सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Fostering Resilience : Good, Replicable and Innovative Practices

2025

Government of India
Nirman Bhawan, New Delhi
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जगत प्रकाश नड्डा
JAGAT PRAKASH NADDA

मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार

Minister
Health & Family Welfare
and Chemicals & Fertilizers
Government of India

Foreword

It is with immense pride and optimism that I present the 2025 edition of the Coffee Table Book on Good and Replicable Practices in Public Health care systems-a reflection of India's relentless commitment to build resilient and inclusive health systems. This compilation stands as a testament to the transformative power of innovation, community engagement, and the unwavering dedication of healthcare professionals, policymakers, and program managers across our diverse states and union territories.

The year 2025 marks a pivotal moment in our journey towards achieving Universal Health Coverage. As we navigate complex health challenges, from emerging diseases to the nuances of public health equity, the initiatives featured in this book exemplify the spirit of collaboration defining India's health landscape. Each practice highlighted here, whether a grassroot innovation or a large-scale systemic reform, offers valuable insights into how tailored solutions can drive meaningful change.

What makes this edition particularly inspiring is the diversity of approaches-from advancing maternal and child health, strengthening primary care, integrating technology for better service delivery, to promote mental health and well-being. These stories are not just about programs; they are about our people, health workers, and communities, coming together to shape a healthier future.

This compilation serves not only as a source of inspiration but also as a practical guide for stakeholders across the health ecosystem. By sharing these replicable models, we aim to encourage cross-learning, foster innovation, and accelerate the adoption of practices that have proven impactful.

I extend my appreciation to the dedicated teams in the Union Ministry of Health & Family Welfare, State Governments, Healthcare Professionals, and Community Health Workers whose efforts have made these successes possible. Your resilience, creativity, and commitment continue to be the cornerstone of India's health progress.

(Jagat Prakash Nadda)

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व
राज्य मंत्री
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार

MINISTER OF STATE
(INDEPENDENT CHARGE) OF
MINISTRY OF AYUSH AND
MINISTER OF STATE OF
MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

Foreword

I am honoured to affirm the Ministry of Health & Family Welfare's commitment to this significant publication, which serves as a comprehensive showcase of the remarkable strides made across various healthcare domains. This book is a celebration of the determined efforts undertaken by our States, health professionals and decision-makers, who have consistently risen to the challenges posed by an ever-evolving healthcare landscape.

On the one hand, we are committed to enhance the citizen's physical and mental health in the most inclusive, equitable, cost-effective way through the Sub Centers/Primary Health Centers//Community Health Centers to reduce the Out of Pocket Expenditure (OOPE) at Primary and Secondary care level. On the other hand, under visionary leadership of Hon'ble Prime Minister Shri Narendra Modi Ji, MoHFW has implemented the 'Ayushman Bharat' program, a landmark initiative of the Government of India, which has been a driving force in our pursuit of Universal Health Coverage. This ambitious program has not only improved access to healthcare services but also provided crucial financial protection to millions of our fellow citizens.

However, as we celebrate our achievements, we must also acknowledge the persistent challenges that lie ahead. Issues such as addressing anaemia, improving immunization coverage in remote areas, and tackling viral hepatitis among marginalized communities demand our unwavering attention and innovative solutions. This book, featuring good and replicable practices from across the country, offers a valuable resource for tackling these challenges head-on.

The initiatives showcased in this book, demonstrate the power of innovative thinking and collaborative action. By sharing these experiences, we aim to foster a spirit of learning and adaptation, enabling other states and healthcare providers to implement similar solutions in their own contexts.

Readers are invited to carefully consider the practices outlined herein, to thoughtfully adapt them to their respective settings, and to actively participate in our shared endeavour to foster a healthier and more resilient society. I commend the efforts of everyone involved in bringing this valuable resource to fruition and encourage its widespread dissemination and utilization

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अनुप्रिया पटेल
ANUPRIYA PATEL

राज्य मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार

MINISTER OF STATE
HEALTH & FAMILY WELFARE
AND CHEMICALS & FERTILIZERS
GOVERNMENT OF INDIA

Message

We extend our highest compliments to the States and all stakeholders who have significantly contributed to the advancement of healthcare. It is with immense admiration that we introduce this Compendium of Good and Replicable Practices that has transformed health services across the nation. This comprehensive volume is a tribute to the unwavering dedication of State Health Departments and their officials, whose exemplary efforts have set benchmarks in State-level implementation.

Over the past years, our collective vision for a healthier nation has been brought to life through innovative strategies and rigorous implementation of key health initiatives. Statistical achievements demonstrated in 2025 clearly outline the remarkable progress made under the State leadership in improving healthcare outcomes. The successes highlighted with this publication are not merely stories on a page; they represent lives saved, communities empowered, and a future reimagined. States have spearheaded initiatives ranging from maternal and child health improvement programs to the leveraging telemedicine services for TB preventive Treatment. These practices have not only enhanced patient outcomes but have also set replicable models that can be adopted nationwide. Such achievements underscore the commitment of healthcare administrators and policy makers in fostering environments that prioritize life-saving innovation.

Special recognition is due to the dedicated officials and teams within the State Health Departments whose relentless pursuit of quality and efficiency has put us on a firm path towards achieving equitable, accessible, and patient-centered healthcare for all. Their commitment, coupled with the tireless efforts of healthcare professionals and community health workers at the grassroots level, has been instrumental in delivering impactful health outcomes and setting benchmarks for excellence.

As we look to the future, it is imperative that these success stories are not confined to individual States but are adapted and replicated across the Nation. Sharing and scaling up good and replicable practices will not only strengthen our health systems but also ensure that best practices reach the most underserved populations. Together, through collaboration and knowledge exchange, we can accelerate progress towards a more resilient and inclusive healthcare landscape for India.

February 25, 2025
New Delhi

(Anupriya Patel)

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पुण्य सलिला श्रीवास्तव, भा.प्र.से.
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PUNYA SALILA SRIVASTAVA, IAS
Secretary

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स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Foreword

It is a privilege to introduce this compendium of Good and Replicable practices in public health systems of India; which is a compilation of the most impactful and innovative healthcare initiatives implemented by States and Union Territories across India in 2024-25. This document serves as a testament to the unwavering commitment and ingenuity of our healthcare professionals and policymakers in their pursuit of a healthier nation.

The initiatives showcased in this document represent a diverse range of approaches to address critical healthcare challenges. From conducting recruitment drives to empowering communities for better health outcomes, these practices highlight the transformative potential of innovation in the healthcare sector.

I extend my sincere appreciation to all the States and Union Territories for their active participation in this endeavour. The successful practices shared by you will undoubtedly inspire others to adopt and adapt these models as per their requirements. Together, we can create a powerful network of shared knowledge and experience, driving continuous improvement in healthcare delivery across the country.

I am confident that this document will serve as a valuable resource for healthcare professionals, policymakers, and researchers alike. By learning from each other's successes, we can accelerate progress towards our shared goal of achieving 'Health for all'.

Let us embrace the spirit of collaboration and innovation as we continue our journey towards a healthier Viksit Bharat.

Date : 25.02.2025
Place : New Delhi

Punya Salila
(Punya Salila Srivastava)

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अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)
Aradhana Patnaik, IAS
Additional Secretary & Mission Director (NHM)

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निर्माण भवन, नई दिल्ली-110011

Government of India
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi-110011

Foreword

The National Health Mission (NHM) has been instrumental in driving transformative changes in India's healthcare landscape by fostering innovation, strengthening implementation strategies, and promoting equitable access to quality healthcare services. Our commitment to achieving Universal Health Coverage and leaving no one behind is built on the foundation of collaboration, adaptability, and continuous learning from best practices across states and Union Territories.

India's diverse public health ecosystem thrives on the principle of shared learning, where states develop and adopt context-specific innovations to address unique healthcare challenges. The identification and dissemination of such good and replicable practices ensure that successful models can be scaled across the country, enabling efficient and effective program implementation.

This compendium of good and replicable practices showcases exemplary initiatives undertaken by various states and UTS to enhance service delivery, strengthen health systems, and integrate technology-driven solutions. These innovations range from improving maternal and child health outcomes to leveraging digital health tools and optimizing healthcare resources. While identifying the best practices, due care has been taken to ensure that the stories identified are replicable, have benefitted a large segment of society and spread over diverse themes. By documenting and sharing these efforts, we wish to create an ecosystem where knowledge exchange drives impactful and sustainable healthcare improvements.

This publication is an opportunity for peer-to-peer learning among states to applaud the efforts of others and adopt practices that are best suited to one's circumstances. I congratulate and extend my heartfelt appreciation to all the states and UTs for their dedication and originality in implementing these pioneering initiatives and the team to spearhead the effort to document these innovative approaches. Their commitment to strengthening healthcare delivery is a testament to India's collective vision for a healthier nation. I hope that this collection of good and replicable practices would serve both as a guide and as an inspiration for all.

Dated: 25th Feb, 2025

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Government of India
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Foreword

It gives me immense pleasure to witness the launch of the compendium of Good and Replicable Practices, a testament to the remarkable efforts of states and Union Territories in enhancing healthcare delivery across Indis. The compendium highlights 44 best practices that provide a glimpse of the many sustainable measures undertaken in different parts of the country and offers an opportunity to emulate these practices. The diversity and ingenuity of these initiatives serve as powerful examples of how innovative approaches can drive systemic improvements and ensure equitable healthcare access for all.

This book serves as a testament to the collective efforts of our States; UTs in showcasing diversity and a range of initiatives. The essence of this document however lies in knowledge sharing und cruss-leaming and its ability to inform policymakers, healthcare professionals, and stakeholders by showcasing practices that have yielded tangible results. These initiatives not only address immediate healthcare needs but also highlight the power of collaboration, innovation, and a people- centric approach to healthcare delivery.

I would like to extend my heartfelt appreciation to all individuals, teams, and organizations that have contributed towards pulling together this compendium. Gathering and showcasing these hest practices takes us on an inspiring journey through the remarkable progress of our states. I'm confident that this publication will dis more than just spark admiration-it will also ignite meaningful diakigue and foster collaboration. As we move forward, let us take inspiration from these achievements, adapt successful strategies to local contexts, and work collectively towards a mure resilient and inclusive healthcare system.

(SAURABH JAIN)

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ODISHA

IMPROVING MASS DRUG ADMINISTRATION – IVERMECTIN, DEC & ALBENDAZOLE COMPLIANCE THROUGH SOCIAL MOBILIZATION AND COMMUNITY PARTICIPATION FOR ELIMINATION OF LYMPHATIC FILARIASIS IN ODISHA.

PROBLEM STATEMENT

Lymphatic Filariasis (LF) remains a major public health challenge in India, including Odisha, with elimination targets missed in both 2015 and 2021 and a new goal set for 2027. The success of the Elimination of Lymphatic Filariasis (ELF) program hinges on the effective implementation of Mass Drug Administration (MDA), which requires high compliance, ensuring eligible populations take the prescribed drugs. Extensive micro-planning is crucial for MDA implementation, as it helps identify hotspots, at-risk areas, and low-coverage regions while incorporating demographic data, human resources, training, communication strategies, and logistical planning to ensure smooth execution. Social mobilization and community participation play a key role in improving compliance, with support from frontline healthcare workers, self-governing bodies, and local influencers—including teachers, religious leaders, and industry personnel—who aid in communication, behavior change efforts, and door-to-door counselling to reach non-compliant individuals.

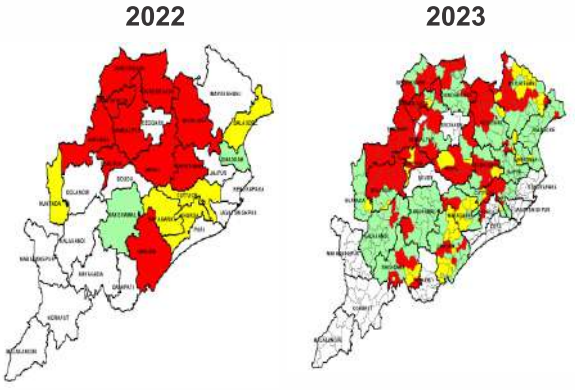
For the first time in Odisha, MDA was conducted using IDA (Ivermectin, DEC, and Albendazole) in 11 LF-endemic districts; however, introducing an additional drug posed a significant compliance challenge, as individuals were required to take up to eight tablets in one go. To address this, aggressive community sensitization and strong social mobilization efforts were undertaken, emphasizing area-specific micro-planning and targeted IEC and BCC interventions.

PROGRAMME DESCRIPTION

The social mobilization and community participation model for the MDA campaign in 11 districts of Odisha, implemented in August 2023, was designed to enhance drug compliance through targeted communication strategies. The initiative identified two key audience segments: the primary audience, comprising communities and focus groups such as Gaon Kalyan Samiti (GKS) members and urban community associations, and the secondary audience, including opinion leaders, teachers, PRI members, self-help groups, school children, private and traditional healers, community-based organizations (CBOs), religious leaders, program implementers, industry representatives, and employees from various institutions. The implementation plan employed multiple methodologies to foster community engagement, including Interpersonal Communication (IPC), small group discussions, advocacy meetings with key officials such as the Collector, District Magistrate (DM), municipal commissioners, and health officers, as well as active involvement of PRI members, SHGs, and local self-governing bodies like market associations and resident welfare associations. Special attention was given to high-risk areas, ensuring outreach to populations that had not taken the drug in previous MDA rounds.

The existing health system officials and staff led the planning, execution, and monitoring of the program, supplemented by temporary manpower in the form of Panchayat monitoring cum social mobilizers, who were engaged for 45 days to target filaria hotspots and low-compliance areas.

TREND OF MICRO-FILARIA RATE: 2022-2023



PROGRAMME OUTCOME

Given the challenges faced with two-drug therapy in the past, concerns arose regarding drug compliance and achieving the desired coverage of over 75-80%. However, through extensive social mobilization and active community participation, the state successfully attained an overall drug consumption rate exceeding 80% across the 11 districts. The compliance report from August 2023 highlights significant achievements, with reported compliance averaging 84.36%, WHO-evaluated compliance at 76.27%, and compliance assessed through coverage evaluation surveys by medical colleges at 80.09%.

FINANCIAL IMPLICATION

The program was implemented with minimal financial investment in social mobilization and community participation, apart from the engagement of Panchayat Monitoring cum Social Mobilizers. The approved budget for this additional human resource was Rs. 2.62 crore for a population of 1.80 crore, translating to approximately Rs. 1.45 per person. Despite the limited budget, the program effectively leveraged existing platforms such as the District Coordination Committee and Block Coordination Committee, ensuring efficient resource utilization and seamless execution of the initiative.

SCALABILITY

This model can be replicated in lymphatic filariasis-endemic areas of other states, as it requires no additional financial resources. Instead, the focus lies on strengthening and optimizing existing resources to ensure effective implementation and wider coverage.

CHHATTISGARH

AN INNOVATIVE TRAINING APPROACH FOR CHOs

PROBLEM STATEMENT

CHOs have now become one of the largest groups of clinical care providers at the primary level in India. The competence of healthcare providers has a significant impact on the range and quality of services that AAM facilities can offer and their credibility within the communities they serve. It has been also emphasized that there is a further need of on-job-capacity building of CHOs to effectively manage a broader range of medical conditions. SHRC developed an innovative comprehensive training plan to boost the clinical acumen and skills of CHOs on providing comprehensive range of primary healthcare services.

PROGRAM DESCRIPTION

The first step process involved a thorough examination of the CPHC packages, consultations with experts, and the utilization of training modules developed by the National Health Systems Resource Centre (NHSRC) specifically focused on CPHC. The module adopts a syndromic approach, organizing diseases and symptoms into chapters. Next, standardized video lectures of various primary care conditions were developed, clinical experts were engaged, and video lectures were recorded. Master trainers were trained by conducting Training of Trainers (ToT) at the state level with help of clinical experts from AIIMS, Raipur. ToT were trained using the recorded video lectures, training modules and live classes.

The training incorporated both offline and online modes. The CHOs initially engaged in 2-hour online classes for six days after their OPD hours. Offline classroom training was then systematically introduced at the district level in a phased manner. The entire training content was segmented into three rounds of 6 days, 5 days, and 4 days, respectively. District-level classroom sessions, led by master trainers, featured recorded video lectures, training modules, case presentations, and problem-solving sessions. Each training class accommodated 30 participants. Additionally, good-performing CHOs underwent a specialized 5-day training at AIIMS Raipur.

PROGRAM OUTCOME

The effectiveness of training was measured in terms of improvements in the post test scores of CHOs after each round of training. The analysis of pre and post test scores shows the significant improvement in their learnings, with scores improving by approximately 17% for the CHOs. This shows the effectiveness of training approach and design. On an average post test scores were improved by one third from the baseline

FINANCIAL IMPLICATION

This training activity and budget is approved under HSS section of NHM PIP. The budget approved per CHO is Rs. 8,000/-. SHCR conducts the low-cost trainings and usually conduct trainings at government venues with lower expenses. The amount saved is again used for planning another round of CHO trainings. Since the initiative utilizes NHM resources, it incurs no additional costs and follows a sustainable, annually repeating training cycle.

SCALABILITY

The innovative training model in Chhattisgarh exhibits characteristics that make it adaptable and scalable. This innovation is simple and requires a one-time investment in terms of resources. Once the training module and lecture video are ready, they can be easily scaled up to any state and district.. Since STP training is an approved line item in the NHM-PIP of all states, it does not have any additional cost implications.

