims at improving the work quality of ASHA workers and connects the ASHA supervisory system with beneficiaries resulting in effective tracking of indicators and community monitoring.

The ASHA report card is a tracker through which the data related to maternal and child health indicators is tracked by ASHA worker. This format is posted at the wall of AWC where the indicators showing not so good achievement are marked by the red pins. The number of red pins on the tracker sheet helps ASHA and ASHA Sahyogi to identify the areas of improvement and accordingly plan their visits to the beneficiaries. This tool also enables the supervisors to plan their ATPs based on the priorities. This tool has been very successful and well accepted by the supervisors and ASHAs both.

Similarly, a tool (format on thermocol sheet) is placed at each pregnant women and lactating mother's house. This has all relevant details regarding the ANC check-ups, immunization, danger signs, HBYC, HBNC, SAM/MAM etc. ASHA worker fills the information in the tracker tool. Red pins are used if any service is missed by the ASHA worker. ASHA Sahyogi and BCMs validates the services given by the ASHA worker and ensure the last mile delivery. The supervisor validates the services only after cross verifying from the beneficiary's end. This is very useful tool in terms of ensuring that the services are delivered.

TAMIL NADU

ESSENTIAL DIAGNOSTIC SERVICES SYSTEM (EDSS)

Integration of all Labs
in Government Health
facilities through
holistic approach

Problem statement

Presence of high-end key diagnostic tests such as Immunohistochemical markers, cytogenetics, troponin can be life-saving. In the absence of such services, many patients are forced to go to private laboratory facilities, which may result in Out-Of-Pocket Expenditure (OOPE). This results in poor compliance and control rates. Drugs and Diagnostics are the two major contributors for Out-Of-Pocket Expenditure (OOPE) in any health systems.

Programme description

As per the 71st NSSO analysis, Tamil Nadu has minimal out of pocket expenditure for drugs in public facilities, but with few limitations. To further reduce OOPE and to provide quality care in parallel with free drug services, NHM Tamil Nadu has conceptualized the "EDSS Model" with the funds from NHM-Government of India – under Free Diagnostics Initiatives (FDI), synergizing with the existing system since July 2019.

A set of free essential diagnostic services at each facility level, namely Primary health centre, the Block PHC or UGPHCS, Sub-District Hospital, District Head Quarters Hospital, Medical Colleges, Apex Lab Centres and Ultra Apex Lab Centre, has been identified in the form of an 'Assured Test Menu' which would be provided free of cost in an assured mode. The tests encompass Biochemistry, Pathology (Clinical Pathology, Cytopathology and Histopathology) and Microbiology (Serology, Mycology, Virology and Bacteriology). A detailed gap analysis was done to ascertain the quantity of consumables and human resources required, depending on the case load for each test at each facility and existing resources.

The test results are available online (through the Lab Information and Management System-LIMS), within the Assured Time Frame.

Programme outcomes

Around 5400 samples were transported from three different zones within 9 months of commencement of the pilot. It also led to a thorough gap analysis to understand the availability of lab equipment & hardware status. The number of inhouse Lab Tests also increased, with a reported 18,88,981 number of inhouse lab tests during the period July 2019 to August 2020 in Pilot district.

Financial implications: Approximate Rs. 86 lakhs were spent on lab equipment, hardware, reagents and sample transportation.

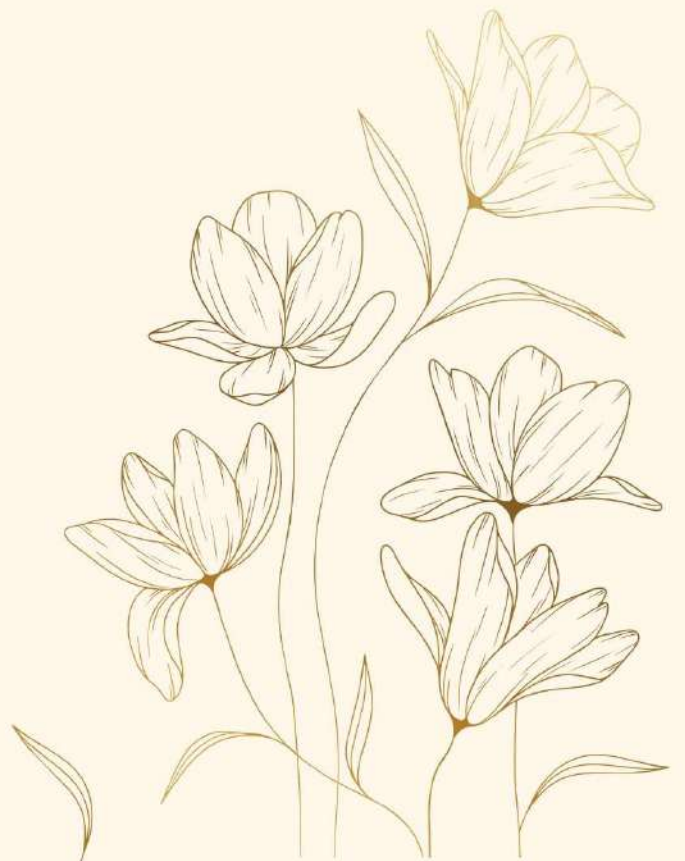
Scalability: The pilot can be replicated by other States for integration of Labs for achieving UHC, to provide high quality diagnostics to the underprivileged.

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EMERGING INITIATIVES

DCP



ASSAM

"COUGH SUPERVISORS" – AN INNOVATIVE APPROACH FOR FINDING THE MISSING TB CASES DURING COVID-19 PANDEMIC



Problem statement: In this approach to find the probable missing TB cases volunteers from the community were engaged for finding the highly presumptive TB cases and help in sputum sample collection and transportation for TB diagnosis.

Programme description: 4 tea gardens and 1 urban slum under Bagchung TB unit (high burden unit) was the intervention area. Total population of Tukulai TE, Gatanga TE, Doklongiaa TE and Murmuria TE is 20,305 and of urban slum Umbedkar Colony under Mariani PHC is 4438. Health workers and volunteers (COUGH SUPERVISORS) who were interested to work during the lock down period for the TB programme were selected. They were mostly the Line chowkidars of Tea gardens, TB Champions (Cured TB patients and their relatives) along with paramedical staffs under the Tea Gardens. Capacity building sessions were planned for the volunteers with a hands-on training to collect the sputum samples.