ANDHRA PRADESH

ZERO VACANCY IN HEALTH FACILITIES

PROBLEM STATEMENT

With growing healthcare demands, insufficient staffing may lead to overburdened professionals, compromised patient care, and increased mortality rates. Properly staffed healthcare systems ensure timely, effective treatments and improve patient outcomes. Furthermore, adequate human resources contribute to sustainable healthcare systems by reducing burnout and fostering a healthier work environment. Investing in health workforce

development is crucial for achieving universal health coverage and meeting global health goals. Addressing this issue requires strategic planning, education, and retention efforts to build a robust, responsive, and resilient healthcare workforce.

PROGRAM DESCRIPTION

Government of AP has taken up a program to fill up all the vacancies in health facilities on mission mode since June 2020. Under this initiative, a dedicated body named the "Andhra Pradesh Medical Recruitment Board" was established exclusively for recruiting personnel to health facilities. The recruitment drive has been further extended by the way of conducting walk-in-interviews; delegation to district administration; and flexi pay to work in health facilities in remote and tribal areas. It includes additional allowance on basic pay to specialists and additional pay to general duty doctors working in tribal areas. The specialists working in tribal areas on contract basis are being offered Rs 2.5 lakhs per month, and those working in remote rural areas are being offered Rs 2 lakhs per month. The Government of AP has also issued orders for service weightage in medical PG admissions for those medical officers who served in tribal areas for two years and in rural areas for three years.

The State government mandated a uniform staffing pattern in all AAM-PHCs, Community Health Centers, Area Hospitals and District Hospitals. To this end, the government has sanctioned 465 posts for additional Medical Officers posts and 898 posts for staff nurse. An additional 289 reserve posts have been sanctioned for the MOs to attend the duties in lieu of medical Officers on leave (short-term or long-term). ANMs are recruited on regular pay. ASHA workers' remuneration has been increased to Rs 10,000 per month.

The available human resources were reorganized into appropriate levels of care for their effective utilization. This includes shifting specialists working at primary level to secondary level, and posting RMNCH+ counsellors at High Delivery Points. The lab technicians (General/ Malaria/TB) were reoriented to attend to all the tests to be conducted at the AAM-PHCs.

PROGRAM OUTCOME

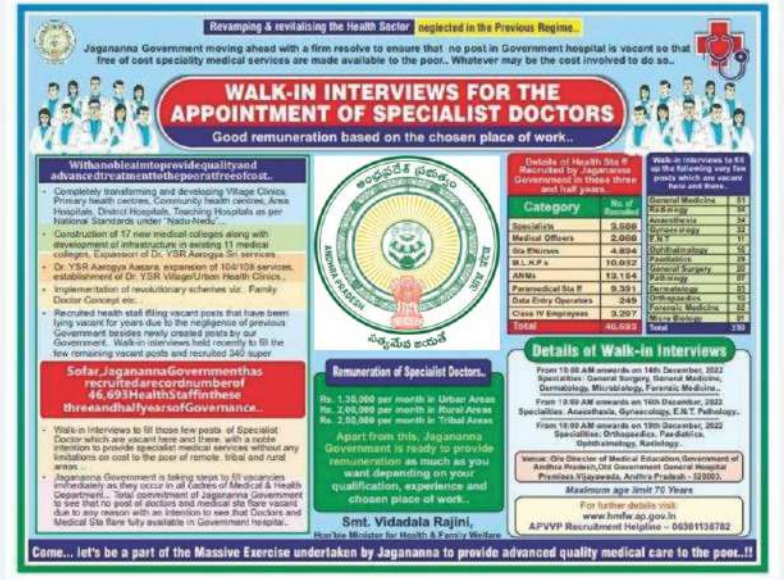
Through concerted efforts, all vacancies in health facilities have been filled. The State has successfully reduced the number of vacant posts from 18,372 in FY 2021-22 to 454 in FY 24-25. As of February 2025, the State has achieved a vacancy rate of 13.67% for the Specialist cadre, 6.06% vacancies for Staff Nurses, and zero vacancies for medical officers and lab technicians.

FINANCIAL IMPLICATION

No additional cost implication incurred.

SCALABILITY

The program can be scaled up effectively across all states, since there is no additional cost implication and budget can be covered by the State and NHM.



MANIPUR

MIRONBISING GI KHUDOL (A GIFT FOR EXPECTANT MOTHER), AN EXTENSION OF PMSMA

PROBLEM STATEMENT

Manipur's challenging geography poses a significant barrier to maternal healthcare access, with 90% of the state covered by hills and only 10% as valley areas. Maternal mortality remains disproportionately high in hill districts (MMR: 82) compared to valley districts (MMR: 58) over the past five years, largely due to limited human resources, particularly OBGY specialists and radiologists, who are mostly confined to urban areas. Many high-risk

pregnancies in remote rural areas go undetected, exacerbated by low awareness of ANC, danger signs, and maternal nutrition. The disparity in healthcare access is stark, only 39% of pregnant women in Ukhrul district receive four ANC check-ups compared to 93% in Imphal West (NFHS-5). Additionally, first-trimester ANC visits are significantly lower in hill districts (58% in Ukhrul vs. 91% in Thoubal).

The lack of Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) volunteer doctors in hill districts, coupled with transportation challenges and poor road connectivity, further limits access to essential maternal health services. Addressing these gaps requires innovative interventions to bring quality ANC services closer to underserved communities and ensure timely detection and management of high-risk pregnancies.

PROGRAM DESCRIPTION

To reach the unreached and bridge the gap in maternal health service delivery, "Mironbising Gi Khudol" (A Gift for Expectant Mothers) was launched on October 9, 2018, at SDH Moreh. Conducted on the 9th of every month (or adjusted based on the availability of

PMSMA volunteers), the initiative targets remote healthcare facilities lacking specialist doctors and ultrasound services, ensuring comprehensive maternal care for pregnant women in underserved areas. The programme provides holistic maternal health services, including antenatal checkups, basic diagnostic tests, 100% ultrasound services, high-risk pregnancy detection, free referrals, awareness sessions, counselling, and yoga for pregnant women. The State Maternal Health Division, in coordination with district health authorities, identifies service locations a month in advance and secures PMSMA volunteer participation to ensure smooth execution.

On PMSMA days, representatives from the State Maternal Health Division oversee quality antenatal services, including diagnostic tests, drug and micronutrient distribution, and high-risk pregnancy tracking. The initiative also collaborates with the Social Welfare Department to facilitate PMMVY (Pradhan Mantri Matru Vandana Yojana) registrations, demonstrate nutritional best practices, and provide fortified energy-dense food to pregnant women.

A high-risk pregnancy tracking system, developed by the Maternal Health Division, ensures timely follow-ups, with reminders sent based on estimated delivery dates. Media coverage

by DDK Imphal further enhances the programme's reach, creating awareness and encouraging greater participation. By leveraging multi-stakeholder collaboration and prioritizing maternal health equity, Mironbising Gi Khudol is transforming maternal healthcare access across Manipur's most remote regions.

PROGRAM OUTCOME

The program has had a transformative impact on maternal healthcare delivery. It was successfully conducted at AAM Awang Wabagai, leading to the identification of 50 AAM facilities as PMSMA facilities, significantly expanding access to maternal health services. The program has increased the detection rate of high-risk pregnancies (HRPs), with 17.5% HRPs identified, compared to 8.5% in standard PMSMA programs and just 1.9% in HMIS.

So far, a total of 26 sessions have been conducted, benefiting 2,057 pregnant women who received specialized care from MOs/OBGY specialists. The program's interventions have ensured safe deliveries for all 373 high-risk pregnancies detected, demonstrating its effectiveness in improving maternal outcomes. By enhancing access to specialist doctors, the program has significantly improved HRP detection rates compared to the PMSMA initiative. Reporting accuracy on the PMSMA portal has reached 100%, ensuring reliable data management. Furthermore, ANC services have been extended to evening clinics, allowing volunteer doctors to serve underprivileged urban populations.

The AYUSH Department has also played a key role by incorporating yoga sessions, promoting the holistic well-being of pregnant women. Additionally, an increase in PMMVY registrations, facilitated by the Social Welfare Department, has provided financial and nutritional support, further strengthening maternal and child health outcomes in Manipur.

FINANCIAL IMPLICATION

No additional funds are required, as the program effectively utilizes the NHM-approved ROP for PMSMA, supplemented by financial support in both cash and kind from local MLAs, central paramilitary forces (CRPF), local clubs, and district administrations, ensuring sustainability and efficient resource utilization.

SCALABILITY

The program can be scaled up across different states as it effectively leverages existing NHM funds and local financial support, requiring minimal additional investment while ensuring sustainable and expanded maternal healthcare coverage.

TELANGANA

STATE CENTRE OF EXCELLENCE FOR NEWBORN IN HUB AND SPOKE MODEL

PROBLEM STATEMENT

Ensuring newborn health is a critical priority, particularly in peripheral healthcare units where access to specialized neonatal care is limited. High referral rates from Special Newborn Care Units (SNCUs) to tertiary hospitals indicate a lack of confidence and capacity among healthcare providers at these facilities. Many sick newborns are transferred due to fear, lack of expertise, and absence of neonatal specialists, often leading to delays in

treatment and increased risks during transit. To bridge this gap, the scheme leverages the Emergency COVID Response Package (ECRP) fund, which has also been strategically allocated for paediatric care to strengthen neonatal interventions.

The golden hour for neonatal care is crucial, and delays in intervention can result in complications, increased mortality, and financial burden for families, who may seek costly private healthcare options. To address these challenges, a Hub-and-Spoke model has been introduced, with the State Centre of Excellence for Newborns at Niloufer Hospital providing real-time guidance, training, and support to peripheral SNCUs.

PROGRAM DESCRIPTION

The State Centre of Excellence for Newborns at Niloufer Hospital follows a Hub-and-Spoke model to strengthen neonatal care across peripheral Special Newborn Care Units (SNCUs) in Telangana. This initiative provides real-time guidance, training, and specialist support to peripheral SNCUs, enabling in-house management of sick newborns and reducing unnecessary referrals to tertiary care centres.

Through a dedicated telemedicine system, neonatologists at the Centre of Excellence (CoE) monitor high-risk newborns, conduct daily virtual rounds, and offer case management support to doctors and nurses at peripheral units. The CoE also facilitates reverse referrals, ensuring babies who stabilize at tertiary hospitals return to SNCUs for continued care, optimizing bed availability at higher facilities.

The initiative prioritizes capacity-building by

training staff nurses and doctors through online education sessions, improving their confidence and competence in handling neonatal emergencies. Infrastructure enhancements include a 55-inch video wall for live monitoring, dedicated hotlines for direct communication, video conferencing platforms, and portable tablets at SNCUs for seamless virtual consultations.

By leveraging the ECRP fund for paediatric care, the programme ensures timely interventions, promotes Kangaroo Mother Care (KMC) and breastfeeding practices, and enhances infection prevention protocols.

PROGRAM OUTCOME

The State Centre of Excellence for Newborns at Niloufer Hospital has transformed neonatal care across Telangana, significantly reducing referral rates from 5.76% in July 2022 to 1% by January 2025. Since its inception, the programme has strengthened in-house management at peripheral SNCUs, reducing unnecessary transfers to tertiary hospitals. As a result, SNCU admissions have increased, while LAMA (Leaving Against Medical Advice) cases have declined, ensuring better continuity of care.

The programme has been successfully scaled up to 28 SNCUs, integrating real-time virtual guidance, capacity-building, and specialist-led case management. This intervention has improved respiratory support practices, enabling timely and appropriate use of CPAP and intubation, reducing complications, and boosting staff confidence. The reverse referral system has ensured that stabilized newborns return to SNCUs for continued care, optimizing resources at tertiary hospitals. With enhanced telemedicine infrastructure, regular virtual rounds, and ongoing training, the programme has significantly improved newborn survival rates.

FINANCIAL IMPLICATION

The initiative has been implemented in a cost-effective manner, utilizing the ECRP fund allocated for paediatric care. The total one-time infrastructure cost for the Hub and Spoke is approximately 1.15 crore. The annual recurring costs for remuneration, internet connectivity and licenses is roughly 45 lacs. With a total investment of approximately ₹1.5 crore, the initiative has significantly enhanced neonatal care across the state, reducing referrals and optimizing healthcare resources.

SCALABILITY

The Hub-and-Spoke model is highly scalable, leveraging ECRP funds for paediatric care, with the capacity to connect additional SNCUs using existing infrastructure, minimal recurring costs, and flexible expansion of telemedicine support across the state.

MEGHALAYA

RESCUE MISSION: SAVING LIVES OF MOTHERS & INFANTS

PROBLEM STATEMENT

Meghalaya historically had high maternal and infant mortality in comparison to the national average. In 2019 , Meghalaya's Maternal Mortality Ratio (MMR) was 145 to India's 97, and its Infant Mortality Rate (IMR) was 33 to India's 28.

Most of these deaths were due to locally endemic health problems, such as not taking into consideration the social aspects of health; & shallow understanding of the causes of maternal

and infant deaths. For instance, low institutional births were understood as being a result of women's preference for using traditional birth attendants. Hence, the importance of ensuring quality care for expectant mothers should be underscored across healthcare facilities.

PROGRAM DESCRIPTION

Under the initiative, the state has developed a multi-pronged approach to tackle the issue of high MMR and IMR. Regular reviews of actions taken to address maternal and infant deaths at district and facility level are conducted, which involves stronger communication across all levels to drive collaboration and action between stakeholders. Local leadership building at all levels through a decentralised catalytic leadership model that encourages problem-solving at all levels is ensured. Moreover, community institutions called Village Health Councils (VHCs) have been established to drive community action and ownership on health and nutrition issues. Effective use of data for identifying high-risk pregnant women and gaps in service delivery is encouraged for the healthcare workers. The state has also pioneered an innovative open data platform called MOTHER APP. Moreover, the mission is now empowering the communities by making health and nutrition data available to them through a VHC APP. Additionally, a strengthened collaboration between relevant departments including Social Welfare (Women & Child Development), Health & Family Welfare, and Community & Rural Development enables collaborative action for addressing the social dimensions of health.

PROGRAM OUTCOME

Rescue Mission has resulted in an exponential decrease in maternal and infant deaths within a short span of time. Between 2020 & 2024, there has been a 49% decline in maternal deaths and a 32% decrease in infant deaths.

FINANCIAL IMPLICATION

Nil.

SCALABILITY

The program's low-resource strategy leverages existing Central Sector Schemes such as the National Rural Livelihood Mission (NRLM) and Integrated Child Development Services (ICDS) to solve local health problems. This approach, combined with a sense of purpose, enables scalability across different settings without any additional cost implications.

MADHYA PRADESH

STREAMLINING THE PERFORMANCE-BASED INCENTIVE UNDER AYUSHMAN BHARAT: COMPREHENSIVE PRIMARY HEALTHCARE THROUGH AYUSHMAN AROGYA MANDIR

PROBLEM STATEMENT

The implementation of Performance-Based Incentives (PBIs) under the National Health Mission (NHM) aims to enhance health outcomes by motivating healthcare providers and frontline workers. However, the existing system faces several challenges, including

restricted access to reporting portals, delays in payment processing, lack of clarity in payment procedures, and inadequate tracking of submissions and disbursements. Block-level officials often struggle with delayed verification due to limited portal access, manual paperwork, and accounting errors, which further hinder timely incentive payments. Additionally, frontline health workers (Multi-Purpose Workers-MPW and ASHAs), including Community Health Officers (CHOs) encounter difficulties in understanding payment guidelines, reporting indicators, and fund disbursement processes. The absence of a streamlined tracking mechanism makes it challenging for administrative bodies at the district, division, and state levels to monitor report submissions and payment releases effectively.

PROGRAM DESCRIPTION

The PBI model is built on the principles of accuracy and transparency, incorporating five key design features to ensure efficiency and effectiveness. The first feature defines what is incentivized, expanding beyond the 15 indicators in the Induction Training Module by adding four state-priority indicators related to High-Risk Pregnancy (03) and Teleconsultation (01). The second feature specifies who is incentivized, adopting a team-based approach where CHOs, MPWs, and ASHAs working within the same SHC-AAM receive collective incentives. The third feature ensures timely and fixed-frequency incentive payments, eliminating delays and reinforcing trust in the system. The fourth feature establishes a clear basis for payment, linking incentives to performance thresholds derived from government guidelines, past reporting data, the National Health Profile, and Annual Health Surveys. The ranking of AAM-SHCs at the Block, District, Division, and State levels serves as an objective measure of effectiveness and motivates continuous improvement.

The fifth design feature introduces a tracking mechanism, allowing authorities at all administrative levels to monitor the time lag between reporting and payment, ensuring

timely follow-ups and issue resolution. To operationalize these features, the state has developed a web-based reporting portal that streamlines the process into five key steps: registration, block-level approval, report preparation and submission, verification and validation, and final disbursement. The model is implemented without the need for additional human resources, leveraging the existing health cadre, including CHOs, BMOs, CMHOs, RJDs, and State officials. Additionally, a reward and recognition system has been integrated, automatically ranking AAM at different administrative levels based on performance indicators.

PROGRAM OUTCOME

As of January 2025, a total of 9,969 CHOs successfully registered on the portal with 9,825 (98.5%) CHOs trained. There has been 72% increase in OPD reporting, and 60% increase in wellness sessions. The AAM payment release time at block level was reduced to 16 days from 90 days. And incentives amounting ₹365.6 crores had been verified, demonstrating the significant financial commitment towards strengthening healthcare service delivery.

FINANCIAL IMPLICATION

The development of the web portal incurred no additional financial burden, as it was created by the IT-Cell of NHM-MP.

SCALABILITY

The web portal is built on an open-source framework, making it easily adaptable and shareable with other states for seamless implementation.

KARNATAKA

KARNATAKA BRAIN HEALTH INITIATIVE (KaBHI)

PROBLEM STATEMENT

India is facing a rising burden of neurological diseases, with stroke and dementia emerging as leading contributors to disease burden and mortality. Additionally, epilepsy, headaches, infections, and head injuries significantly contribute to long-term disability. The prevalence of neurological disorders is alarming, with over 1 million individuals living with epilepsy (PWE), representing nearly 1% of the population. Dementia also poses a significant challenge, affecting over 3.7 million people aged 60 and above, including 2.1 million women

and 1.5 million men. Alarmingly, the number of persons with dementia (PWD) is projected to double by 2030, exacerbating the healthcare burden. These statistics highlight the urgent need for comprehensive, multi-disciplinary strategies to strengthen neurological and mental healthcare infrastructure in the country.

PROGRAM DESCRIPTION

The Karnataka Brain Health Initiative (KaBHI) is a statewide program launched by the Department of Health and Family Welfare, Government of Karnataka, in technical collaboration with NIMHANS. It aims to prevent, diagnose, and manage neurological disorders such as stroke, epilepsy, dementia, and headaches while promoting brain health through an integrated and sustainable model.

Key interventions include the establishment of Brain Health Clinics across all districts, statewide training of ASHA workers, Community Health Officers (CHOs), physicians, and nurses, and strengthening referral pathways from Ayushman Arogya Mandirs (AAMs) to district hospitals and tertiary care centers. The initiative also incorporates tele-neurology consultations, tele-mentoring, and tele-rehabilitation services to improve access to specialized neurological care, especially in remote areas.

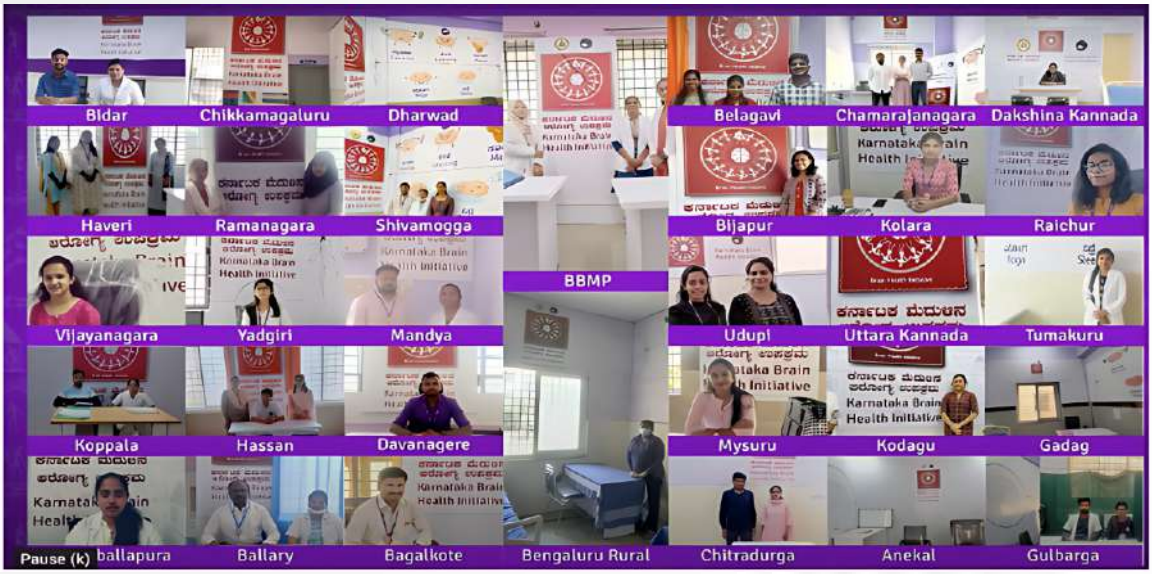
KaBHI emphasizes awareness campaigns, community screenings for high-risk individuals, and intersectoral coordination with existing NCD, NMHP, and stroke programs to ensure holistic care. The program also focuses on digital health management, medication access, and sustainable financing to create an evidence-based model for brain health across India.

PROGRAM OUTCOME

From March 2024 to February 17, 2025, the KaBHI has made a significant impact on neurological healthcare accessibility and awareness across the state. A total of 3,00,360 individuals were screened for neurological disorder risk, with 48,077 neurological consultations provided through multidisciplinary care teams.

The initiative has successfully expanded tele-neurology services, facilitating 1,132 remote consultations, ensuring specialist support for patients in underserved areas. Additionally, 1,589 state-wide awareness and IEC activities were conducted, leading to the sensitization of 1,93,104 individuals through community engagement programs.

Capacity-building efforts have resulted in 201 structured training sessions, benefiting 9,123 healthcare professionals across all levels, with notable improvements in post-training evaluations. The implementation of weekly AIR (All India Radio) sessions, totaling 33 broadcasts, has further strengthened public awareness about brain health.



FINANCIAL IMPLICATION

KaBHI operates with an estimated cost of ₹50 lakh per unit per district, including human resources. By integrating services within the existing healthcare system, including district and primary care levels, the program minimizes additional infrastructure costs. This approach also reduces the financial burden on families.

SCALABILITY

The Government of Karnataka has provided full support and funding for the statewide expansion of KaBHI across all districts in FY 2023-24 under a Hub & Spoke Model, which is currently in progress. The initiative is scalable, as it leverages existing healthcare infrastructure, human resources, and digital health systems, making it adaptable for statewide and national expansion with minimal additional investment.

Bellary

Belgaum

BBMP KC General

Shimoga

Dakshina Kannada

Udupi

Bidar

Davangere

Tumkur

Chamarajanagar

Yadgiri

Ramanagara

JHARKHAND

STRENGTHENING COMMUNITY PROCESSES – SAHIYA APP, SWASTHYA PRAHARI, ODD & EVEN TRAINING AND SAHIYA RADIO

PROBLEM STATEMENT

Around, 40,000 Sahiyas are employed across the 24 districts of Jharkhand covering 194 CHCs, 3985 AAM-SHCs, 4118 GPs. Their tireless effort is crucial to improving community health. However, the lack of a single unified digital database acted as a barrier in delivering services by hindering monitoring and addressing gaps in identifying idle positions to improve

workload distribution. A digitized database, thus became important particularly integrating spatial intelligence linking each sahiya to their administrative boundaries to optimize real time tracking of services.

PROGRAM DESCRIPTION

The "odd-even" approach serves as an on-the-job training strategy where sahiyas are paired in an odd-even pattern, with one sahiya receiving training from the sahiya sathis while the other observes and replicates, thus promoting peer learning and reducing residential training days. Complementing this is the Sahiya-radio program, a 15-minute educational segment in an entertainment-education format, conducted in Hindi. This program uses conversational dialogues to address health issues, offer guidance from expert doctors, and provide information on health services and government schemes, thereby enhancing health awareness among rural populations and dispelling misconceptions. Additionally, the Sahiya

App, created to enhance the efficiency of sahiyas in their reporting tasks provide a user-friendly interface available in both Hindi and English. It encompasses various programmatic components to ensure comprehensive data capture, including home visit reporting, newborn tracking, high-risk newborn monitoring, and Anganwadi center tagging for improved service tracking. Data is reviewed at the village, block, and district levels to ensure accuracy and accountability. Furthermore, the Swasthya Prahari initiative assesses and recognizes the services provided by sahiyas through a performance-based mechanism conducted via the Sahiya App every 3 to 6 months. This assessment covers 14 key indicators, including institutional deliveries, ANC check-ups, HBNC, VHSND support, disease screening, and PLA meeting facilitation. Sahiyas are scored on a 0-100 framework, with those scoring above 90, 80-90, 70-80, and 60-70 receiving Golden, Silver, Bronze, and White badges, respectively with "Sahiyas are evaluated on a 0-100 scale, with those scoring above 90, 80-90, and 70-80 receiving Gold, Silver, and Bronze badges, respectively, along with monetary rewards. Those scoring 60-70 receive a White badge.", respectively. Sahiyas scoring below 50 are given assistance to improve their service quality and, if they fail to improve within a stipulated time, notices are issued, and new recruitments are initiated.

PROGRAM OUTCOME

Approximately 40,000 Sahiyas have been trained through the "Odd-Even" approach significantly reducing training costs from ₹12 crore to ₹90 lakhs. The initiative has also

improved community engagement. A total of 288 episodes of the Sahiya radio program has been broadcasted since October, 2019 focusing on various public health issues and programs. As a result, the overall knowledge, attitude and practice related to RMNCH+A, NCDs and other health programs has increased amongst the sahiyas.

The Sahiya App has streamlined the entire reporting process, significantly reducing the burden of physical documentation. The Swasthya Prahari initiative has assessed over 39,964 sahiyas across 24 districts in F.Y 2024-2025 using the sahiya app, with a total incentive distribution of ₹22 crores. It has led to increased motivation, workload balance and improved service quality. Additionally, the android-based system, functioning both online and offline, has allowed 30% of users to submit reports seamlessly. The structured format has enabled sahiyas to complete PLA forms in under two minutes and HBNC/HBYC reports in 5-6 minutes, significantly reducing reporting time. The app's auto-calculation feature for visit dates based on a child's health status has ensured timely home visits, while its secure database provides a reliable means of tracking children and maternal health interventions.

FINANCIAL IMPLICATION

The activities are funded by State NHM.

SCALABILITY

The program has been scaled at the State level. It is scalable to other states as it is funded under NHM.

KERALA

SANTHWANAM MENTAL HEALTH PROJECT

PROBLEM STATEMENT

Rehabilitation and mainstreaming of patients with severe psychiatric illness are crucial issues in ensuring quality health care to all. There are many patients undergoing treatment for mental illness who are in remission and do not have active symptoms. These patients do not need to be hospitalized, but should be cared for at home to facilitate their gradual into mainstream society. However, often after being discharged, these patients become a burden on their families. Unemployment and social rejection can drive them to substance

abuse, leading to missed medications and eventual rehospitalization. Occupational therapy can help these individuals build self-esteem, confidence and re-enter mainstream society like any other individual.

PROGRAM DESCRIPTION

Santhwanam Mental Health Rehabilitation Project is a Day Care Centre for mentally ill patients in remission. The initiative has been ongoing since its inception in 1995 under the support of the Block Panachayat, Grama Panchayat and the District Mental Health Program (DMHP) of Thiruvananthapuram. The first community based Occupational Therapy Unit for the mentally ill patients of the district was established in 2012. The project focused on the rehabilitation of mentally challenged people and the capacity building of inmates by making them occupied with different types of works which included soap making, cover making, etc. The income generated from those products were distributed among inmates for their livelihood. Healthcare services are provided to the patients by the DMHP team. Recreational activities like craft-making, indoor games are also conducted for creating a conducive environment for the inmates.

Currently, it is being implemented by the District Mental Health Programme, funded by the Grama Panchayat alone. There are about 15 patients brought to the center from their homes with the help of the vehicle provided by the Panchayat, and are provided with food and medicines.

PROGRAM OUTCOME

This rehabilitation center provides a supportive environment for individuals to manage their mental health conditions. It facilitates the rehabilitation of patients who are in remission, helping them acquire skills to care for themselves. The project also imparts basic skills, ensuring the dignity and self-worth of individuals by allowing them to receive remuneration for the skilled work done. Additionally, the families of these individuals benefit from reduce stress and burden as their loved ones receive professional care and support.

FINANCIAL IMPLICATION

Fund allocated for this project is Rs 8 Lakhs/FY from Local Self Government. This fund is utilized for providing food for inmates and remunerating the staff (an Aaya and Cook). Funds for vehicle (mobility support for patients) are sourced through MLA funds. Treatment and medicines are provided free of cost for the inmates by DMHP. Currently, 31 community-based Day Care Centres are functioning in the State under District Mental Health Programme, in collaboration with Local Self Governments. Rs 6 lakhs are provided to each of these centres from NMHP under the Planning & M&E head, and Rs 10 lakhs from the State Plan Funds.

SCALABILITY

Based on its success, Day Care Centres with Occupational therapy units were started in all 14 districts of the State at Panchayat level.

HIMACHAL PRADESH

TELE-STROKE PROJECT

PROBLEM STATEMENT

In Himachal Pradesh, about 5000 patients are estimated to suffer from Stroke every year. About 50% of the patients do not survive beyond 6 months and around 25% become dependent for life. The state suffers from extreme climate conditions, as it is one of the thirteen mountainous States of India with 90% of its population living in villages. There are two tertiary care hospitals with neurologists. For treating ischemic stroke, the simplest and most effective method is thrombolysis. This procedure involves dissolving the clots blocking

the blood vessels, provided it is performed within a short window period of 3 to 4 hours for maximum efficacy.

PROGRAM DESCRIPTION

The Tele-Stroke project, initiated in 2014 in collaboration with stroke specialists from AIIMS Delhi, IGMC Shimla, and RPGMC Tanda, encompasses 17 government hospitals with CT scan facilities. Out of these 17 hospitals functioning as the Spokes, 8 Sub-district Hospitals and 9 District Hospitals have been linked with the two tertiary care hospitals, who serve as the Hub centres. Workshops were conducted at various district hospitals to build the capacity of medical officers to recognize stroke and read plain CT-scan heads to rule out haemorrhage even without a radiologist's help. Written protocols for thrombolysis in ischemic stroke with explicit inclusion and exclusion criteria were provided. Apart from the CT head scan, only blood sugar and ECG were required before thrombolysis. Tissue plasminogen activator (tPA) injections are available at all these centers and provided free of cost through hospital pharmacies. Neurologists at the hub are available 24x7 via phone, WhatsApp, and Skype to guide doctors at the spoke centers. Social networking sites like WhatsApp are used for transmitting CT-scan images to neurologists for consultation. A mobile app has been developed to make the project IT-enabled for wider reach. The 17 stroke centers are strategically located, covering 11 out of 12 districts in the state.

PROGRAM OUTCOME

Under the project, a total of 831 patients have received treatment. Of these, 114 patients were treated below district hospitals. Moreover, consistent state-level monitoring of cases has significantly reduced the mortality rate, with only 2 deaths reported after thrombolysis.

FINANCIAL IMPLICATION

No additional cost since the programme is covered under NHM budget.

SCALABILITY

This model can be replicated in other similar settings; however, the critical window period of 4 hours must be adhered to for its success.

WEST BENGAL

INTEGRATED VIRAL HEPATITIS SERVICES IN CORRECTIONAL HOMES: ESTABLISHING SYNERGY

PROBLEM STATEMENT

Global evidence highlights that incarcerated populations are particularly vulnerable to Hepatitis B and C, a concern further reinforced by higher prevalence rates observed in program data. Additionally, the reach of state healthcare services within prisons/correctional homes remains limited, restricting timely diagnosis and treatment for affected individuals. Furthermore, the frequent and often rapid release of undertrial

inmates results in missed opportunities for intervention, allowing infections to persist and spread within the broader community. To address these challenges, Viral Hepatitis services for prison/correctional homes inmates in West Bengal were first initiated in mid-2021 across 8 Central and 16 District Correctional Homes (CH). This initiative introduced real-time prison-based screening for all inmates at the point of entry for HBsAg and anti-HCV, ensuring early detection. Those testing positive were linked to designated mentor Treatment Centres for further investigations and necessary care, strengthening the public health response within the correctional system.

PROGRAM DESCRIPTION

The Viral Hepatitis program for prison inmates in West Bengal began in July 2021 across six Central and eight District Correctional Homes, introducing real-time screening for HBsAg and anti-HCV by trained prison health staff, peer educators, and para-legal volunteers. Positive cases were linked to designated treatment centres for further investigations, including viral load testing and baseline assessments. By September 2021, the initiative expanded to eight more correctional homes. Dumdum Central Correctional Home was designated as the first Regional Viral Hepatitis Treatment Center in February 2022, followed by Jalpaiguri in March 2022. By June 2023, Berhampore and Midnapore were also enabled as Regional Referral Treatment Centers, bringing the total to four. A Standard Operating Procedure (SoP) ensured that all anti-HCV reactive inmates underwent viral load testing, with only RNA-positive cases

referred for treatment, while HBsAg-positive inmates were directly linked to care. To ensure continuity post-release, inmate contact details were shared with District Nodal Officers.

To reduce delays in treatment initiation, Point-of-Care (PoC) Viral Load testing using Truenat PCR technology was introduced in select correctional homes from May 2024, eliminating delays in sample processing and reporting. A single-window, single-venepuncture blood collection system enabled same-day viral load estimation and baseline investigations within 48 hours at nearby medical colleges. Other key improvements included universal real-time screening, capacity-building for prison health staff, improved tracking of under-trial inmates, and enabling major correctional homes to continue in-house treatment. Tele-mentoring by Viral Hepatitis Treatment Centres further strengthened medical guidance and adherence, significantly improving service delivery and increasing retention rates of Hepatitis-positive inmates in care.

PROGRAM OUTCOME

The implementation of four Regional Referral Treatment Centres, supported by approximately 30 mentoring treatment centres and tele-mentoring services, has significantly strengthened the continuity of care for Hepatitis-positive inmates. The introduction of PoC reflex viral load testing, synchronized with screening, has drastically reduced the time from diagnosis to treatment, ensuring quicker medical intervention and reducing the risk of disease progression.

In the financial year 2023-24, a total of 28,500 inmates were screened for both HBsAg and anti-HCV across 53 correctional homes, with positivity rates of 0.71% and 0.79%, respectively. Despite challenges in tracking under-trial inmates post-release, nearly 50% of HBsAg-positive individuals were successfully linked to appropriate care. For anti-HCV reactive inmates, viral load testing was initially conducted for 43%, and all RNA-positive cases were initiated on antiviral treatment.