Along with sensitization on basics of NTEP, all the volunteers were sensitized on the current Covid-19 situation along with all "Dos & Dons" and also on the Infection Prevention Control measures to be undertaken both for TB and Covid-19 as per guidelines laid down by Govt of India. To increase the sensitivity of diagnosis in this "small sample group of presumptive TB patients" decision was taken to test the samples in CBNAAT only. Covid-19 was ruled out among the identified presumptive TB patients as per the GoI guidelines under the guidance of the Medical Officers concerned.

Programme outcomes: Though this study was done in a small population of 24,743, it was found that with a simple innovative approach of engaging the community and TB Champions for screening and linking presumptive TB patients to NTEP, 7 TB patients out of 20 presumptive cases were identified within a period of 15 days which translates to 35% positivity rates among these vulnerable population.

During this Covid-19 pandemic and lock-down period, this approach gave an opportunity for early diagnose and treatment for the TB patients.

Total no of sputum samples collected (A)	Of (A) no (%) tested in CBNAAT (B)	Of (B), no (%) diagnosed as MTB detected (C)	Of (B) no (%) detected as MDR TB	Of (C), no (%) initiated-on Rx
20	20 (100%)	7 (35%)	0 (0%)	7 (100%)

Financial implications: No additional cost was involved as all were part of continuous activities under NTEP

Scalability: The concept of identifying and availing the services of "Cough Supervisors" can be helpful in a long way in early identification and treatment of TB patients

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ASSAM

RESPONSE TOWARDS TB CARE DURING COVID-19 EMERGENCY SITUATION



Problem statement

Emergence of the Covid-19 pandemic across the world necessitated all the states to take pro-active measures and innovations to overcome the challenges and ensuring un-interrupted service delivery for the TB patients and Assam.

Programme description

During lockdown, a series of services were ensured to TB patients, such as un-interrupted drug supplies for the existing 20,000 (approx.) no of patients adopting various mechanisms such as home delivery of the drugs by NTEP staffs including DTOs and through community volunteers including ASHAs, engaging officials' vehicles of DTOs/ MOTCs / STS / STLS for supplying ATT to the patients, provision of Govt pass for staffs and vehicles for movement within the district for drug transportation. Home visits at residence of bed-ridden DR-TB patients were conducted by District PMDT Coordinators for sample collection and initiation of domiciliary treatment. Service delivery at Districts were clubbed together arranging transportation of samples for LPA to Intermediate Reference Laboratory, Guwahati due to shutdown of courier services. As per directive of Govt of Assam, districts adopted pro-active measure to club TB surveillance & screening activities along with Community Surveillance for ILI and SARI. Virtual sensitization of district staff was conducted and mechanisms were established to collect list of TB patient from difficult to reach areas (TB Units / PHIs). These patients were counselled over phone and patients who were facing difficulties in accessing drugs were linked to their respective STS and nearest PHIs for ensuring drug supply for at least a month.

Programme outcomes

Adopting various strategies for un-interrupted supply of drugs, 20,000 (Approx) TB patients could be provided anti-TB drugs at home who otherwise were facing issues to reach to the health institutions for collecting drug themselves. More than 5000 TB patients could be provided telephonic counselling for ensuring treatment adherence. By providing door step service delivery to Drug Resistant TB, many precious lives were saved by reducing the treatment delay.

Financial implications: No additional cost involved as all were part of continuous activities implemented on Mission Mode

Scalability: To mitigate challenges of accessibility to both diagnostic and treatment services, all these innovative approaches are very much scalable upto the most peripheral geography.

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CHHATTISGARH

NLEP LEPTRACK

Scalability: The plan is to implement this application in all the districts of Chhattisgarh with 148 Block User for specific Block Report, 27 District User for Block Reports of respective district and State User- all Districts Reports. The implementation of LEPTRACK has been prioritized in the 7 districts with 60% of total state case load.

Contact

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Problem statement: Surveillance in Public Health is collection and analysis of health-related data for action. Chhattisgarh has highest burden of Leprosy cases in the country and special action is required to lead to the GOAL of ELIMINATION of Leprosy. The number of NMA/NMS staff of NLEP are gradually decreasing in the field, the surveillance and NLEP field activities faces implementational challenges due to lack of trained staff.

Program description: The need of having robust leprosy surveillance and follow up of cases was acknowledged by the state and use of digital platform was thought upon to support the present system. The digital platform was conceived with the guiding principle of being easy to use, easily understood by health workers and supplementing the NLEP services. The need of closely analysing the village level epidemiological information will help the program to plan interventions and prevent the spread of the disease. LEPTRACK is a web based mobile application for Leprosy Disease Surveillance and patient follow up in State of Chhattisgarh.

This software enables the program managers at State, District and Block level to take informed, prioritized and timely action to plan effective and efficient interventions. All data contained in this application has the public health surveillance attributes: Person, Place, Time and all data has village level information for geographic reference by click of a button. The design and development of this application are intended to the strengthening of Leprosy Surveillance for planning public health interventions. This application provides real-time information on Leprosy surveillance from anywhere on any electronic device, this facilitates point entry of data through hand held smartphones and with ease.

This Application has used the digital format of the existing familiar patient card and ULF formats for input.

The MPW/NMA/ RMA inputs screening data and follow up data and Medical Officer confirms the diagnosis and prescribes treatment. All login is User ID and Password are protected and linked to HRMIS- CG. District Level trainings for MO, RMA, NMA, NMS, MPW were organized for pilot districts with installation of application in the personal smartphones.

Program outcomes: The State Level Dashboard is functional with more than 1000 suspects being entered and around 700 confirmed cases with all epidemiological data available. The 430 suspects not confirmed can be tracked. Village level action plan can be prepared as per the new GOI guideline of 'Active Case Detection and Routine Surveillance'.

Financial implications: No Cost to the NLEP program for development of this application. Approximately INR 2,00,000 has been allocated by NHM as staff incentive.

Dadra and Nagar Haveli

COUGH & COLD CENTRES AND SPUTUM SPOTS AT PUBLIC HEALTH FACILITIES

Scalability: This approach adopted in the UT of DNH and DD do not require additional cost and is easily replicable and applied to anywhere else in the country. This approach not only helps in reducing transmission of Tuberculosis but also to other communicable respiratory diseases.

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Problem statement: India contributes about 27% to annual new cases of Tuberculosis worldwide. Cough is the most common symptom of Tuberculosis. Coughing promotes airborne transmission of infection both in the community and within a household. It is one of the commonest modes of Hospital Acquired Infection (HAI). As outdoor patient area caters a huge chunk of patient load, airborne transmission of infection through coughing can infect many visitors to hospital and healthcare providers as well.