The systematic sharing of inmate contact information with District Health Teams has improved post-release follow-up, allowing for the retrieval of lost-to-follow-up (LFU) cases and enhancing long-term treatment adherence. In the ongoing financial year 2024-25, HBsAg positivity and anti-HCV reactivity have been recorded at 0.72% and 0.85%, respectively, indicating continued disease burden within the prison population. On average, the duration from testing positive to treatment initiation or medical advice has been reduced to approximately one month.

FINANCIAL IMPLICATION

There are no additional cost implications, as the budget is fully covered by the State Health Department & Correctional Services Department.

SCALABILITY

The program is scalable in the state with plans to expand real-time screening across all 60 correctional homes and establish two additional Regional Treatment Centres in West Bengal. It is also replicable in other states, provided the State Health & Correctional Services allocate necessary resources for implementation.

UTTAR PRADESH

BEHAVIOURAL TRAINING FOR HOSPITAL STAFF

PROBLEM STATEMENT

Mera Aspataal, an initiative by the Government of India (GoI), captures patient feedback on healthcare services received at hospitals. When utilized, data from the portal helps identify areas needing improvement to enhance healthcare quality and patient experience. The Health Department of Uttar Pradesh reviewed the Mera Aspataal Performance Report from April 1, 2023, to June 30, 2024, and found that 27% of patients reported dissatisfaction with the services provided at healthcare facilities. The primary reasons for dissatisfaction were a lack of cleanliness (10%), high cost of treatment (22%), other reasons (26%), and

poor staff behavior, which emerged as the leading cause (40%). Of these, 21% were specifically offended by non-clinical staff behaviour. The identified factors contributing to inappropriate behaviour attributed to lack of orientation of their roles and responsibilities, rules and regulations, mandatory requirements and other hospital policies. Additionally, overburdened health facilities and shortage of staff and consumables hamper efforts to maintain a conducive environment.

PROGRAM DESCRIPTION

Recognizing the need to improve service quality and enhance patient-provider interactions, the State National Health Mission (NHM) identified the necessity to develop a behavioral training intervention to sensitize healthcare providers and non-clinical staff to provide respectful and patient centric care.

A three-pronged strategic approach was designed, focusing on identifying critical touchpoints where provider behavior significantly impacts patient experience; training facility staff and healthcare leaders as trainers and mentors to ensure accountability; and rewarding and appreciating the contributions of support staff at healthcare facilities to keep them motivated.

A comprehensive behavioral training module was developed, incorporating adult learning principles, a participatory approach, and personal reflections. The module was presented through audio-visual materials. Following the module's launch, Training of Trainers (ToT) was conducted by SIHFW in Lucknow. As per State reports, nine batches of TOTs have been completed for CMSs, senior nurses, hospital managers, and quality consultants (318 master trainer trained from 104 DH). Currently facility-based training has been initiated, and 4865 hospital staff have trained (in 140 batches).

PROGRAMME OUTCOME

The effectiveness of the training was assessed qualitatively by gathering feedback from stakeholders, including participants and patients. The feedback underscored the training's effectiveness in terms of improved provider sensitization, enhanced patient experiences, and strengthened patient-provider relationships.

FINANCIAL IMPLICATION

Supported through NHM (PIP).

SCALABILITY

This innovative training module has the potential for nationwide implementation, provided it is adapted to local contexts for better acceptability. Adaptation should consider implementing the reward and recognition system across all healthcare facilities, conducting quarterly reviews of Mera Aspataal portal data to assess facility performance, ensuring supportive supervision and mentorship by senior medical officers to maintain quality behavioral training, and carrying out concurrent third-party evaluations to assess the long-term impact of the intervention.

MANIPUR

CHIEF MINISTER'S MENSTRUAL HYGIENE SCHEME (CMMHS)

PROBLEM STATEMENT

In Manipur, menstrual hygiene remains a key area of focus, particularly for adolescent girls in rural areas. The Menstrual Hygiene Scheme under NHM currently reaching 25% of rural girls; yet, there remains a need to expand access to ensure every girl has the opportunity for safe and hygienic menstrual management. According to NFHS-5, 61.3% of girls aged 15 to 19 years still rely on cloth, and 3.1% use locally prepared sanitary napkins, methods that

may not always provide optimal hygiene and comfort. Traditional beliefs and limited awareness further influence menstrual practices.

PROGRAM DESCRIPTION

Launched in December 2022, the Chief Minister's Menstrual Hygiene Scheme (CMMHS) aims to improve menstrual health among school-going girls aged 10 to 19 years by providing free-of-cost high-quality sanitary napkins and promoting awareness on menstrual hygiene. The initiative enhances self-esteem, social participation, and school attendance, ensuring both urban and rural coverage across all 16 districts of Manipur. Implemented in collaboration with the Education Department, National Health Mission, and Health Department, the scheme integrates with the School Fagat-Hansi Mission for greater impact. It also supports local entrepreneurs in manufacturing and procuring sanitary napkins while equipping schools with vending machines and incinerators for easy access and safe disposal.

Regular monitoring, stakeholder coordination, and human resource management ensure smooth execution, making CMMHS a sustainable step toward menstrual hygiene empowerment.

PROGRAM OUTCOME

The CMMHS has significantly improved menstrual health and school attendance among adolescent girls in Manipur. Implemented across 74 schools in 16 districts, the initiative provided 51,951 girls from Classes VI to XII with access to 88,730 sanitary napkins through 69 vending machines and incinerators, ensuring both availability and safe disposal.

Between February 2024 and January 2025, 1,453 menstrual hygiene sessions were conducted, with 28% of enrolled girls attending monthly, leading to greater awareness and reduced stigma. Capacity-building efforts included a State-Level Sensitization Meeting with 53 officials and a Nodal Teachers' Orientation Programme attended by 66 teachers, ensuring sustainability.

The scheme directly impacted school attendance, with an 8% increase at Wangkhei High School and a 27% rise at Malom Megha High School from 2022 to 2024 since the scheme's implementation. With 57% of adolescent girls adopting sanitary napkins from April 2024 to January 2025, CMMHS is fostering empowerment, awareness, and dignity in menstrual hygiene management across the state.

FINANCIAL IMPLICATION

Fully funded by the State Government of Manipur, CMMHS operates without additional financial costs.

SCALABILITY

The program has demonstrated an effective intervention in the state with minimal financial burden on the government. Its scalable and cost-efficient model allows for seamless expansion to government, government-aided, and private schools and colleges across the state. With its success, other States and UTs can adopt similar strategies to enhance menstrual hygiene management for adolescent girls in schools.

HIMACHAL PRADESH

MAINSTREAMING ADOLESCENT HEALTH SERVICES IN THE ERA OF UNIVERSAL HEALTH COVERAGE BY STRENGTHENING THE AFHCs IN THE STATE OF HIMACHAL PRADESH

PROBLEM STATEMENT

Adolescents represent a huge opportunity that can transform the social and economic momentum of the country. Hence, adolescent health has been among the focus areas of state governments. Under RKSK, Adolescent Friendly Health Centers (AFHCs) 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. However, the existing AFHCs in Himachal Pradesh were underutilized due to inadequate infrastructure, insufficient counselling services, and untrained staff in clinics, which affected service delivery.

PROGRAM DESCRIPTION

Under the initiative launched in May 2020, a total of 103 facilities were notified as Nayi Disha Kendra (NDKs) in the state, to provide counselling services to adolescents on various health issues through a comprehensive service package. These are established at Medical College/Zonal Hospital/District Hospital/Community Health Centre. A team of 3-4 health care providers (Medical Officers/FHW/Staff Nurse/Lab Technician/ Pharmacist/ Counselors etc.) was constituted for each Nayi Disha Kendra, and were trained on RKSK and its components.

The State RKSK cell prepared a gap analysis checklist which was administered through observations, from the NDK staff and ASHAs/ health workers. After filling the gap analysis checklist, color coded report (green and red color) was prepared along with suggested actions to be taken. The report was then submitted to the State cell, and the districts to address the gaps. The BMOs and Medical Officer in-charge initiated necessary actions such as establishing infrastructure using annual funds, displaying IEC materials in the facility, imparting training to the staff posted at NDKs, and ensuring online reporting in DHIS 2.

PROGRAM OUTCOME

As a result of the gap analysis and actions taken in the State, there were significant improvements in the availability of infrastructure, IEC materials, service delivery and HR at

the NDKs. This led to an increase in the number of adolescents availing the services at NDKs in three financial years. Adolescents registered in FY 2021-22 were 30,662 which increased by over 100% within a year (i.e. 67,807 in FY 2022-23), and has reached 1,39,668 in FY 2023-24 Significant improvement in online reporting under DHIS 2 was also observed.

FINANCIAL IMPLICATION

The budget approved in RoP for maintenance and establishment of AFHCs was utilized for filling the gaps and establishing Nayi Disha Kendra as per the guidelines of the State government. A budget of Rs 50,000 for new NDKs and Rs. 10,000 as contingency amount for old NDKs services was provided by the government.

SCALABILITY

The model is scalable across the country given that it is integrated within the RKSK initiatives and may not require additional HR or cost implications. The checklist has been derived from the National Guidelines and thus it can be replicated in other States.

KARNATAKA

SHUCHI NANNA MAITHRI MUTTINA CUP YOJANE

PROBLEM STATEMENT

The Shuchi Program, a State-owned menstrual hygiene program, has been distributing free sanitary napkins to adolescent girls (aged 10 to 18 years) of all Government & aided schools, and colleges since 2013-14. Although the program has been performing well, issues like lack of period friendly toilets, and a lack of provision for safe disposal of used sanitary napkins heightened the risk of infections and morbidity among the adolescents. Further, the use of pads generated a lot of sanitary waste. To address these concerns, and improve the ease of

disposal of sanitary napkins, the State government has introduced reusable menstrual cups for young adolescents (PUC girls).

PROGRAM DESCRIPTION

The program was initially piloted among 300 girls (150 each) from 2 districts (Chamarajanagar and Dakshina Kannada) to understand the acceptance in the community. Among them, 276 beneficiaries reported menstrual cup acceptance and use for more than 6 periods/ months. The piloted cohort were further trained as 'champions' to motivate other beneficiaries. Based on the positive response, the health department expanded the program in both districts, encompassing training, supply of Menstrual Cups (MC) and follow-up for acceptance. The implementation is overseen by Specialists (OBG), CHOs and RKSK-AH counsellors at the district, block and sub-block level under NHM.

The beneficiaries have been sensitized on adopting newer Menstrual Hygiene Methods (MHM) through adequate training. The children who have adopted menstrual cups have been helpful in generating awareness in the community as well as in their respective families. Additionally, the staff involved in the implementation of the program were also encouraged to adopt the eco-friendly menstrual cups.

PROGRAM OUTCOME

As of January 2025, a total of 15,000 menstrual cups were distributed across 112 colleges in Chamarajanagar and Dakshina Kannada districts, out of which 12,882 females (i.e, 85.8%) reportedly were using the cups. 90% of the adolescents adopted the menstrual cups distributed through the program. Over 70% of girls have shown to consistently use the cups throughout their college years.

FINANCIAL IMPLICATION

Previously, the cost per schoolgirl for menstrual hygiene products was 27.77 per month, totalling 166.62 per child for six months. For PUC girls in two districts, the cost of sanitary napkins over three months amounted to 3,25,492. In contrast, menstrual cups require a one-time investment of 100 per cup, with a lifespan of up to five years (and potentially 10 years with proper maintenance). The procurement cost would be around Rs. 15 lakhs. Training and IEC initiatives generated a cost of around Rs 60 lakhs. Additionally, the initiative has eliminated sanitary waste generation, which previously amounted to around 391 Kg per month (based on 39,070 pads used at 10 grams per pad).

SCALABILITY

The positive outcomes from the initial phase of the project indicate its potential for expansion to other districts and states. However, the community acceptance needs to be fostered through rigorous sensitization and training.

HIMACHAL PRADESH

IMPLEMENTATION OF "HEALTH PROMOTING EDUCATIONAL INSTITUTE" STRATEGIES IN THE STATE OF HIMACHAL PRADESH, CHALLENGES, OPPORTUNITIES AND THE WAY FORWARD

PROBLEM STATEMENT

Health promotion at school level is highly important in strengthening its capacity as a healthy setting for living, learning and working influencing health-related behaviors i.e. knowledge, beliefs, skills, attitudes, values and support for healthy future. Health promotion in a school involves educating the children about health-related matters and creating a healthy

environment that reflect on the health in a more holistic way. Keeping in view these facts, it has been decided to adopt the setting-based approach for healthy future through certification of the Educational Institutes as health promoting educational institutes based on certain checklist/ criteria prepared in consultation with the Education Department in Himachal Pradesh.

PROGRAM DESCRIPTION

An expert committee was constituted in 2020 to prepare the state specific strategy for certification of the Educational Institutes who are undertaking Health Promotion in the state. Experts from Health and Education department including academic institutions were included in the committee. The WHO Health Promoting Educational Institutes guidelines were referred to and modified with state specific context, to make them more relevant to the setting. The educational institute were certified by the nearest BMO for a period of two years based on the assessment by the team constituted for this purpose. The grading and certification of the institutions was done based on the scores obtained by them, where higher marks led to the certification; and further grading was done to identify the colleges/schools as "achiever" or "aspirant". This also led to more convergent approach between schools/colleges to involve all key stakeholders in order to get qualified or certified for this intervention.

PROGRAM OUTCOME

State has set the target as "one school as model" in each health Block till March 2025. The process of certifications has been started in all 77 Health Blocks and 37 schools has been certified as Health Promoting Schools till February 2025. Orientation of the district and sub district officials from Education and Health departments is conducted twice a year as a part of this initiative.

FINANCIAL IMPLICATION

No additional financial implications.

SCALABILITY

Program can be scaled up effectively in other states through inter-convergent efforts between Education and Health Departments.

MADHYA PRADESH

ANAND DIWAS

PROBLEM STATEMENT

Effective vaccine management is crucial for ensuring the potency, safety, and availability of vaccines across all levels of the healthcare system. The EVM assessment of 2022 in Madhya Pradesh highlighted critical gaps in supportive supervision, training, storage infrastructure, and cold chain maintenance, which directly impact the effectiveness of routine immunization programs. Regular supportive supervision visits are essential to identify and correct field-level errors, train vaccine cold chain handlers on updated guidelines, and

ensure that new medical officers are well-versed in the latest immunization protocols. Strengthening vaccine management through structured supervision, capacity-building, and adherence to protocols will help ensure effective vaccine delivery, minimize errors, and improve immunization coverage, ultimately strengthening public health outcomes.

PROGRAM DESCRIPTION

To strengthen cold chain management and improve vaccine quality, monthly monitoring of all 1,307 cold chain points in Madhya Pradesh was recommended as a key strategy to enhance supportive supervision and rectify erroneous practices. The Anand Diwas initiative was introduced as an innovative approach, designating the first working day of every month for comprehensive supportive supervision and monitoring of all cold chain points. This initiative aimed to improve key components such as infrastructure, human resources, cold chain equipment, temperature monitoring, vaccine management, and documentation (M&E), ensuring vaccines of superior quality for immunization. By implementing this structured monitoring process, nearly 20 lakh children received high-quality vaccines, significantly enhancing routine immunization efforts.

The Anand Diwas initiative involves government officers and partners, who are assigned to each facility for supervision. During these visits, officials fill out SVS, RVS, DVS, and Sub DVS forms in the supportive supervision app developed by the Ministry of Health and Family Welfare (MoHFW). The findings are used to share feedback with the district teams, allowing them to track improvements and address challenges effectively. Districts are expected to review their blocks using block-wise findings, ensuring a multi-level monitoring system that drives continuous improvement in cold chain management.

PROGRAM OUTCOME

The Anand Diwas initiative has led to a dramatic increase in supportive supervision of cold chain points, as reflected in the 263% rise in FY 24-25, compared to just 17% in FY 19-20, 41% in FY 20-21, and 39% in FY 21-22. Strengthened supervision has addressed gaps in cold chain management, improved compliance with protocols, and enhanced overall vaccine quality.

FINANCIAL IMPLICATION

The initiative has been funded by the NHM.

SCALABILITY

This initiative is scalable, provided it leverages the existing human resources and technology.

MADHYA PRADESH

IMMUNIZATION WHEEL

PROBLEM STATEMENT

One of the primary challenges contributing to low Full Immunization Coverage (FIC) in Madhya Pradesh is the high drop-out rate in the vaccination lifecycle of children. In 2015-16, the state's FIC stood at 54%, with 19% of beneficiaries dropping out between the BCG vaccine and the third dose of the DPT vaccine, and another 13% failing to receive the Measles vaccine after completing the DPT series. A 2018 survey further highlighted that 22% of children remained either unvaccinated or partially vaccinated. Key factors leading to

these drop-outs include poor due-list practices, gaps in social mobilization, and a lack of awareness among caregivers, often exacerbated by fears surrounding Adverse Events Following Immunization (AEFI). Additionally, 40% of beneficiaries miss vaccinations due to an information gap being unaware of when, where, and why immunization is necessary while 24% are left out due to family reluctance.

PROGRAM DESCRIPTION

To address the challenges of low FIC and high drop-out rates, the Immunization Wheel (Tikakaran Chakra) was introduced as an innovative job-aid tool to support frontline health workers (FLWs) and caregivers. This visual tool, designed based on the National Immunization Schedule (NIS), features a rotating clock hand that calculates vaccination due dates when aligned with a child's date of birth, ensuring caregivers understand the importance of timely immunization. Acting as an interactive IEC aid, the wheel lists vaccines, the diseases they prevent, and key messages that healthcare workers must communicate. Three versions were developed: ANM/Staff Nurse (Vaccinator), ASHA (Mobilizer), and Caregiver versions (the latter yet to be rolled out).