Program description: The Cough & Cold Centre has dual purpose of providing awareness to those visiting the government health facilities as well as help and guide the patients with respiratory symptoms in availing immediate and appropriate services at the health facility.

A Cough & Cold Centre (CCC) is a designated space near the registration counter of a public health facility (PHC/CHC/Sub-District Hospital/District Hospital) with prominent display as Cough & Cold Centre. The space includes display of awareness messages on 'Cough Etiquettes', signs & symptoms of TB and availability of services related to TB and other respiratory symptoms. The space will include signage indicating the way to "Sputum Spot" where a patient with cough can cough out a sputum sample for diagnosis of TB. The patients entering a public health facility will automatically reach the Cough & Cold Centre as it is near the registration counter. Every patient at the registration is asked for respiratory symptoms. If the patient has any of the respiratory symptoms, he/she will be immediately sent to appropriate OPD with instructions for using mask/tissue/hanky and will be attended in OPD on priority basis. If sputum sample is needed, he/she is directed to sputum spot where he can cough out a sample with no hazard to other OPD attendees. 'Sputum Spot' is a dedicated space for collection of sputum sample in the premise of health facility. The space for this spot is an isolated open/ventilated area displaying a board "Sputum Spot – a place for collection of sputum sample" and instructions how to produce a good sputum sample. This area will also include messages on Airborne Infection Control Measures which should and can be taken at home as well as in the community. The sputum spot will also have sanitizer and tissue paper dispenser for use by the patients coming there for producing a sputum sample.

Program outcomes: This innovative approach is started recently in the UT of Dadra and Nagar Haveli and Daman and Diu. The expected outcomes are: 1. Decrease in airborne transmission of Tuberculosis, 2. Decrease in number of new cases of TB.

This will help the UT in reaching its target of TB Free DNH and DD by 2022.

Financial implications: The cost of establishment and implementation of Cough & Cold Centres and Sputum Spots is minimal as it needs no additional human resource or space. The existing space and staff is used after suitable display of signage, boards and messages on awareness.

GUJARAT

DIAGNOSTIC ROLE OF GASTRIC ASPIRATION IN SPUTUM NEGATIVE PULMONARY TUBERCULOSIS AMONG ADULTS

Contact

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Problem statement: National Strategic Plan (2017-25), advocates for early Identification of presumptive TB cases, at the first point of care, be it private or public sector, and prompt diagnosis using highly sensitive diagnostic tests to provide universal access to quality TB diagnosis including drug resistant TB in the country. Gastric aspiration is a technique which has been employed in paediatric population for suspected cases of primary complex. NTEP recommends microbiological confirmation of sputum negative cases of pulmonary tuberculosis suspects by CBNAAT [TOG 2016].

Program description: This retrospective study was conducted at the Bhavnagar Medical college Hospital for a period of one year, aiming to find the Diagnostic role of gastric aspiration in sputum negative pulmonary tuberculosis among adults. The study subjects were classified into three groups: 1. Those who have sputum production with radiologically active lesion but sputum smear negative for AFB. 2. Those patients who have neurological deficits (meningitis/CVA etc) and very sick, who cannot bring out sputum. 3. Those who have a radiological significant lesion without sputum production.

Program outcomes: 114 patients were selected based on eligibility criteria. Total 37 cases detected by molecular testing of Gastric aspirate, out of which 76% were new cases. One Rif resistance (DRTB) case was detected in New (3.5%) while one Rif resistance (DRTB) case was detected in PT (11%) which is in more alignment with NDRS survey results (New-2 to 3%, PT-10 to 13%) [PMDT guidelines 2019]. These RR cases could have been missed if efforts were not made to aspirate gastric lavage. Absence of this intervention would have led to not only underdiagnosis of microbiologically confirmed TB among community but also spread of DRTB among community.

The findings concluded that Gastric aspirate for AFB smear and culture can be used as a tool in diagnosis of pulmonary in patients who cannot submit sputum and patients who are smear negative as suggested by the study. At PHC and CHC level where sophisticated techniques like bronchoscopy are not available, the patient presenting with no sputum under suspicion of tuberculosis, gastric aspirate can be performed as a diagnostic technique which is a simple outpatient procedure. With availability of NAAT technology at district and subdistrict level, this intervention can be an innovative policy for diagnosis of both drug sensitive TB and Drug Resistant TB. The procedure can be performed by trained health care professional like staff nurses, unlike bronchoscopy which needs to be performed by trained bronchoscopist with constant monitoring.

Financial implications : NA

Scalability: The model suggested by the Study can be applied after relevant training of manpower.

GUJARAT

PROJECT RE-VISIT : An experience of mandatory follow-up visits of TB patients and screening of their household contacts in post-lockdown period

Problem statement

The Covid-19 pandemic has significantly affected the health system. During the lockdown period it had significantly limited the movement of health service provider and the care seekers (TB Patients). The National TB Elimination Program has implemented various public health action strategies to be undertaken in the community throughout the course of treatment for TB. Contact Tracing of household contacts for TB and follow-up visit to evaluate drug compliance and monitoring adverse drug reaction are the activities which had suffered the most during lockdown period.

Program description

A cross-sectional study was carried out in the month of June & July 2020 in Gujarat after lockdown was called off, with objectives:

- ✦ To know the clinical status of the patient who were initiated on treatment for TB from October 2019 to May 2020 by home visit.
- ✦ To find out new cases by screening of contacts the on-treatment TB patients through contact tracing.
- ✦ To evaluate drug compliance and identify adverse drug reaction if occurred for prompt management

The Senior Treatment Supervisors and TB Health Visitor of NTEP program of all districts had done the exercise of follow up visits and contact tracing using Nikshay mobile application. The data was entered in the Nikshay Software and the analysis was done using MS Office Excel. All the newly identified TB cases were notified in the Nikshay Software.

Program outcomes

Total 4% (4509) symptomatic contacts could be identified during the project which were subjected to appropriate TB diagnosis afterwards. Total 105 new cases of TB could be diagnosed during the project revisit.

Financial implications: NA

Scalability

The model suggested by the Study can be applied after relevant training of manpower.

Contact

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Himachal Pradesh

SUNDAY ACF BY ASHA STRATEGY TO FAST TRACK ENDING TB PROCESS

Scalability: State NHM has provided android based Mobile to each ASHA to capture the Sunday ACF data on real time in the TB mukt Himachal App for an early intervention and support to the TB patients.

Contact

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Problem statement: Tuberculosis is an old disease in India having highest mortality and morbidity among all infectious diseases. Himachal Pradesh Government has set an ambitious goal to meet the targets to 'End Tuberculosis by 2021'. State came out with its own strategies and launched a new scheme "Mukhya Mantri Kshay Rog Nivarna Yojna"(MMKRNY) with a major focus to fill the gap in the infrastructure, knowledge among general population about TB

Program description: A systematic screening of population to find out presumptive TB cases in a campaign mode was initiated as Sunday ACF activity. This is being done by ASHA as one of the components of MMKRNY. Himachal Pradesh State has a network of 7736 ASHA who are supporting State in implementation of all National Health Programs and schemes as front-line workers. In NTEP, their role was limited to DOT provider so far. With an objective of early diagnosis of TB cases, Department of Health & Family Welfare piloted "Sunday ACF activity by ASHA" in four districts Hamirpur, Bilaspur, Kangra and Una in August,2018. During the COVID period there was a substantial drop in the case notification as the patients were not able to reach the health care facilities. In June,2020 this activity was scaled up across the state under Mukhya Mantri Kshay Rog Nivaran Yojna. Each ASHA on Sunday visits at least 20 households and screens atleast 80 persons for any symptoms of TB. Sputum samples of all the presumptive TB patients are collected and transported to the nearest DMC by ASHA.

SOPs for Sunday ACF were prepared. Orientation of Block Medical Officers and NTEP supervisory staff had been conducted across the districts. Health workers network and ASHA network were trained at block and PHI level. Each ASHA was directed to screen 100% of her assigned population in every quarter and administer interview checklist with standardised questionnaire. Reporting mechanism from ASHA to HSC, PHI, Block, District and State on a standardised formats and protocols is being implemented. Supervision of this activity is being done by BMOs, MOs, STSs, Health supervisors and health workers during their visits to the field in the week days. If the supervisors find that the performance of any ASHA is not as per protocol, then they ensure that the ASHA concerned is given onsite training.

Program outcomes: More than 56 lakh persons have been screened and 12,018 samples have been examined in DMC and CBNAAT. An additional yield of 202 cases was achieved from the Sunday ACF activity in the State.

Financial implications: Funds are being made available under Mukhayamantri Kshay Rog Nivaran Yojna from the State Budget. An honorarium of Rs. 100 is being given to ASHA worker for the activity day.



KARNATAKA

BEST PRACTICES OF NATIONAL TUBERCULOSIS ELIMINATION PROGRAM (NTEP) DURING COVID 19 TIMES

Problem statement

Karnataka diagnoses approximately 90,000 TB patients every year out of which approximately 20,000 patients are notified from private sector. COVID-19 pandemic has affected all the key strategic interventions of TB program resulting in almost 52% decline in TB case notification in April 2020 as compared to previous year.

Program description

A multi-pronged approach was followed in this project. Presumptive TB patients were identified by house-to-house visits by Accredited Social Health Activists (ASHA) and enrolled in Presumptive TB register. These patients were further screened on chest X-ray and cartridge based nucleic acid test (CBNAAT)

CBNAAT testing was provided to all patients admitted in hospitals with influenza like illness (ILI) and severe acute respiratory illness. Similarly, COVID-19 negative patient details were collected from RT PCR labs, and all persons who contacted APTHAMITRA care line (14410) patients were traced back and screened and tested for TB and by CBNAAT

Program outcomes

State has supplied doorstep delivery of 2 months anti-TB drugs to all the TB patients in order to prevent drug stock outs at the patient's end. In the month of August from 10th August to 17th August a contact tracing drive was initiated. During the contact tracing drive 12,254 households with TB patients were visited. 49509 contacts were screened for TB and among them 3760(8%) of them were identified as presumptive TB. Around 100 TB patients were diagnosed across the state through this initiative.

Financial implications

NA

Scalability

State has initiated Bi-directional TB-COVID screening and Screening of TB among ILI/ SARI cases from October 2020.

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KERALA

DECENTRALISED TB SURVEILLANCE FOR ADVOCACY, LOCAL PLANNING AND ACTION

Problem statement

The state government has launched "Kerala TB Elimination Mission" as 'people's Movement against TB' through community ownership and social mobilization. Kerala TB Elimination Mission is being implemented through the stewardship of Local Self Government Bodies with the theme "My TB free Panchayat".

Program description

Of the 1034 LSG Heads, 1021 (98.7%) were sensitised on TB Elimination Mission initially. Among the LSG bodies, 951 (92%) formed TB Elimination Task Forces. TB Elimination Task Forces chaired by LSG head plans and reviews TB Elimination activities of that Panchayat/Municipality/Corporation. Nutritional support projects for TB patients worth INR27,25,711 was implemented from LSGs own fund. Treatment Support Groups were formed in 334 (36%) LSGs. TB messages reached 7428886 / 8560731 (87%) households in the state. All welfare and developmental activities including addressing determinants of TB are being done through LSG mechanisms. TB data used to be analysed at Panchayat level for surveillance purpose. Presumptive TB Examination Rates & TB Notifications used to be captured Panchayat wise.

Program outcomes

Out of 1034 LSGs (Grama Panchayat/Municipality/ Corporation), 561 LSGs had zero paediatric TB, 709 LSGs had ZERO Drug Resistant TB and 688 LSGs had ZERO lost to follow up for 12 consecutive months in 2019.

All these LSGs were declared AKSHAYA KERALAM award by Hon Health Minister of Kerala K K Shailaja Teacher on October 2, 2020. Appreciation awards were distributed to eligible LSGs.

Financial implications

NA

Scalability

Analysing data at Village/Panchayat level will help to identify trends and program performance which will help for local planning and solutions. This will also develop competitive spirit to ensure Political Stewardship which will lead to Social Mobilisation.

Contact

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PUNJAB

EXPANSION OF HEPATITIS C SCREENING AND MANAGEMENT AMONG HIGH-RISK GROUPS IN PUNJAB DURING COVID



Financial implications: No extra cost is levied. The cost of screening, viral load testing and medicine is booked under NVHCP.

Scalability: The program can be scaled up in similar settings after relevant training.

Contact

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Problem statement : Since Hepatitis-C is a blood-borne disease, injecting drug users (IDUs, PLHIVs and other persons) are at very high risk of contracting the disease. Recognizing the need to reach out to such high-risk individuals, the Punjab government expanded the horizon of the existing screening and management of Hepatitis-C from passive screening towards active screening and management.