The tool was tested in multiple phases. Design testing in September 2020 validated its feasibility in real-time settings, followed by a pilot study in Harda district, where over 9,000 beneficiaries, 55 vaccinators, and 350 mobilizers participated, showing positive outcomes in caregiver awareness and FLW communication capacity. Based on these results, the Government of Madhya Pradesh scaled up the program across 52 districts, distributing 14,000 wheels to vaccinators and 62,000 to mobilizers.

The program leveraged existing human resources at state, district, and block levels, requiring no additional staff. Capacity-building efforts included training collaterals, SOPs, audio-visual materials, and ToT sessions, ensuring FLWs received proper guidance on usage.

Training responsibilities were cascaded down from sub-district officials, supported by state and district-level monitoring. Additionally, an online training video was developed for wider access.

PROGRAM OUTCOME

The Immunization Wheel underwent comprehensive field evaluation through both qualitative and quantitative research. During the design testing phase in September 2020, qualitative methods were employed using the Socio-Ecological framework, with FGDs and IDIs conducted among FLWs, caregivers, secondary caregivers, village heads, and government officials. The study found that the Immunization Wheel generated significant interest and excitement among stakeholders. ANMs particularly appreciated its utility in record-keeping, emphasizing that the arrow feature simplified the calculation of due dates, especially on days with high beneficiary load. A key recommendation from the study was to develop a separate version for ASHAs and AWWs, as officials and FLWs believed it would greatly assist them in their daily work.

Results from the pilot study demonstrated significantly improved awareness, mobilization, and adherence to immunization schedules among both ANMs (vaccinators) and ASHAs (mobilizers) in Madhya Pradesh.

FINANCIAL IMPLICATION

The Government of Madhya Pradesh funded the statewide expansion of the RI Wheel, recognizing it as a highly cost-effective intervention. With a unit cost of just INR 15, the state made a one-time investment of approximately INR 12 lakh to equip 15,000 ANMs and 65,000 ASHAs, ensuring widespread accessibility without incurring recurring expenses.

SCALABILITY

The Routine Immunization Wheel is scalable, with its cost-effective design, ease of use, and successful integration into existing immunization programs, making it adaptable for statewide, national replication to strengthen vaccination coverage and awareness.

ODISHA

IMPLEMENTATION OF FPC-KMC IN AAM-PHC: NEW MANAGEMENT PROJECTS RUNNING UNDER PPP MODE

PROBLEM STATEMENT

While Odisha has made significant strides in reducing infant and neonatal mortality, with the Infant Mortality Rate (IMR) declining from 38 to 36 and the Neonatal Mortality Rate (NMR) standing at 28 per 1,000 live births (SRS 2020), the pace of reduction remains slow, particularly in rural and tribal areas. NFHS-5 highlight stark disparities, with neonatal mortality at 28 in rural areas and 42 among Scheduled Tribes, while the IMR and Under-Five

Mortality Rate (U5MR) among Scheduled Tribes remain alarmingly high at 56 and 66, respectively. One of the key contributing factors is the lack of healthcare-seeking behaviour and poor awareness among mothers and families about neonatal danger signs, especially in hard-to-reach areas. Additionally, inadequate follow-up care for sick and low birth weight (LBW) infants discharged from Special Newborn Care Units (SNCUs) further exacerbates the problem. In response, Family Participatory Care (FPC) and Kangaroo Mother Care (KMC) have been introduced as evidence-based, cost-effective interventions that engage families in neonatal care, reducing mortality among LBW infants by up to 50%.

PROGRAM DESCRIPTION

To enhance neonatal care in hard-to-reach areas, the State has expanded Family Participatory Care (FPC) and Kangaroo Mother Care (KMC) services beyond First Referral Units (FRUs) to Primary Health Centers (AAM-PHCs). 17 remotely located AAM-PHCs, each managing at least 10 deliveries per month, across 11 districts were identified for piloting this initiative. A technical committee finalized the infrastructure, equipment, and logistical requirements necessary for establishing the dedicated KMC rooms in these AAM-PHCs, and each facility was equipped accordingly to ensure effective implementation. The program specifically targeted stable low birth weight (LBW) infants weighing between 1,800 to 2,500 grams, born after 34 weeks of gestation, and without major congenital anomalies. These infants received continuous monitoring at AAM-PHCs, with follow-ups conducted through in-person visits, mobile check-ins, or ASHA-led community outreach. In case of any concerns, ASHAs facilitated the referrals to higher health facilities to ensure timely interventions. Follow-ups continued until the infant reached 2.5 kg and completed their first immunization dose.

To strengthen implementation, all AAM-PHC staff have been provided structured training on FPC-KMC concepts, record-keeping, and reporting protocols, with medical officers and

nurses receiving hands-on demonstrations. This structured approach bridges facility-based and community-based care, ensuring that newborns in Odisha's most underserved areas received timely and effective neonatal care, ultimately improving survival outcomes.

PROGRAM OUTCOME

MIS data showed that infant deaths per 1000 live birth in the intervention areas have reduced from 25.3 (2022-23) to 20.4 (2023-24) to 17.7 (April-Dec 2024). Active participation from mothers and other family members was observed, with more than 40% of LBW babies receiving KMC from caregivers other than the mother. Institutional delivery rates were also high, with 93% of LBW infants born in FPC-KMC implemented AAM-PHCs, while 7% were referred from other institutions. Additionally, 15% of the LBW babies had been discharged from Special Newborn Care Units (SNCUs), reinforcing the critical role of AAM- PHCs in post-discharge neonatal care. Between FY 2020-21 and 2023-24, there has been a 2.1% decrease in the LBW babies, and 1.1% increase in their survival status.

The initiative has also had a measurable impact on infant growth and development. The average duration of KMC per baby per day was found to be 4 hours, contributing significantly to weight gain among LBW infants. Babies who initially weighed an average of 2,168 grams at birth showed a steady increase, reaching an average of 2,908.6 grams by the end of six weeks. This weight improvement underscores the effectiveness of FPC-KMC in promoting neonatal health.

FINANCIAL IMPLICATION

The establishment of a fully equipped KMC unit costs approximately INR 73,600, which is funded through the State Innovation Fund.

SCALABILITY

The implementation of FPC-KMC in 17 AAM- PHCs has proven effective in enhancing neonatal care, increasing family participation, and supporting weight gain in low birth weight infants. It may be implemented in high-delivery-load facilities in the State.

HIMACHAL PRADESH

EVIDENCE BASED SCALE UP OF STEMI MANAGEMENT PROGRAM

PROBLEM STATEMENT

Acute Coronary Syndrome (ACS) is a leading cause of cardiovascular mortality worldwide, with ST-segment Elevated Myocardial Infarction (STEMI) carrying a higher risk of morbidity and mortality, particularly in low-income countries and younger populations. Timely reperfusion through primary Percutaneous Coronary Intervention (PCI) is the most effective treatment; however, its accessibility remains extremely limited, especially in geographically challenging regions like Himachal Pradesh. Given the state's difficult terrain

and long ischemic time, delays in initiating thrombolytic therapy significantly impact patient outcomes. Registry data from India highlight that symptom-to-hospital reporting time is considerably longer compared to high-income countries, further exacerbating delays in treatment. While thrombolytic therapy, if administered within two hours, can be as effective as primary PCI, many ACS-enabled centers are concentrated in urban areas and medical colleges, making access difficult for remote populations. Establishing a hub-and-spoke model by strengthening primary and secondary healthcare facilities as peripheral centers for thrombolytic therapy can ensure timely intervention, reduce ischemic time, and ultimately improve survival rates in STEMI patients across Himachal Pradesh.

PROGRAM DESCRIPTION

The STEMI care program in Himachal Pradesh was initiated as a pilot project in 2020, implementing a hub-and-spoke model across the district hospitals (DHs), civil hospitals (CHs), and community health centers (CHCs) in Shimla. This model aimed to improve timely diagnosis and treatment of ST-segment Elevated Myocardial Infarction (STEMI) by reducing ischemic time and increasing the thrombolysis rate. The pilot study, conducted with 255 STEMI patients, demonstrated significant improvements in thrombolysis rates (65.5% in intervention group vs. 45.7% in control group) and a reduction in mortality (15.5% to 7.8%). Encouraged by these results, the state government approved a statewide scale-up in 2023, integrating the STEMI care program into all districts under the National Programme for Non-Communicable Diseases (NP-NCD). The expansion strategy involved early diagnosis through WhatsApp-based ECG consultations, initial stabilization, timely fibrinolytic therapy, structured follow-ups, and data-driven monitoring using live reporting tools.

To implement the program at scale, a structured framework was established, including the appointment of district nodal officers (technical and programmatic), training sessions led by cardiologists from IGMC Shimla, and the designation of spoke centers equipped with ECG machines and trained medical officers. District-level WhatsApp groups were created to facilitate real-time ECG consultations, replacing the app-based reporting used in the pilot phase due to connectivity challenges. Training sessions for medical officers from spoke centers were completed by December 2023, and daily monitoring was implemented through live Google Sheets, capturing key process indicators such as ECG postings, consultation times, and thrombolysis administration. Additionally, tenecteplase, the thrombolytic drug, was incorporated into the state's Essential Drug List (EDL) to ensure availability. The program utilizes simplified patient data recording tools and daily reporting mechanisms to enhance evidence generation and continuous performance tracking, reinforcing a systematic approach to reducing STEMI-related mortality.

PROGRAM OUTCOME

The program has demonstrated significant improvements in early diagnosis, timely intervention, and streamlined reporting mechanisms. From December 2023 till date, a total of 4,090 ECGs have been posted in district WhatsApp groups, leading to the identification of 468 STEMI cases. Of these, 318 patients were successfully thrombolysed at spoke centers,

ensuring timely treatment and reducing ischemic time. The daily reporting mechanism has also seen marked progress, ensuring better monitoring and data-driven decision-making.

FINANCIAL IMPLICATION

Nil.

SCALABILITY

A total of 179 spokes have been identified and designated by the districts for the STEMI scale-up initiative across the state. To ensure effective implementation, all districts have successfully conducted training sessions aimed at building the capacity of medical officers at these designated spokes. As a result, 211 medical officers from 180 spokes have been trained in STEMI management at the district level.

KARNATAKA

DANTA BHAGYA YOJANE

PROBLEM STATEMENT

The aim of the program is to provide complete dentures and partial dentures to patients who have lost complete or partial dentition. Providing dentures will enhance mastication, facilitate better nutrient absorption, and improve aesthetics and phonetics.

PROGRAM DESCRIPTION

Completely edentulous patients, and patients with 3 or more missing teeth over the age of 45 years having BPL card will be given complete and partial dentures under free of cost. Implementation is through the association of 42 private dental colleges, 2 government dental colleges and 13 government dental labs of district hospital with government dental health officers and dental technicians. The community healthcare workers support the identification of edentulous patients, and refer them to the nearby empaneled dental college for treatment.

PROGRAM OUTCOME

Under the Danta Bhagya Yojane, around 37,470 free Dentures have been distributed since 2015.

FINANCIAL IMPLICATION

A budget of Rs 100 lakhs have been allocated through NHM PIP. Through this scheme, Rs 2000 will be provided for Complete Dentures, and Rs 1000 will be provided for partial Dentures for dental colleges and dental labs.

SCALABILITY

The initiative is scalable, given the State forges partnership with the existing dental colleges for service delivery. As edentulous patients are increasing every year there is a wider scope to expand the services to larger groups.

MANIPUR

CONVERGENCE FOR EFFECTIVE SERVICE DELIVERY ON VIRAL HEPATITIS FOR THE MARGINALIZED COMMUNITIES

PROBLEM STATEMENT

Viral Hepatitis remains a major public health concern in Manipur, particularly among high-risk and marginalized communities such as People Who Inject Drugs (PWID) and prison inmates. A study among PWID in the state found that 43% had exposure to Hepatitis C, highlighting the urgent need for targeted interventions. Despite the availability of free treatment under the National Viral Hepatitis Control Program (NVHCP), which was rolled

out in July 2019 with Model Treatment Centres (MTCs) at RIMS and JNIMS, later expanding to all 16 districts by 2020, access to care remains challenging.

Barriers such as poor health-seeking behaviour, delays from screening to treatment (often exceeding two weeks), and the reluctance of high-risk groups to engage with healthcare services have contributed to low uptake of available treatment. Additionally, prison inmates require specialized care, given the sensitivity of their health conditions and the constraints of the correctional system. Recognizing these challenges, enhanced coordination with NGOs, CBOs, and the Manipur State AIDS Control Society (MSACS) is crucial to bridging service gaps, increasing outreach, and ensuring timely access to treatment for the most vulnerable populations.

PROGRAM DESCRIPTION

Under the National Viral Hepatitis Control Program (NVHCP), screening, diagnosis, and treatment for Hepatitis B and C are provided free of cost. However, to effectively reach marginalized communities, including high-risk groups (HRGs) and prison inmates, collaboration with NGOs, community-based organizations (CBOs), and the Manipur State AIDS Control Society (MSACS) is essential, as these organizations have longstanding experience working with these vulnerable populations.

To address Hepatitis among prison inmates, a Hepatitis Screening Program was initiated in Central Jail Sajiwa on April 22, 2022. As part of this initiative, weekly screenings for Hepatitis B, Hepatitis C, HIV, and Syphilis are conducted every Friday, ensuring early detection and timely intervention.

Additionally, a pilot project titled "Same Day Test and Treat for Hepatitis C among PWIDs" was implemented from November 12, 2021, to January 21, 2022. This project was

conducted across 23 drug rehabilitation centers in four valley districts of Manipur, ensuring rapid diagnosis and immediate treatment initiation for PWIDs. During the project, Hepatitis B screening was also conducted, and individuals who tested HBsAg non-reactive were provided Hepatitis B vaccination as a preventive measure.

PROGRAM OUTCOME

Since the rollout of NVHCP in July 2019, significant progress has been made in screening, diagnosis, and treatment of Hepatitis B and C in Manipur. By December 2024, a total of 216,963 individuals were screened for Hepatitis C, identifying 8,506 positive cases, of which 5,756 had confirmed viral load detection. Among those eligible, 5,087 individuals initiated treatment, and 4,085 successfully completed treatment, ensuring a high treatment adherence rate.

For Hepatitis B, since its integration into NVHCP in July 2021, screening has expanded, with 305,257 individuals tested by December 2024. Out of these, 1,939 tested positive, with 815 confirmed viral load detections. Among those eligible, 816 individuals were enrolled for treatment, and 758 remain under ongoing treatment, reflecting a strong commitment to long-term disease management.

These figures highlight NVHCP's impact in expanding access to screening and treatment, reducing the burden of viral hepatitis in high-risk populations, and ensuring better health outcomes through early detection and timely intervention.

FINANCIAL IMPLICATION

All the required screening kits, diagnosis and treatment were provided under the NVHCP.

SCALABILITY

Programme can be scaled up effectively since budget is covered under NVHCP.

UTTARAKHAND

DENGUE CONTROL MEGA CAMPAIGN

PROBLEM STATEMENT

The State had experienced a surge in dengue cases due to climate change and global transmission of particular Dengue Type-2 strain. Considering the past trend of an annual case load of 10,622 cases during the FY 2019-20, the State had anticipated a similar, or higher number of dengue cases for the FY 2023-24.

PROGRAM DESCRIPTION

Anticipating the case-surge, an intensive dengue control mega campaign was implemented in a systematic manner to prevent occurrence of any epicentre, outbreak and high transmission. To adequately contain spread of Dengue, “Hotspots” were identified where

clustering of dengue cases were notified. A Micro-Plan was prepared with roles and responsibilities of identified front line health care workers, Municipal workers and work force from other departments for identified areas with supervisory roles for robust monitoring. Intersectoral and Inter-convergent actions along with the Municipal corporation/ municipality were intensively taken in the identified hotspots to conduct source reduction, fogging and awareness activities. House coverage targets were given to all healthcare workers engaged in the mega drive.

Mass IEC and awareness campaigns were being conducted through hoardings, pole kiosk, audio video display, jingles, Hon'ble Chief Minister and Health Minister messages, media bites and Nukkad nataks (street plays). Full sleeve uniforms were made mandatory in all the schools. Control rooms were established in all the districts especially in Dehradun for resolving all admission, Treatment and Platelets related grievances of people. Platelet availability was managed by the control room, with the support of blood donors. 30% beds in all government and private hospitals were reserved for dengue treatment. Currently 2141 beds were reserved for dengue in Uttarakhand State.

PROGRAM OUTCOME

During the FY 23-24, a total of 1,12,377 houses have been surveyed by dengue volunteers. 9,67,159 containers/water tanks were inspected, out of which dengue larvae were found in 1,01,115 containers/water tanks. The identified breeding sites were cleaned, and penalties were imposed on person/institution by the Local Governing Bodies A total of 1,256 challans were issued in 2023. The concerted efforts brought a significant decrease in Dengue cases, with 4,320 ELISA positive cases in 2023 compared to 10,622 cases in 2019.

FINANCIAL IMPLICATION

No additional financial implications incurred.

MEGHALAYA

USE OF DIGITAL, MOBILE X-RAY MACHINES EQUIPPED WITH AI BASED TECHNOLOGY TO IMPROVE CASE DETECTION OF TUBERCULOSIS

PROBLEM STATEMENT

Meghalaya's challenging geography, with its mountainous terrain and remote hamlets, creates significant barriers to healthcare access. Poor road connectivity and financial constraints often delay patients from seeking timely medical consultations. The lack of adequate health infrastructure, particularly X-ray facilities, further limits early detection and

diagnosis of tuberculosis (TB). Additionally, a shortage of radiologists delays timely interpretation of imaging results, leading to missed or late diagnoses. As a result, undiagnosed and untreated TB cases continue to spread within families and communities, exacerbating the disease burden and affecting patient outcomes.