Program description: The active screening program was envisaged in 2017 and further launched in October 2018, to initiate Anti-HCV screening for PLHIVs at ART centres and IDUs at TV/OST sites across the state. The project was initiated with the support of FIND (Foundation for Innovative New Diagnostics) and now taken over by the State. For Viral load testing four GeneXpert machines were installed at four laboratories. Viral load sample transport networks were mapped to screening centres (ART/OST sites) thus minimizing the sample transport distance, decreasing costs, and optimizing lab capacities. By developing simplified data and patient flows, the Punjab Government streamlined linkages to care and developed a screening protocol to scaleup HCV testing to PLHIVs at 13 ART centres and IDUs at co-located 11 OST centres. Till date, more than 26,000 patients have been screened at ART centres and more than 3400 patients screened at OST centre. To facilitate effective outreach to patients, the 13 ART centres and co-located 11 OST centres were designated as Treatment centres in June-2020. Under COVID situation it helped ensuring that positive patients get Treatment at the respective sites only at the earliest. The Medical and Para medical staff of 13 ART and 11 OST sites were sensitized and trained by the experts from PGI and State for screening and management of Hepatitis-C. Virtual training was organized for Peer Support in July-2020 using ECHO platform for data digitization.

Program outcomes: Till date, more than 26, 823 patients have been screened with an average positivity of 20.5%. The positivity varies from 8% at Pathankot to 44% at Ferozpur. Of these 26,823 screened PLHIVs at ART, 5,524 were found positive and 5,532 were referred for viral load test in which 4,508 were found positive. So far, treatment of 2,371 patients has been initiated, out of which 1,368 completed their treatment. Total 536 patients were tested for SVR (viral load test post treatment) and 451 were cured with cure rate of 84%. Further, at the OST Centres, more than 3,459 patients have been screened with an average positivity of 62.8%. The positivity varies from 19% at Patiala to 80% at Ludhiana. Of these 3,459 screened IDUs at OST, 2,175 were found positive and 1,921 were referred for viral load test in which 1,554 were found positive. Till date 2,39 have been initiated on treatment, out of which 117 completed their treatment. Total 14 patients were tested for SVR (viral load test post treatment) and 9 were cured with cure rate of 64%.

In collaboration with WHO, Punjab become the first state to implement "Injection Safety Implementation Project" thus reducing overall burden of diseases caused by unsafe injection practices and incorrect disposal of used injection waste. During COVID situation, 13 ART and 11 OST centres designated as Treatment centres thus ensuring that patients complete their treatment without any gap.

RAJASTHAN

ONLINE TB TRAININGS REVIEW

Scalability: The model was taken up during pandemic but has a potential to be used by other States in similar settings.

Contact

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Problem statement: Rajasthan, like all states, too faced the unprecedented challenges posed by COVID-19 pandemic impacting health systems and programme implementation. Health seeking behaviour was also compromised because of social distancing, travel restrictions and widespread community reluctance precipitated from COVID-19 fear. Furthermore, at few places diagnostic facilities like CBNAAT machines got diverted for COVID activities and hospitals got converted as Covid Health facilities that led to some gap in NTEP services. This was evident from drop in notification, diagnostic testing, case finding and treatment initiation. Furthermore, sudden decrease in in-person training and hand holding support resulted in urgent need for the capacity building of NTEP staff.

Program description: State initiated regular Review Meetings to ensure continued engagements and also initiated online Nikshay training for NTEP staff to address the gaps in capacity building. These meetings were organized in at three levels: State Level: Review by ACS-1, PHS-1, JS-1 MD NHM-2 (In May, June, July, August & September 20); Zonal Level: Two series of Zonal Reviews, held in August & November in 9 batches conducted from State HQ; District Level: STO participated in various district level meetings through VCs.

The attendees included State NTEP staff, District NTEP Staff at the DTC and TUs, STDC, and Partners. All sessions marked full attendance and ensured the necessary safety guidelines. Following indicators were analysed among the districts while Districts presented the TU wise analysis. These activities help in the gap assessment and focused interventions of: TB Notification, Treatment Initiation status, UDST, Contact Tracing, including Chemoprophylaxis, TB-comorbidities and Bi-directional screening, Treatment Outcome Status, DBT (Bank Account Seeding, validation of seeded bank accounts, Maker Pending, Checker Pending.), DRTB Patients diagnosed V/s Treatment Initiated and treatment outcome, Entries in Nikshay Aushadhi, Updation of near expiry drugs in Nikshay Aushadhi, Output of ACF

State also focussed on regular virtual training on various thematic areas and conducted online NIKSHAY training with special focus on DBT from 7th to 11th September 2020. These online trainings were facilitated by the STO and development partners, all NTEP key staff participated in the training and also shared their performance, challenges, strategies, and exchanged ideas from other districts.

Program outcomes: The online portal not only helped in displaying the real time status of NTEP indicators, it also facilitates in program analysis and evidence-based decision making; which was reflected in the ongoing district level meetings and need based onsite and online training.

Financial implications: NA



TAMIL NADU

INNOVATIVE MODEL OF DBT UNDER NIKSHAY POSHAN YOJNA FOR TB PATIENTS

Problem statement

The Direct Benefit Transfer (DBT) component of the National Tuberculosis Elimination Programme (NTEP) has been implemented by the Government of India for financial assistance to patients, healthcare providers and treatment supporters.

Program description

Many states have chosen to do the generate print payment advise from PFMS at either the district level or block level. Tamil Nadu decided to transfer this approval authority from district to state level in 2019. Till recently, the Mission Director (National Health Mission) and the Joint Director- Tuberculosis (JD-TB) were the signatories for the PPAs of the PFMS. In July 2020, PPAs were replaced by Digital Signature Certificates which were procured at the state level and are being authorized at two levels.

Program outcomes

92% of beneficiary whose bank details are validated for NPY, have received at least one benefits between Jan to Aug 2020 (source-DBT dashboard, Nikshay portal). Centralization of the DBT approval at the state resulted in low turnover time between approval of benefits and payment of benefits to beneficiary and further reduction in time delay for transfer of funds to districts for DBT applicable components. DBT specific funds do not lie in unused pockets at District level accounts using the centralised approval approach. It also resulted in minimised administrative and financial communication between state and district for DBT troubleshooting, for e.g, PPAs had a validity of fixed days validity, so timely approval from at least 2 physical agencies had to be obtained, transfers/retirement/leave/availability of signatories at district may pile up files, insufficient funds for payment.

Financial implications

No additional cost involved in implementation of this strategy.

Scalability

There is possibility to scale up his initiative in other states also which will lead to faster payment of benefits under Nikshay poshan Yojana scheme for TB patients.