PROGRAM DESCRIPTION

The Government of Meghalaya has launched an initiative to enhance tuberculosis (TB) and lung disease screening by introducing door-to-door diagnostic services through digital hand-held X-ray technology. This approach is integrated into Active Case Finding (ACF) efforts and health melas, ensuring early detection and intervention in even the most remote and hard-to-reach areas.

To facilitate this, trained radiographers and lab technicians, along with local project managers, have been deployed to operate portable digital X-ray machines equipped with AI-enabled software (CHOCO software). These systems allow real-time image analysis and generate confirmatory reports by qualified radiologists, ensuring accurate and timely diagnoses. The initiative is further supported by two-wheeler-based mobile screening units, which are equipped with sputum sample collection and storage facilities, along with customized stands for X-ray machines and DR plates, enabling efficient home-based screenings.

Currently, five fully equipped mobile screening units have been deployed across five districts in Meghalaya, significantly improving access to diagnostic services and strengthening the state's TB control and lung health initiatives.

PROGRAM OUTCOME

Under the initiative, the total sites covered by December 2023 were 151 in 5 districts (East Khasi Hills, Jaintia Hills, Ri Bhoi, West Garo Hills & East Garo Hills). The initiative has achieved significant progress in detecting and managing tuberculosis cases. From December 2023 to November 2024, a total of 27,209 individuals were screened, with 27,125 undergoing X-ray examinations. During the 100 Days TB Campaign, an additional 11,276 screenings and 11,081 X-rays were conducted, demonstrating a high outreach and rapid case detection rate.

Among those screened, 1,512 cases showed radiological abnormalities over the 13-month period and 791 detected during the 100-day campaign, reflecting a 23.29% performance index in identifying abnormalities. Additionally, 7,722 sputum samples were collected, of which 37 tested positive, while the campaign alone contributed 4,470 sputum collections and 26 positive detections, leading to a 73.72% performance index in sputum positivity.

Furthermore, 190 individuals were diagnosed with LTBI over 13 months, with 64 cases detected in just 100 days, achieving a 7.62% performance index. These figures highlight the effectiveness of targeted screenings, the importance of rapid diagnostics, and the need for continued outreach and intervention efforts to ensure early TB detection and treatment initiation in Meghalaya.

FINANCIAL IMPLICATION

The initiative utilizes funding under the NTEP. The operational cost for each unit is 3,50,000 per month plus GST (18%), while the cost per X-ray, sputum transportation, and coverage per person amounts to 275, ensuring efficient resource utilization and financial sustainability for long-term implementation and scalability.

SCALABILITY

The initiative is scalable, as it can be sustained and expanded using available funds under the NTEP.

UTTARAKHAND

IMPROVED TREATMENT SUCCESS RATE IN A COHORT OF TB PATIENTS SUPPORTED BY NIKSHAY MITRA

PROBLEM STATEMENT

Tuberculosis (TB) remains a major public health challenge in India, accounting for nearly one-fourth of the global TB burden. To accelerate TB elimination by 2025, India recognizes the need to address not just medical treatment but also key socio-economic determinants such as undernutrition, food insecurity, and stigma. The bidirectional relationship between TB and undernutrition weakens immune response, hinders recovery, and impacts

treatment adherence. To tackle these challenges, the Government of India launched the Pradhan Mantri TB Mukt Bharat Abhiyan (PMTBMBA) on September 9, 2022, introducing the Nikshay Mitra program, which mobilizes individuals and organizations to support TB patients through monthly nutrition kits. Beyond addressing nutritional needs, the initiative fosters a compassionate support system that counters the stigma surrounding TB, encouraging social acceptance and improving treatment compliance.

PROGRAM DESCRIPTION

The support mechanisms offered by Nikshay Mitra in Uttarakhand are diverse and inclusive. Nikshay Mitra's actively provide personalized assistance to TB patients, ensuring a tailored approach to each individual's needs. The role of Nikshay Mitra extends beyond nutritional support, as they play a pivotal role in reducing the stigma associated with TB by fostering understanding and empathy within communities. Additionally, Nikshay Mitra may facilitate job opportunities for patients or their family members, providing a comprehensive approach to address financial insecurities. NGOs have stepped forward as Nikshay Mitra, extending their resources and expertise to contribute to the cause. Their involvement demonstrates the collaborative nature of the initiative, bringing together government bodies, individuals, and organizations to collectively combat tuberculosis.

On 27th December 2022, IOCL supported 304 TB patients in Haridwar district by distributing nutrition kit bags. This distribution was facilitated on a monthly basis by a non-governmental organization, Rajat Shahri Evam Gramothan Sansthan, Haridwar, which played a crucial role in maintaining regular contact with TB patients, distributing food bags, and offering essential psycho-social support. Meanwhile, the district and state TB cell ensured rigorous monitoring of the entire process, conducting regular health condition assessments and maintaining the consistency of treatment regimens. Essential diagnostic tests were performed at regular intervals to provide comprehensive healthcare to the patients.

PROGRAM OUTCOME

The CSR-NGO model resulted in a significant improvement in the treatment success rates of the cohort of 304 TB patients under this support. Out of the total 304 patients, 287 (94%) achieved TB treatment success. No mortality or loss to follow-up was reported in the supported cohort.

SCALABILITY

With the available evidence of improved success rates in the supported cohort of TB patients, the Indian Oil Corporation Limited is extending support to 501 more TB patients in Haridwar district under the same CSR-NGO driven model. The success witnessed in Haridwar district serves as a testament to the positive impact of CSR initiatives, community engagement, and government collaboration in enhancing TB treatment outcomes.

JHARKHAND

STRENGTHENING COMPREHENSIVE PRIMARY HEALTH CARE THROUGH COMMUNITY MONITORING AND SOCIAL ACCOUNTABILITY EXERCISE BY JAN AROGYA SAMITIS

PROBLEM STATEMENT

Community engagement plays a pivotal role in shaping effective and sustainable healthcare systems. The context we sought to address was the need for effective community engagement in healthcare systems, particularly in the Ayushman Arogya Mandir. AAM symbolizes community ownership and require continuous feedback, gap identification, and

issue resolution for improved service quality and utilization. To address this, GOI institutionalized a community-led committee called Jan Arogya Samiti (JAS) to enhance service delivery at Ayushman Arogya Mandirs. However, implementing government guidelines for JAS required a streamlined approach.

PROGRAM DESCRIPTION

The intervention aimed at piloting the operational aspects of JAS across 35 Ayushman Arogya Mandir - Sub Health Centres in Khunti and West Singhbhum districts of Jharkhand in a given period of 18 months.

The key activities undertaken for the process included a situation analysis to gain a comprehensive understanding of the Ayushman Arogya Mandir operations, constitution of JAS by selecting members according to GoI norms including consultation with Community Health Officer (CHO), Auxiliary Nurse Midwife (ANM), Accredited Social Health Activist (ASHA/Sahiya), AFs/Sahiya Sathi, BAF/BTT, DAF/STT and Panchayati Raj Institution (PRI) representatives for selection process. Finally, the Civil Surgeon of the District approved and recommended the list, establishing JAS for all 35 Ayushman Arogya Mandir. Health visioning

and health planning were carried out in all 35 intervention Ayushman Arogya Mandir including transit walks, seasonality analysis, development of a Chapatti diagram and Focused group discussions for Health Visioning to develop a Community Health Plan. Monitoring was also conducted through monthly meetings of JAS, patient satisfaction surveys, annual public dialogue, social accountability exercise and a Technology (IVRS) Based Community Monitoring System.

PROGRAM OUTCOME

As a part of the pilot, the JAS committee was constituted in all 35 intervention facilities across Khunti and West Singhbhum districts of Jharkhand constituting a total of 676 JAS members. These 676 JAS members includes 305 (45.12%) Health Functionaries such as Medical Officer, CHOs, ANM and ASHA and 371 (54.88%) Non-Health Functionaries such as PRI representatives, VHSNC members, Women Self Help Group Members, School Health Ambassador, Peer Educator, and Special Invitees such as Tuberculosis survivor, Youth representatives and "any male" who has undergone sterilization after one / two children. A total of two Social Accountability Exercises were done in each of the 35 intervention facilities. The average number of participants in social accountability exercise has increased from 29.5 to 35.5 in Cycle 1 to Cycle 2. 448 JAS carried out patient satisfaction surveys throughout the pilot and high satisfaction scores were reported from patient satisfaction surveys in facilities where JAS has been constituted. The overall average patient satisfaction scores monthly were around 21.42% in February 2023 as compared to only 15.96% in April 2022. The pilot also witnessed improvement in service utilization statistics. The quarterly average OPD footfall from April to June 2023 increased by 1207.

FINANCIAL IMPLICATION

Nil.

SCALABILITY

The program has been scaled up across all AAM facilities in the state by NHM Jharkhand. It can be replicated across all states.

MEGHALAYA

ASHA FIRST PAYMENT APPLICATION

PROBLEM STATEMENT

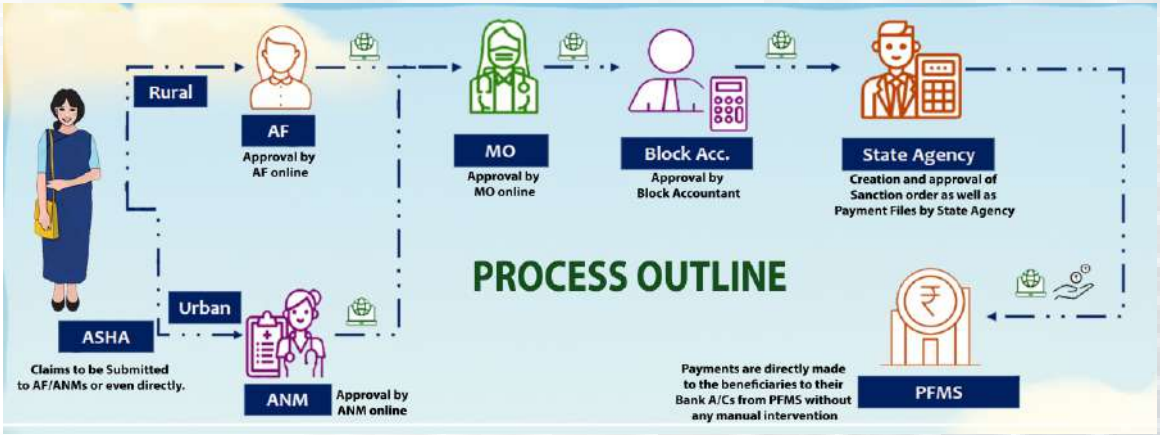
The ASHA programme was introduced as a key component of the community processes intervention under the National Health Mission in the year 2005. The programme has emerged as the largest community health worker programme, and is considered a critical contributor to enabling people's participation in heath. ASHA is primarily an “honorary volunteer” selected from the community she resides in and is eligible for performance-based incentives offered under various national health programmes as compensation for

her work as a health Volunteer. Currently, the total Number of ASHAs registered and approved in the application is 7084.

PROGRAM DESCRIPTION

The State has implemented an end-to-end DBT application of payments to ASHAs with the sole purpose of easing the payment process and ensuring timely disbursement of the same. The application is also an important support tool for programme officers at all level as it enables regular monitoring and tracking of ASHA payment and ensure minimum time lag in payments. With this application, the ASHAs make their claims directly through Smart phones or a laptop, the objective of which is to ensure that timely payments are made.

Through this application, the ASHA raises her claim directly through her smart mobile phone or a laptop/desktop, and forwards it to the ASHA Facilitator (in rural areas)/ ANM (urban areas). The ASHA Facilitator (in rural areas) /ANM (in urban areas) verifies and then forwards the claim to the Medical Officer, the Medical Officer after verification submits it to the Block Accountant, the Block Accountant to the State for final payment, and finally payments are directly made to the account of the ASHAs.



PROGRAM OUTCOME

The application has been successfully rolled out across the State, enabling claims made through the application to be released for payment to ASHAs within 5-7 days of being raised. The application ensures increased accountability, timely and transparent online payments to ASHAs, and the online generation of reports, eliminating the need for manual reporting. Additionally, it allows for effective monitoring of ASHAs' performance and the overall program uptake at the community level.

So far, the total amount of claims registered through the ASHAFirst application is Rs. 72.86 crore, out of which Rs. 69.03 crore (94.7%) has been paid.

FINANCIAL IMPLICATION

The initiative is funded by the National Health Mission (NHM).

SCALABILITY

The initiative is scalable provided it leverages the existing human resources and technology.

CHHATTISGARH

WEB-BASED PERFORMANCE LINKED PAYMENT SYSTEM IN NHM CHHATTISGARH: "REVOLUTIONIZING HEALTH SYSTEMS MANAGEMENT THROUGH TECHNOLOGY"

PROBLEM STATEMENT

In the realm of healthcare, motivation and accountability are pivotal for delivering quality services. The Ayushman Bharat initiative, with its focus on Comprehensive Primary Health Care through Ayushman Arogya Mandir (AAM), recognizes this through its Performance

Linked Payments (PLP) strategy. This strategy aims to bolster motivation, ensure high-quality service delivery, and maintain accountability for health outcomes. The PLP assessment system faces significant challenges including lack of structured systems for incentive claim verification and payment, persistent delays in claim submission and verification, delayed payment processes, absence of robust performance monitoring mechanisms and underutilization of financial provisions.

PROGRAM DESCRIPTION

The NHM Chhattisgarh understood the challenges through multi stake holder joint review and field study and planned to simplify the process of Performance reporting and automated process of submission data validation and payment system. A cornerstone of this initiative is the development of a specialized software and mobile application by the National Informatics Centre (NIC), aimed at streamlining performance reporting and automating data validation and payment processes.

The objectives of the software are to establish a transparent and efficient Performance Linked Payment system, enable accurate measurement and timely reporting of CHOs & HWC team performances and facilitate swift disbursement of. This system is designed to integrate seamlessly with existing health department software, creating a cohesive digital ecosystem. It encompasses various management modules including: A web/mobile-based

interface for ease of access, a CHO module for facility registration, team building, and monthly PLP entry, a Block Module for HRMIS updates, target verification, and payment processing and a District/State Module for overall monitoring and administrative approvals. lock Data Managers recheck the data and payments are authorized by BMOs through OTP authentication. Disbursements are made by Block Account Managers through PFMS.

PROGRAM OUTCOME

Of the 3500 Community Health Officers in the state, over 2800 (80%) received incentives by November 2023. The payment of incentives increased from 56% in 2022-23 to 80% by November 2023. The system also provides CHOs with easy access to their information and historical data. Online submission reduces delays and data loss risks. Real-time monitoring is enabled at all administrative levels. CHOs are graded and incentivized based on performance. The program has also contributed to enhanced motivation of CHOs.

FINANCIAL IMPLICATION

This project, developed in-house by NIC Chhattisgarh, incurred no additional development costs, showcasing cost- effectiveness and resource efficiency.

SCALABILITY

The system's design, rooted in NIC's robust framework, is user-friendly and adaptable, making it a viable model for replication across the country.

ASSAM

SWASTHYA SEWA UTSAV

PROBLEM STATEMENT

Quality assessment at the primary and secondary level of healthcare facilities is a crucial component in ensuring quality service delivery and comprehensive care provision. The Government of India has aimed at ensuring 100% NQAS certification in the country by December 2026, and steps have to be taken at the grassroots level to ensure compliance to the standards for quality health service delivery to all.

PROGRAM DESCRIPTION

"Swasthya Sewa Utsav" is an initiative to assess the quality of the service providers and service delivery of the health institutions. The objective of the program is to assess the health institutions, its infrastructure, human resource and quality of services rendered through independent assessors to attain quality of services in each health facility. Evaluation was done in two phases: Internal Assessment (by respective Medical Officer in-charge of the health institution along with one trained Assessors) and the second was an External Assessment by External Assessor (by the team of external assessor comprises of two assessors: one senior officer from the district and another one is from faculty of medical college). Further, External Evaluators (Hon'ble Minister, Hon'ble MP, Hon'ble MLA, Senior Officers IAS/ IPS/ IFS/ ACS) also visited the health facilities during the external assessment.

A comprehensive checklist has been developed for the assessment. The check list covers all parameters of IPHS 2022, DH Ranking, AAM-PHC Grading, CHC Grading and important parameters of NQAS, Kayakalp and all programmes. A portal (https://swasthyautsav.assam.gov.in/) was developed to capture checklist filled out by Internal Assessor, External Assessor and External Evaluators. A comprehensive Dashboard is also included in the portal. External evaluation of 1st round of Swasthya Sewa Utsav was carried out from 6th to 8th April 2023, in which 1245 facilities were assessed. The 2nd round of Swasthya Sewa Utsav was conducted from 20th to 22nd November 2023 followed by direction of Hon'ble Chief Minister. A total 1259 health facilities (DH, SDCH, CHC and AAM-PHC) were covered in the assessment. In the 3rd round, held from 3rd to 5th December 2024, a total of 1599 facilities were assessed including primary and secondary level facilities.

PROGRAM OUTCOME

In the first round of assessment a total of 1,245 health facilities were assesses, out of which, 153 (12%) scored Grade A, 607 (49%) scored Grade B and 485 (39%) scored Grade C. In the 2nd round, out of the total 1259 facilities assessed, 731 (58%) scored Grade A, 457 (36%) scored in the Grade B category and 71 (6%) scored in the Grade C category.