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TRIPURA

TB HAREGA DESH JEETEGA

Contact

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Problem statement: It is anticipated that people suffering from both TB and COVID-19 may have poorer treatment outcome especially if TB treatment is interrupted. Further, both diseases have similar symptoms, so chances of missing diagnosis of both diseases is higher than usual. In addition, mode of transmission of both diseases is similar, so contacts of patients are at higher risk of acquiring the disease. A drastic reduction in OPD attendance during COVID-19 times was seen in the State, with a footfall reduction of 39.6% between April to June when compared with same for April to June in 2019. Due to low OPD attendance, both Passive Case Finding and Intensified Case Finding was affected.

Program description: Active Case Finding activity among vulnerable population started in 6 Districts- South, Gomati, Khowai, Dhalai, Unakoti and North Tripura in March during which 2487 No samples have been collected and examined. The second round Active Case Finding Activity among vulnerable population started in June in 04 districts namely West, South, Khowai, Gomati during which 798 number of samples has been collected and examined. ACF activity during COVID-19 pandemic maintained the momentum of sample collection and examination. all SARI/ ILI cases who report to Fever Clinics are screened simultaneously for both TB and COVID-19. Similarly, during contact tracing of COVID-19 Positive patients, TB test is being performed on all suspected cases. All eligible beneficiaries of various incentives under NTEP are given the applicable incentive on time. So far, 605 no of patients have received Rs 11,87,000/- as incentive through DBT. Mobile CBNAAT Van has been very instrumental in ensuring outreach in difficult and remote areas during lockdown phase. Between Mar'20 to June'20, the van has travelled a distance of 1956 kms with daily average of 23 kms.

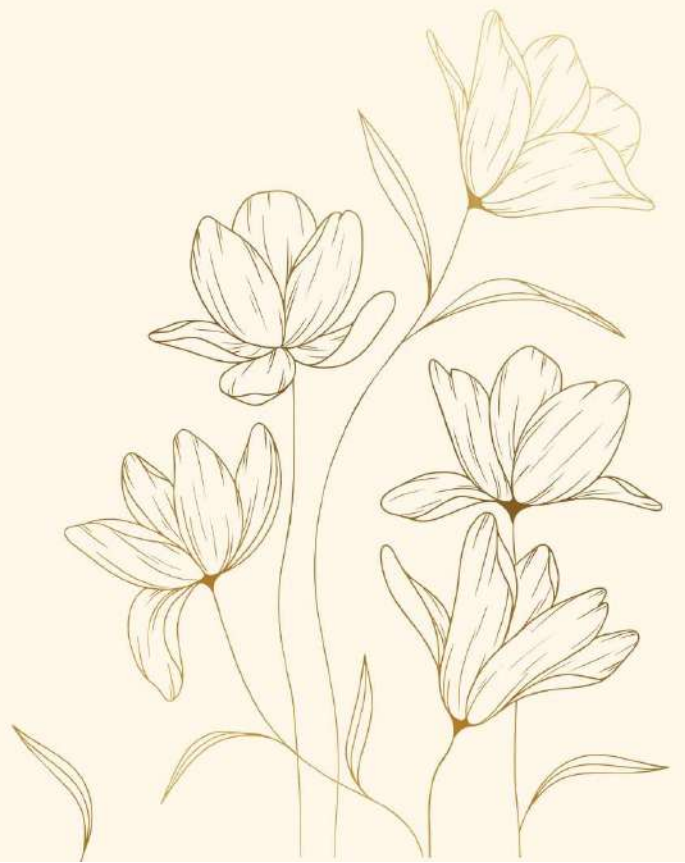
Program outcomes: Continued service delivery was ensured through doorstep delivery of drugs. Total 480 patients have been supplied medicines at doorstep from April '2020 till June'2020. Treatment with Anti-TB drugs started in 533 new TB cases without delay. Simultaneously, UDST was performed on all positive cases for early detection of MDR TB (UDST has been done 77 %age of notified cases). Using Nikshay Aushadhi, sufficient stock of First Line and Second Line Anti-TB drugs was maintained. There was no shortage of any drug, reagents, consumables, etc throughout the lockdown phase. Approximately 684 patients on treatment received phone calls on a weekly basis between 3rd Week of March to June 2020, to ensure compliance with treatment and to deal with treatment related adverse reactions. 605 patients received timely incentive under Nikshay Poshan Yojana between January to June 2020.

Financial implications: NA

Scalability: The model was implemented during the nationwide lockdown and is easily scalable in similar settings across the country.

EMERGING INITIATIVES

NCDs



ASSAM

TICKLER BAG IN MONITORING AND SUPERVISION OF DIAGNOSED NCD PATIENTS



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Problem statement

Follow up of Non-communicable diseases is a challenge as there is already high attrition among patients. Ensuring medicine adherence along with maintaining confidentiality is difficult.

Programme description

The Tickler Bag is a simple bag comprising 15 pockets, mentioning 12 months in a year, one mentioning the dropped out/left out, one mentioning the deceased and the last one for treatment completed.

The bag is kept in the HWCs wherein the patients are screened and given medicines. The patient is provided one NCD card and one copy of the same is retained with the HWC, which goes to the tickler bag. For e.g., A patient X visits the HWC in January 2020 and is given medicines for 3 months. His NCD card's second copy will be kept in tickler bag in the month of April 2020. In case the patient X does not visits for his follow up check-up, his details will be acquired from the copy of his card and he will be informed by ASHA/over phone for his due visit. If the patient completes the treatment course, his card goes to the respective pocket.

Thus, the tickler bad helps in overall tracking of the NCD cases in an area. The model has been successfully piloted in Nagaon District of Assam.

Programme outcomes

Many of the HWCs have reported that the systematic use of Tickler Bag has streamlined the follow up and monitoring has become much easier now. This practice has helped in getting people's confidence and overall HWC functioning.

Financial implications

No cost involved in preparing this, staff and ASHAs have been doing voluntarily.

Scalability

This no cost innovation has huge potentiality to scale up

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CHHATTISGARH

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS & VISUAL IMPAIRMENT - COMPREHENSIVE EYE CARE

Problem statement

Glaucoma, retina, cornea and optic nerve diseases may lead to permanent blindness hence identification in early stage is more important. Eye diseases such as cataract is the major cause of blindness which is curable. Other blinding diseases cause permanent blindness, and need to be addressed, as early as possible. Mission Director National Chhattisgarh

Programme description

Under the programme, door to door visit is done by teams of health worker, PMOA and eye surgeon across all blocks and districts, to identify diseases including cataract, glaucoma, refractive error, retina, cornea and optic nerve diseases. Complicated cases are referred to District hospital, Medical College or RIO. The treatment may be medical, optical, surgical, rehabilitative and preventive based on the requirement. The interventions include spectacle correction, glaucoma screening, minor surgery at block level, cataract surgery at district level recognized hospitals, blindness certification, health education, registration for keratoplasty and updation of village blind register. One day training of ophthalmic assistant officers, health workers is conducted.

Programme outcomes

More than 27 million people have benefitted under the programme since 2013-14. Total 2019 cases of glaucoma and 1487 cases of posterior segment diseases have been treated, which would have gone into permanent blindness, which is more serious than cataract blindness.

Financial implications

The initiative incurs an annual expenditure of approximately 31 lakhs, which is mainly on honorarium of specialists, PMOA, MPW/ANM; travel expenses, etc.

Scalability

The initiative is a low-cost intervention to identify possible vision impairments and blindness among community and thus can be scaled up easily.

Contact

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CHHATTISGARH

JASHPUR NAGAR GOES SMOKE FREE

Problem statement

World Health Organization considers smoke-free laws to have an influence to reduce demand for tobacco by creating an environment where smoking becomes increasingly more difficult and to help shift social norms away from the acceptance of smoking in everyday life. Implementation of the NTCP and COTPA 2003 and protecting non-smokers from hazards of tobacco smoke is a continuous challenge.

Programme description

Third party compliance study (MPH wing of AIIMS Raipur with technical support from the UNION) was completed as per specific criteria-based checklist. The study was carried out for 4 to 5 days with prior trainings/sensitization workshops. Around 30 to 40 days were given to the district for the preparation of the study.

A series of sensitization trainings for persons involved in the process of Smoke Free Declaration was done, with first training of the District Level Coordination Committee members (related interdepartmental members) in presence of the District Magistrate. This was followed by training of other stakeholders like Food and Safety department, Police Department, Labour Department, education department, municipal corporation, transport, tourism etc.

Programme outcomes

The district received more than 80% in the compliance survey making it eligible for SMOKE Free Declaration. The Jashpur Nagar was declared Smoke free on 26th January 2020.

Financial implications

Cost required for the sensitization/ capacity building workshops and for the survey team accommodation and survey charges.

Scalability

The same process can be carried out in different districts and different blocks of the same districts for Smoke free declaration.

Contact

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KARNATAKA

DANTHA BHAGYA - PROVIDING FREE COMPLETE/PARTIAL DENTURES TO BPL PERSONALS OVER THE AGE OF 45

Problem statement

Underprivileged population often ignores their oral health due to anticipated high out of pocket expenditure.

Programme description

Oral Health Policy in Karnataka was announced by the Hon'ble Chief Minister of Karnataka during the budget speech of 2014-15. Under this policy Danta Bhagya Yojane was introduced with the main objective to provide free complete dentures/Partial Denture (artificial teeth set) for BPL card holders. The project is underway in 2 Government Dental Colleges, 7 District Hospitals (having Dental Labs) and 43 Private Dental Colleges of Karnataka.

Apart from giving free complete dentures, this programme also focusses on prevention of dental diseases and oro-mucosal lesions. It also aims to educate people about the importance of maintaining good oral health and role of good oral hygiene in general health.

Programme outcomes

NA

Financial implications

For each complete Denture an amount of Rs. 750 and for partial denture Rs. 300 is paid to the Dental Colleges towards expenses of consumables for the fabrication of the dentures. In FY 2020-21 the rates were revised and the cost for Complete denture is raised to Rs. 2000/- and for partial denture is fixed to Rs. 1000/-

Scalability

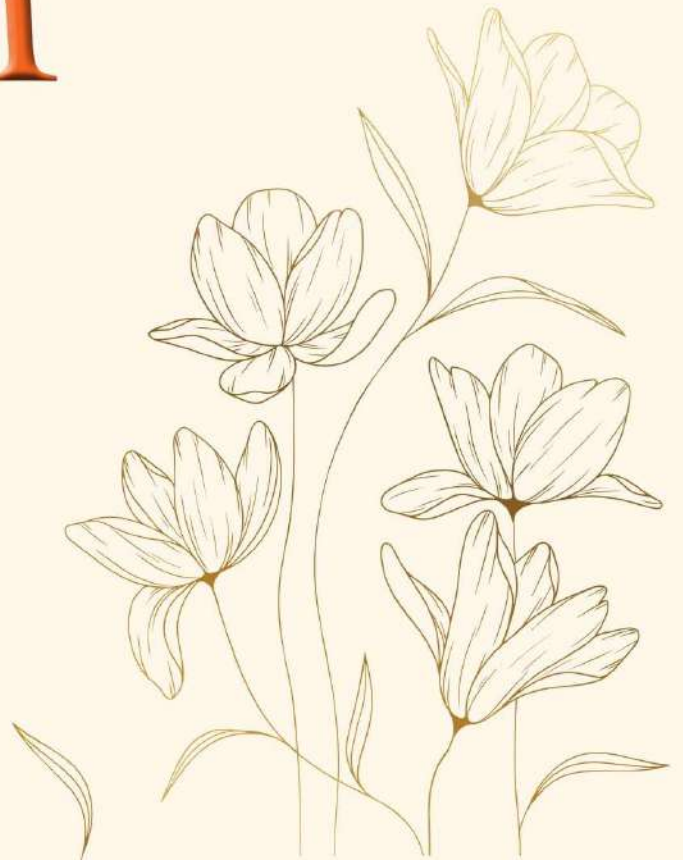
The programme can be scaled up in other Districts/States as State initiative or under NHM.

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EMERGING INITIATIVES

NUHM



BIHAR

VISION CENTRES IN URBAN PRIMARY HEALTH CENTRES FOR FREE EYE CARE SERVICES



Problem statement

Bihar is the third most populous state in the country with a population density of 880 persons per sq. km., which is more than the national average. Huge population load brings the bigger responsibility for the healthcare of the urban beneficiary group in which the incidence of curable and avoidable blindness incidence is quite high.

Programme description

State Health Society, Bihar took the initiative of Urban Eye Health Project (Amrita Drishti) of Sight savers under NUHM to provide basic ophthalmic services at UPHC-HWC level to estimated 32 lakh people. In first phase this service was started in 16 UPHC-HWC of Patna district. Currently 23 UPHCs of Patna district are providing eye OPD services including eye screening at outreach camps, refraction, primary disease diagnosis, visual impairment correctness, counselling and cataract identification. Cataract cases are getting referred to higher centers for free operation. This service has gained popularity in short span and now state is in process of expanding this initiative in another 30 UPHCs of different cities of the state. Existing manpower is being utilised where 4 Optometrists from Sight savers are serving these 23 VCs on a weekly basis along with 6 urban cluster coordinators where coordinators take care of catchment areas.