FINANCIAL IMPLICATION

No additional cost implications

SCALABILITY

The program can be scaled up effectively across states.

GUJARAT

HEALTHCARE LEADERSHIP ENHANCEMENT PROGRAM (HLEP)

PROBLEM STATEMENT

The Department of Health & Family Welfare, Government of Gujarat along with the National Health Mission Gujarat envisaged a program for Enhancing Healthcare Leadership initiative through training and mentoring under "innovation" as part of its annual Programme Implementation Plan. The State Health System Resource Centre – Gujarat (SHSRC-G) is the nodal agency.

PROGRAM DESCRIPTION

A total of 48 Senior cadre officials of Gujarat Health system went through systematic mentoring and training program over the period of one year. Leadership training experts from premier institutes like IIPHG, IIM-A, IITs, MICA, & Others. The program design is combination of three things including, training residencies, in-between mentoring sessions and continuous hands-on experience of training skills through specially designed practice assignments followed by one week visit to other state- Tamil Nadu. It addressed crucial areas like decision making, stress management, media management, negotiation, financial management, Change management, leadership communication and system transformation etc. The program also employed a diverse range of pedagogical tools, including case study discussions, simulation exercises, role-playing, crisis communication activities, movie analysis, and self-administered psychometric assessments. Mentoring sessions were conducted by prominent figures in the fields of public health and healthcare. The real-world experiences and challenges faced by these health officers were integrated into specially crafted case studies for the leadership program. At the end of the program, five days visit to other state (Tamil Nadu) was conducted to exchange and observe best practices and innovation by health department.

The valuable feedback was collected through a feedback form provided to the participants during the last residency program. The survey aimed to understand the overall experience of the participants on different aspects of training program such as different sessions provided by the experts, transferability, practice assignments and mentoring sessions and field visit.

PROGRAM OUTCOME

The program has the potential to develop leadership and problem-solving skills among healthcare staff.


GENROBOTICS

MEGHALAYA

VILLAGE HEALTH COUNCILS

PROBLEM STATEMENT

As a Sixth Schedule state, Meghalaya lacks elected community-level institutions which can take ownership of local health and nutrition challenges. Moreover, existing traditional community institutions do not have representation for women, and lack a focus on discussion of health and nutrition issues.

PROGRAM DESCRIPTION

The objective of the VHC is to act as the nodal community institution that will mobilise action on health and nutrition issues, and serve as a critical link between the state health systems and community members. The council serves as a platform to generate demand for healthcare services, lead awareness campaigns, and help disseminate IEC materials on health, nutrition, and positive parenting. It coordinates with the Sector Team, including MO, BDO, CDPO, BPM (NHM), BPM (MSRLS), ANM, AWW, and ASHA, to hold state systems accountable for service delivery by highlighting gaps and needs. The council also discusses common health challenges, facilitates local problem-solving and action, and implements health infrastructure projects based on community needs.

The VHC in comprised of a General Body which has all adult members of the village above 18 years of age, an executive committee (EC) which has 10-20 members elected by the village (each member represents a group of households, and 50% of the members are women). The EC is re-elected every 3 years. The leadership comprises the Chair, who is the village headman; the Co-chair, who is the president of the VO; and a Secretary, who is an active EC member, except for ASHA, ANM, or AWW. ASHA, ANM, and AWW, along with CGHA and teachers, are also permanent members of the VHC.. The state is also strengthening the VHCs through a VHC IEC book that contains information on various health & nutrition related topics, a VHC register to help maintain the record of activities, attendance and finances and a seed fund to help VHCs hold regular meetings and undertake promotive & preventive actions on health & nutrition. The state has also developed a VHC app for record maintenance and to access the information about VHCs, including expenses and status of the mothers and children in the village, for decision making purposes.

PROGRAM OUTCOME

Under the initiative, VHCs have been established in 6796 villages , of which, 96% have been trained. Around 78% of the VHCs have bank account, and as of the latest data, 31,224 VHC meetings have been conducted.

FINANCIAL IMPLICATION

An amount of Rs. 10,000 is being given to the VHC as an untied fund every year. An additional amount of Rs. 10,000 from the state resource is given to the VHCs who have utilized 80% of the untied fund. Additionally, an award amount of Rs 10,000/- have also been provided to the VHCs who fulfil certain criteria (>90% ID/last year; No teenage pregnancy; Gap of 3yrs or > in 80% cases of births during last year.) from the Chief Minister Safe Motherhood Scheme (CMSMS).

SCALABILITY

The program can be scaled up effectively across states.

ARUNACHAL PRADESH

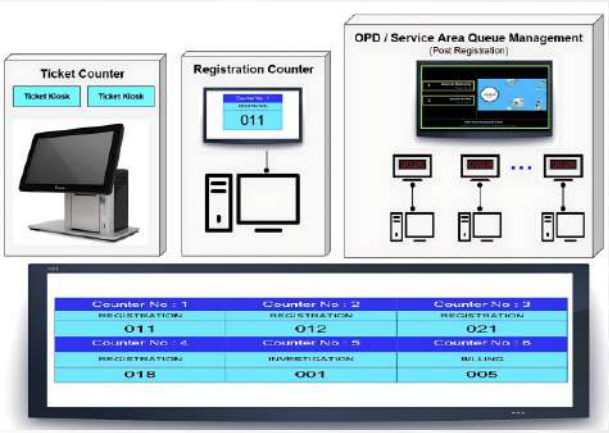
iHMIS

PROBLEM STATEMENT

On the 74th Independence Day, Prime Minister Narendra Modi announced the National Digital Health Mission (NDHM), launched on 15th August 2020, rooted in a 2018 NITI AAYOG proposal. The mission ensures seamless healthcare through robust information technology, creating a National Digital Health Ecosystem for universal health coverage that is efficient, accessible, inclusive, affordable, and safe, while safeguarding personal health information. On 27th September 2021, the NDHM was rebranded as the Ayushman Bharat Digital Mission (ABDM) nationwide. The ABDM connects digital health solutions across

hospitals, streamlining processes and offering facilities like OPD registration, e-prescriptions, digital consultations, and seamless insurance claims under CMAAY - PMJAY, with all medical records securely stored and linked to "Health ID – Ayushman Bharat Health Account (ABHA) / ABHA Card." This iHMIS foundation aims to bridge gaps in the healthcare ecosystem through digital means.

PROGRAM DESCRIPTION



C-DAC's e-Sushrut Hospital Management Information System is a major step towards adapting technology to improve healthcare. The proposed hardware and networking solution for the iHMIS is an online centralized hosted model, built on a multi-node cluster in a cloud environment at the CDAC Data Center. This model will utilize on-demand provisioning of computing resources, ensuring network and internet redundancy in hospitals for high availability. Servers will be configured in a fail-over and load-balancing environment to provide uninterrupted access and data safety. The project will be implemented under a hosted model, with modules customized and deployed at the CDAC Data Center. Upon issuance of the work order, DH&FW and C-DAC will conduct a kickoff meeting to discuss the project plan and identify nodal officers. C-DAC will deploy the base e-Sushrut HMIS application, followed by a verification process and customization based on identified gaps. Dept. of H&FW will issue certificates at each milestone, and C-DAC will release master data templates for health facilities. User IDs and access roles will be created, and end-user training will be conducted. The customized

application will then go live statewide, with ongoing technical support and awareness initiatives by the on-site PMU team. Key areas of development include implementing the Hospital Management Information System and facilitating telemedicine services. Challenges, such as lack of internet connectivity, were addressed by deploying a customized offline version of e-Sushrut. The project, funded under various schemes, was initiated in large hospitals and gradually rolled out to all health facilities, with teleconsultation hubs and devices deployed to enhance healthcare delivery.

PROGRAM OUTCOMES

The iHMIS portal, now live at https://hmisar.dcservices.in, has significantly enhanced transparency and efficiency in healthcare delivery across all levels in the state. Modules such as OPD Registration, Emergency Registration, Billing, Doctors Module, Investigation, IPD, ADT, MRD, and Enquiry are fully operational on the e-Sushrut/e-Swasthya Seva Arunachal platform. Real-time data on patient registrations, billing, e-prescriptions, and specialty visits are accessible to medical administrators at various levels. The state government has strengthened IT infrastructure in health centers, including networking, desktops, and laptops for 726 doctors, facilitating e-prescriptions and teleconsultation. Exceptional achievements include the establishment of a comprehensive telemedicine network with 308 spokes registered on the e-Sanjeevani in AAM portal, and 1,466 healthcare professionals and 300 health facilities registered under the Ayushman Bharat Digital Mission (ABDM). Additionally, 3,31,000 ABHA/Health IDs have been created, with 1,85,575 health records linked to these IDs. Digitalization has empowered citizens to securely access and manage their health records, while e-prescriptions ensure transparency in medication prescriptions. Real-time data on patient registrations, billing, and doctors' activities are accessible to the government. This digital transformation, funded under various schemes, has created a sustainable and replicable model, with health records linked to ABHA IDs available nationwide on patient consent, facilitating seamless insurance claims under CMMAY/PMJAY.

FINANCIAL IMPLICATION

Cost of HMIS covering MCH/DH/SDH/CHCPHC for a project duration of 3 years covering a total of 132 facilities would be around 91.26 Lakhs for software maintenance support and allied services, and costing of HMIS Hosting and DC platform management services for 3 years will be around 48.6 lakhs. In case DH&FW decided to migrate the application to Local Data Center or any other Data Center, the migration charges INR 15.00 Lakhs + Applicable Taxes would be charged additionally. Additional charges for some optional services will be levied if required.

SCALABILITY

The sustainability of this public utility service in healthcare delivery hinges on uninterrupted, high-bandwidth internet connectivity across all health centers and the timely updating and training of healthcare professionals in the digital health ecosystem. Replicating this scheme up to AAM and digitalizing at the ASHA level through app-based health data capture would complete and strengthen the digital transformation at the primary care level, ensuring comprehensive and effective healthcare delivery.

GOA

GOA STROKE PROGRAMME

PROBLEM STATEMENT

According to NFHS-5, the prevalence of hypertension among men in India is 24%, while in Goa, it is 18%. Among women, the prevalence is 21.3% in India and 13% in Goa. Given the rising burden of stroke cases, it is crucial to ensure timely access to stroke care through public awareness, training healthcare professionals, and implementing protocols for rapid assessment, diagnosis, and treatment. In Goa, the Department of Neurology at Goa Medical College has played a pivotal role as the only government hospital equipped to provide thrombolysis for stroke patients.

PROGRAM DESCRIPTION

The Goa Stroke Programme, is a landmark initiative modeled after the successful STEMI-Goa Project. Launched in collaboration with the Directorate of Health Services and the Department of Neurology at Goa Medical College (GMC), this program aims to enhance stroke care across the state. Since January 2023, the program has been operational in both North Goa District Hospital (NGDH) and South Goa District Hospital (SGDH), ensuring timely and specialized treatment for stroke patients.

To facilitate rapid diagnosis and treatment, GMC, NGDH, and SGDH are all equipped with CT scan facilities, enabling immediate assessment of patients with stroke symptoms. Patients exhibiting warning signs of stroke are transported directly to these hospitals via the 108 ambulance service. In cases where patients or their relatives insist on visiting a peripheral health facility before reaching a district hospital or GMC, the 108 ambulance personnel must notify the nearest PHC to ensure staff preparedness. Additionally, trained 108 ambulance personnel activate a "Stroke Alert" at the designated District Hospital, allowing the stroke team in the emergency department to be fully prepared for patient arrival.

Upon reaching the hospital, stroke patients undergo an urgent medical examination before being prioritized for a CT scan in the radiology department. If the CT scan confirms the presence of a brain clot, patients are promptly administered Inj. Tenecteplase 20 mg, a thrombolytic agent, within the golden window of 4.5 hours from symptom onset. These life-saving interventions, aimed at reducing stroke-related disability and mortality, are provided free of cost, ensuring equitable access to high-quality stroke care across Goa.

PROGRAM OUTCOME

It has been observed that stroke patients at the District Hospital who receive thrombolytic treatment within 4.5 hours of symptom onset achieve superior outcomes. From January 2023 to February 2025, a total of 103 patients underwent thrombolysis across both District Hospitals.

FINANCIAL IMPLICATION

The stroke management programme in Goa is currently funded by the National Health Mission (NHM) through the NP-NCD programme.

SCALABILITY

The initiative is scalable provided it leverages the existing human resources and technology.

UTTARAKHAND

HOUSEHOLD CONTACTS OF TB PATIENTS ON TB PREVENTIVE TREATMENT USING E-SANJEEVANI TELEMEDICINE

PROBLEM STATEMENT

Since a large part of Uttarakhand has tough geographical terrain, mobilizing 'healthy' household contacts to visit health facilities for medical consultation is challenging. To overcome this barrier, the Joint Effort in Elimination of Tuberculosis, supported by the National TB Elimination Program, has adopted an innovative approach using telemedicine. The eSanjeevani hub of the National Health Mission serves as a platform for hosting an

online TB clinic, actively facilitating the screening of household contacts of Drug-Sensitive TB patients.

PROGRAM DESCRIPTION

Medical officers were selected and trained on the preliminary usage of eSanjeevani. In implementing telemedicine for TPT, healthcare staff serve as the primary point of contact with household contacts of index patients. They visit the households, connect the families with an online doctor, and facilitate virtual consultations. The doctors counsel index TB patients on treatment adherence and conduct symptomatic screening for all household members. Based on discussions with the family, relevant prescriptions are generated at no cost. Staff then mobilize family members for diagnostics or initiate preventive treatment as per the prescription. This process also aids in the early identification of TB presumptive cases, ensuring prompt referral for TB diagnostics.

PROGRAM OUTCOME

The intervention was initiated on January 10, 2023, and as per preliminary results until March 2023, 40 teleconsultations have been conducted with the household contacts of index patients.

SCALABILITY

The preliminary results also emphasize the importance of expanding this model to every location and incorporating more specialists into the panel to enhance its effectiveness.

ASSAM

POKHILA: CUSTOMIZED HEALTH SOLUTIONS "LEAVING NO ONE BEHIND" BY OPTIMALLY USING ALL AVAILABLE COUNSELORS, ENGAGED UNDER DIFFERENT HEALTH PROGRAMS UNDER THE BANNER "POKHILA"

PROBLEM STATEMENT

POKHILA is an Assamese word, which means "Butterfly". The way "butterfly" flies from one flower to another and carries sweet fragrance, in the same way, state has decided to bring all counselors engaged under different health programs with the tag name "POKHILA"

and to use the counseling expertise of all Counselors so as to ensure that people (target group) take the messages from counselors and expected behavioral changes are seen towards positive health care. Bringing counselors under one banner (by breaking the program wise boundary) has given counselors a sense of honor, as they will find themselves making a larger contribution to overall health improvement. This initiative aims to ultimately improve health seeking behaviour and it has been making health systems more responsive to the community needs.

PROGRAM DESCRIPTION

Team POKHILA is developed as a state specific initiative under the leadership of MD, NHM. The program was rolled out with the goal of strengthening the Art of Counseling to emerge as a role model for frontline health workers in reaching out to community and to have a cadre of motivated program advocates with comprehensive understanding of the health issues. The Psychologists/Counselors or those having an academic background on Psychology or Social Work are the Brain and spine of the program. A Counselor leads the team at the health block level and is helped by Block coordinator, Block community mobilizer, Asha Supervisor and Multipurpose Worker. Their work includes supporting high-risk pregnant women, addressing the needs of families with children diagnosed with Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM), especially those resistant to intervention. Additionally, they play a pivotal role in counseling to prevent teenage marriages, reintegrate out-of-school children, and provide guidance and support to adolescents dealing with gender-based violence.

The Block Counselor prepares case report of each case, according to a given format. S/he then forwards the report to the Block Coordinator who does the compilation of the report of the block. The Block Coordinator then forwards the compiled block report to the respective District Media Expert (DME). The DME compiles the district report and

forwards it to the State Team. The State team does continuous evaluation of the performance of the Team POKHILA based on these reports and ground inputs.

PROGRAM OUTCOME

Multiple success stories have been reported by the districts, that due to timely intervention by the POKHILA team members, the target person / family could be mobilized and could be saved from the disaster – be it early marriage or not taking vaccination or not opting for institutional delivery etc. The report of such team is compiled at state level for further analysis. The total number of resistance cases catered to till February 2025 were 1410, and almost 90% of the cases saw a successful outcome for the issue.

FINANCIAL IMPLICATION

No cost was involved in conceptualizing this innovation and in execution. Optimum utilization of the counsellors engaged is being done through the initiative.

SCALABILITY

This no cost innovation has huge potentiality to further scaling up. The scalability potential of this initiative is significant due to its cost-effective model and the streamlined use of existing human resources.


AWARENESS CUM COUNSELLING
ON HEALTH ISSUES IN TEA GARDENS
BY TEAM POKHILA
DISTRICT HEALTH SOCIETY, DIBRUGARH

BIHAR

BIHAR'S PIONEERING EFFORTS: ADVANCING IMMUNIZATION WITH DIGITAL MICRO-PLANS, TELE-CALLING, AND IMPROVED MONITORING STRATEGIES.

PROBLEM STATEMENT

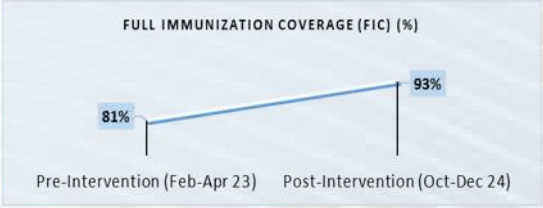
A strong national immunization program requires efficient data collection, analysis, and reviews for monitoring and accountability. The presence of regularly updated and representative data can enable strong policy formulation and ensuring last mile delivery of immunisation services. However, challenges persist in leveraging data for decision-making and performance tracking.