Programme outcomes

The initiative is leading integration of eye health within the three-tier structure of NUHM- community level, primary health care level and secondary health care level. The average OPD footfalls have risen to 150 patients per month per centre; and goes upto 100+ per day in some centres. The intervention focuses on female inclusion, which has resulted more than 60% female footfalls in the vision centres and has led to increase in overall footfalls in the UPHC. Between October 2020 to October 2021, more than 57 thousand eye camps have been organised, around 6400 persons with refractive error were prescribed spectacles and approximately 3300 people have been diagnosed with cataract.

Financial implications

Rs. 1.60 lakh were utilised for setting up one Vision Centre.

Scalability

Newer vision centres were established in 30 UPHCs in FY 2020-21 as a potential scale-up.

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KARNATAKA

AN ANDROID BASED INTEGRATIVE COMMUNITY ACTIVITY PLATFORM IN BENGALURU CITY: NAMMA SAMUDAYA

Problem statement

International health bodies including Indian Council of Medical Research (ICMR) have highlighted the poor data quality in Indian healthcare system. There are difficulties in defining and demarcating their working sectors/areas at much higher resolution and smooth delivery of health care services. Also, identifying pockets of populations, addressing the heterogeneity of urban population is a tough task.

Programme description

The aim of this initiative is to implement paperless data collection with IT enabled support system; reduce the work load of field workers by eliminating need to carry registers/forms. It also reduces chances of data loss, data entry errors, and simplifies data monitoring and validation. This results in better planning and delivery of outreach services to the vulnerable pockets.

An app based house hold survey tool to assess the vulnerability and health conditions among the urban poor was developed by Department of Community Medicine, BMCRI in collaboration with BBMP, adding a layer of geo-tagged household level data to the existing GIS health map. Tool was revised in consultation with all stakeholders and IT division of BBMP developed app for data collection. Medical Officers (70) and ASHAs/ ANMs (850) were trained for supervision & monitoring and data collection using app, respectively. CBAC Checklist for NCDs and TB were also included in the app.

Programme outcomes

The initiative resulted in integrating of all surveys together with enumerated population demographics, preparation of electronic family folders, formation of geotagged layer for all survey data, availability of real time survey data, ease in supportive supervision activities, etc. The platform can be utilised for planning of establishing new health facilities, planning outreach sessions, organisation of UHNDs, placements of MMUs, evening clinics.

Financial implications: NA

Scalability

The initiative can be scaled up in similar settings.

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EMERGING INITIATIVES

RMNCHA+N





TRIPURA

CHILD FRIENDLY MCH CLINIC IN DHALAI DISTRICT

Problem statement

Dhalai is an aspirational district of Tripura, with a hilly terrain and 70% Tribal population. The district has some specific challenges and constraints despite improvements in ANC coverage, institutional deliveries, RI, etc. COVID 19 pandemic has posed a great threat to public health as most of the national health programs hampered to large extent to deliver its service to people. Routine Immunization services also faced challenges due to the lock down.

Programme description

Under the programme, the health facilities adopted the strategy to prepare robust Micro Planning including RI Session Plan (specially for COVID-19), upgrade Cold Chain Point and MCH Clinic, provide tele-conferencing to minimize contacts with Mother and Health Care Worker, and increase community awareness on benefits of routine immunization (During and Post COVID-19). Training was given to cold chain handlers, ANM/vaccinator, ASHAs and MO I/Cs on cold chain management, eVIN, RI, etc. Tel-Conferencing with mothers waiting at meeting Room by Cold Chain Handler is done to counsel mothers and fill up MCP card, convey key messages on immunization, orient mothers/caregivers on COVID appropriate behaviours, etc.

Programme outcomes

The initiative ensured efficient RI sessions and full immunization to beneficiary groups even during the pandemic. 100% of RI sessions planned were held in Manughat CHC and Masli PHC. The reported full immunization coverage at Manughat CHC was 75% and 85% at Masli PHC in 1st quarter of 20-21.

Financial implications

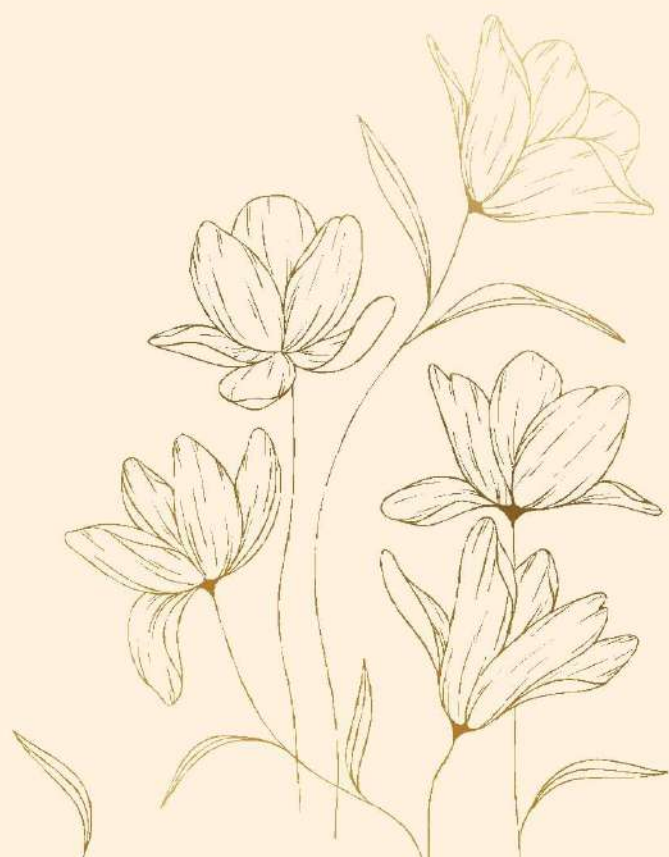
The cost for upgradation of MCH and CCP was met from Rogi Kalyan Samity/Kayakalp fund of respective health facilities. The major part of beautification of CCP was done by respective Cold Chain Handler by utilizing unused materials from PHC, which did not have any major financial implications.

Scalability

The initiative is included in Routine Immunization since it has the potential to be scaled across States to improve the immunization coverage especially during post COVID-19 pandemic.

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Ministry of Health and Family Welfare
Government of India