PROGRAM DESCRIPTION

The tele-calling monitoring initiative in Bihar is a systematic, state-level effort involving 14 program experts who make scheduled calls on session days to frontline workers (FLWs). This initiative gathers data across key programmatic indicators over time to identify gaps and address them promptly. The initiative evolved through four key phases. In the Ideation Phase, Bihar's immunization division studied existing health initiatives, securing approval from state health leadership to implement tele-calling in alignment with the digital Micro-plan. In the Creation Phase, guidelines were formulated, including a structured calling schedule tied to Village Health, Sanitation & Nutrition Days (VHSND), an empathetic calling approach, and a targeted data collection strategy using 12 fixed and 3 flexible indicators. The Implementation and Data Collection Phase saw program experts making 4-5 empathetic calls daily, covering 534 planning units across 38 districts, generating insights from 144 sessions per day and 2,304 sessions monthly. Calls were conducted using random sampling to ensure broad coverage. Finally, in the Utilization Phase, the insights derived from tele-calling contribute to program improvement by informing decision-making at planning units through daily analytics reports. While effective, the initiative is moderately resource-intensive, requiring significant manual effort for both calls and data entry into Google Sheets.

PROGRAM OUTCOME

From May 2023 to December 2024, sessions per micro-plan improved by 9%, vitamin A availability by 19%, PCM syrup by 79%, MCP cards by 12%, anaphylaxis kits by 78%, and IEC materials by 65%. Bihar's Full Immunisation Coverage (FIC) also saw an improvement since the inception of the initiative, with an increase of 12% FIC between February 2023 and December 2024.

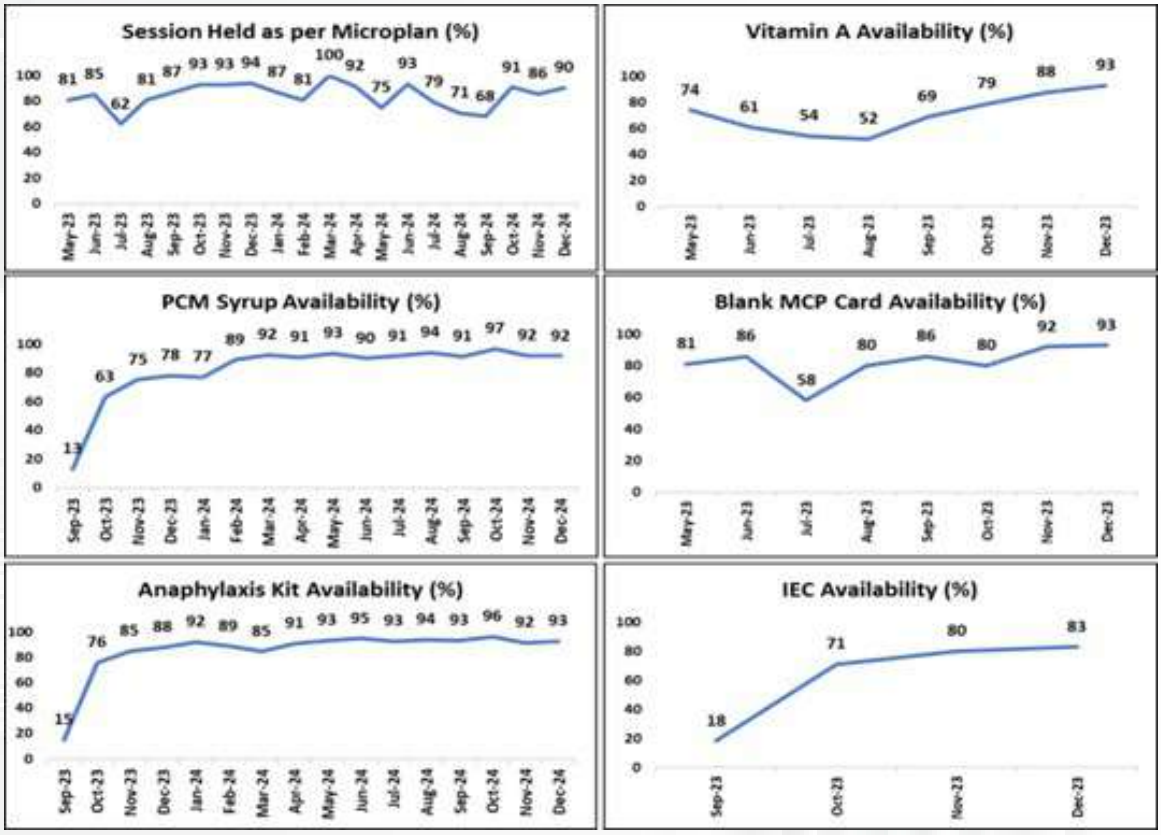


FINANCIAL IMPLICATION

There is no additional financial implication for the initative.

SCALABILITY

The program requires additional HR capacity to be deployed in order to provide tele-calling services through program experts, and thus, may impose additional costs to the budget. Hence, the scalability may be low for the initiative.



BIHAR

SHRAWAN SHRUTI PROJECT, GAYA

PROBLEM STATEMENT

Hearing loss hinders communication, leading to academic struggles and limited job opportunities. In India, 63 million people have significant auditory impairment, with Bihar carrying a substantial share of this burden. As a resource-constrained state, Bihar faces challenges such as low awareness, lack of diagnostic tools, shortage of skilled professionals, and limited post-surgical rehabilitation, causing delays in diagnosis and intervention for

hearing-impaired children. Early detection can prevent most cases, ensuring timely treatment for language development, social skills, and overall well-being.

PROGRAM DESCRIPTION

Shrawan Shruti adopts a multi-pronged approach, encompassing screening programs, medical and surgical interventions, therapy, and ongoing support services. The Otoacoustic emission (OEA) screening identifies children with hearing disabilities, categorizing them into temporary and permanent impairment. Temporary cases undergo conservative treatment, while those with permanent impairment receive cochlear implants. The family-centered approach ensures that the family's role is acknowledged and integrated into the care process, enhancing the overall effectiveness of the intervention.

Trained counsellors initiate the process by providing information and counseling to families, emphasizing the importance of early detection and intervention for hearing impairments in children. A collaborative effort between health officials, community workers, and relevant stakeholders creates a comprehensive work plan including details of location, dates, logistics, required resources, and roles and responsibilities for the screening camp. Coordination with local health authorities, SHGs, and community organizations to pool resources such as medical equipment, transportation, and personnel is ensured. Screening camps are organized at Anganwadi Centers, strategically selected as nodal points for accessibility and community reach as per micro plan.

Trained personnel, including health workers and audiologists, administer OAE tests to identify hearing impairments in children. Children who show positive results are carefully identified for further evaluation. Children identified with hearing impairments are referred to the District Early Intervention Centre (DEIC) in Gaya for a comprehensive diagnosis and treatment plan. Detailed medical assessments, including Brainstem Evoked Response

Audiometry (BERA), are conducted at the DEIC. Children with positive BERA results, indicating severe hearing impairment, are referred for free cochlear implant surgery. The surgery is performed at reputed medical facilities such as AIIMS Patna or Dr. S. N. Mehrotra Memorial ENT foundation, Kanpur.

PROGRAM OUTCOME

The Shravan-Shruti Initiative had a far-reaching impact, screening 4,25,911 children across 2,659 Anganwadi Centres, including remote and underserved areas, ensuring early diagnosis and treatment for economically weaker families. As a result, 1,769 children received treatment, 70 underwent cochlear implant surgery, and 1,839 children regained hearing and speech through therapy. The overwhelming success of this model has also inspired the Government of Bihar to launch the state-funded "Bal Shravan Yojna", expanding hearing care services across the state.

FINANCIAL IMPLICATION

While the initial investment in screening programs, medical interventions, and support services is considerable, the long-term benefits far outweigh the cost. The cost-effectiveness is further enhanced by the project's emphasis on resource pooling and collaboration, maximizing the impact of available resources. On every cochlear implant, there is an approximate cost of 800,000 involved and that is borne by State Government and partners together. There is a Memorandum MOU between Gaya district and Late Dr. S. N. Mehrotra Memorial ENT foundation which is empaneled in Government of India Scheme of Assistance to Disable Person scheme (ADIP). The Health department has borne the cost of screening camps and OAE & BERA tests using in-house experts, providing hearing aids, free speech therapy and free ambulance and transport services. Meanwhile, AIIMS, Patna and Mehrotra Hospital, Kanpur have covered the cost of cochlear implant, including free speech

therapy and follow-up sessions, as well as accommodation for the family. Integrated Child Development Services Scheme program (ICDS) has supported in mobilization and screening of Children and with spreading the awareness about the project.

SCALABILITY

The Shrawan Shruti project's easily replicable design positions it as an ideal model for other healthcare systems. Its success in addressing the diverse needs of children with hearing loss makes it adaptable to various settings. Collaboration with local and out of the state partners can facilitate the expansion of the initiative, ensuring its reach to a larger population.

BIHAR

FAMILY PLANNING CONVERGENCE PROGRAMME

PROBLEM STATEMENT

Bihar faces significant challenges in reproductive health, reflected in its Total Fertility Rate (TFR) which remains far above the replacement fertility rate. Although Bihar's TFR decreased to 3.0 by 2019-21 (NFHS 5), it still remains well above the replacement rate, while India's TFR dropped further to 2.0 (NFHS 5). Additionally, Bihar's modern contraceptive prevalence rate (mCPR) is significantly lower than the national average. In

2019-21 (NFHS 5), Bihar's mCPR was only 45%, compared to India's 56%, pointing to the limited use of family planning methods in the state. The use of reversible contraceptive methods remains particularly low (NFHS 5), with injectable contraceptives (Antara) at just 1.2% and weekly pills (Chhaya) at 15%. Alongside these issues, as per NFHS 5, the state also faces a high unmet need for family planning and a significant prevalence of early marriage, further complicating reproductive health outcomes.

PROGRAM DESCRIPTION

The Family Planning Convergence Program (FPCP) is a collaborative initiative between the Health Department and the State Rural Livelihoods Mission (SRLM) aimed at improving family planning uptake in Bihar. The program's objectives are to reduce the Total Fertility Rate (TFR), increase the modern contraceptive prevalence rate (mCPR), and empower women. The program began with a pilot phase in 2022-23, covering 10 blocks across 5 districts (Aurangabad, Jehanabad, Sheikpura, Lakhisarai, and Sheohar), with plans for a scale-up phase in 2024-26, expanding to all blocks in these districts. FPCP utilizes JEEViKA's Self-Help Group (SHG) cadres, including Community Mobilisers (CM), Community Nutrition Resource Persons (CNRP), and Master Resource Persons (MRPs), who work to create an enabling environment for family planning, address social norms, and encourage decision-making for young couples. The program provides incentives to encourage participation and form peer groups to focus on delaying, spacing, and terminal methods of contraception. Monthly meetings at the village level promote awareness, while health cadres collaborate with SHG members and ASHAs to facilitate access to services, dispel myths, and offer ongoing support, ultimately striving to improve reproductive health outcomes and empower women across Bihar.

PROGRAM OUTCOME

The FPCP has proven effective in increasing contraceptive use, particularly among Self-Help Group (SHG) members. 90,776 eligible couples have been line listed. 72% of the eligible couples have been linked with the ASHAs for any kind of family planning methods, and 75% of the eligible couples have adopted FP methods. There has been 6% improvement in mCPR in the intervention districts, with a 4.4% reduction reported in the unmet need.

FINANCIAL IMPLICATION

Nil

SCALABILITY

The program may be scaled with the State to address unmet need and improve the FP methods uptake,

HIMACHAL PRADESH

HOW TO ACHIEVE "TOBACCO END GAME" BY 2030

PROBLEM STATEMENT

The National Family Health Survey (NFHS)-5 in 2019-2020 reported that the smoking prevalence in the state of Himachal Pradesh was 32.3% among men and 1.7% among women which was more than the overall prevalence of the country (32.7%). The state has shown a significant reduction in tobacco use from 22% to 11% in Global Adult Tobacco Survey (GATS)-2 and Second-Hand Smoke (SHS) exposure from 82.5% to 19.5% at homes till 2022. The tobacco use is the main reason for high load of lung cancers and COPD in the

state. Himachal has set an ambitious target of reducing the tobacco use below 5% by 2040 as Tobacco endgame under SDG targets.

PROGRAM DESCRIPTION

Tobacco control journey started in the year 2007-08 in the state under the chairmanship of the Chief Secretary. All Secretaries, Head of Departments were sensitized about the need for tobacco control. Subsequently the necessary orders and directions were issued to all the enforcers. It was decided to make Shimla city a model Smoke Free city. A massive campaign was started in Shimla city and based on the compliance assessment Shimla city was declared as Smoke Free by Honorable Chief Minister on 2nd October 2010.

The state notified state, district, block level flying squads and more courts to expedite the enforcement efforts. Awareness notices were issued through the civil society and via print media. The funds collected as fine under COTPA enforcement are being used for financing tobacco control. The state took a lead in the country for search & seizures under Section 5&7 of COTPA, 2003 and launched prosecutions which resulted into convictions. Additionally, the state imposed a ban on Electronic Nicotine Delivery Devices (ENDS), issued the notification for Article 5.3 of Framework Convention on Tobacco Control (FCTC), enacted Vendor Licensing Act, 2016, established 100 'Nayi Disha Kendras' to support tobacco cessation, issued Tobacco Free Educational Institution Guidelines in 2020, integrated health promotional activities within educational institutions and notified Health Promotion Committee in 2021. The resolutions were passed by Gram Panchyats to support tobacco free policies. Further 'Tobacco Free Panchyats' reward scheme has been announced by the Chief Minister where Rs 5 lakh rupees are to be awarded to a Panchayat on achieving Tobacco Free Status. Regular compliance assessments were carried out in the state till 2017 and now we have a digital monitoring system called E-Health card to monitor tobacco use.

PROGRAM OUTCOME

The state received the WHO SEARO award for tobacco control in 2012 and 2023. Effective implementation of the MPOWER polices, COTPA provisions and Tobacco control Program has resulted in substantial reduction in tobacco use from 22 % to 16 % as per the Global adult Tobacco Survey-2 (GATS 2016-17). The second-hand exposure to smoke at home has reduced from 82.5 % to 32.9 %. More than 50% schools have been certified Tobacco Free. As per the E-Health card monitoring system the current prevalence of tobacco use in the state is 12%. 4264 schools (55%) have been declared as tobacco free. 1374 (53%) Panchayats has been covered under Tobacco Free Panchayat Initiative. The Global Youth Tobacco Survey) has reported that HP has lowest prevalence (1%) of tobacco use among youth (13-15 years age group) in India.

FINANCIAL IMPLICATION

Nil.

SCALABILITY

Program can be scaled up effectively across states.

CHHATTISGARH

SPECIAL SICKLE CELL OPD

PROBLEM STATEMENT

A genetic disorder of the red blood cells (RBCs). Prevalence Around 6 to 10% of state population is AS (carrier) and 0.5-1.0% is diseased (SS) patients estimated in state. More prevalent in certain communities (many STs and OBC groups). Sickle cell anemia occurs in individuals who are homozygous for a single nucleotide substitution in codon 6 of the beta globulin chain. This single mutation leads to the formation of abnormal hemoglobin HbS, which is much less soluble when deoxygenated than hemoglobin A, Hb A.

PROGRAM DESCRIPTION

The objectives of the model sickle cell unit in UPHC Nawapara Ambikapur were to screen individuals for SCD disease, carry out confirmatory tests to diagnose Sickle cell disease (SS cases) and Sickle Cell trait (AS individuals), provide essential free treatment and counseling to all SS and AS cases, ensure their entry in the portal for further follow-up treatment and maintain a registry. The program also aims to conduct LFT, RFT, CBC tests at periodic intervals for SS individuals, provide free blood transfusions to SS patients and help them avail CVS test if demanded by a family. An active registry of sickle cell patients is also maintained with regular follow-up with the nurse.

PROGRAM OUTCOME

After the implementation of the initiative, positive outcomes related to sickle cell management have been witnessed. About 2.95 lakh people were registered and around 500 sickle cell patients were identified in a PHC setting, and 45-50% are being followed-up regularly. About 90% blood transfusion requirements have been reduced in the identified patients. Additionally, hospitalization rates were reduced by 15% compared to earlier, and painful sickle cell crises reduced up to 95%.

FINANCIAL IMPLICATION

No additional financial implications incurred.

SCALABILITY

The program can be scaled up throughout the state and further across the country given the no additional cost or HR implications for the initiative.

KERALA

INNOVATIVE INTERVENTIONS AMONG MIGRANT WORKERS

PROBLEM STATEMENT

Ernakulum district, the commercial capital and industrial hub of Kerala has the largest concentration of interstate migrant workers in Kerala. The district is estimated to have nearly six lakh migrant workers from other states. Majority of the workers are from West Bengal, Assam, Tamil Nadu, Odisha, Uttar Pradesh, Bihar and Jharkhand. There are workers who are engaged as informal employees under a contractor/employer in a

shop/establishment/factory and there are also footloose labourers who are not attached to any employer/contractor.

Their working environment is highly vulnerable to accidents/injuries/exposure to hazardous substances. Besides, the living arrangements are congested with limited ventilation and poor sanitation facilities. Since their work timings conflict with the public health facilities their access to public health care is suboptimal. Time, location and language barriers substantially cripple their access to quality healthcare. As a result, they resort to practices such as accessing medicines from non-certified providers or buying medicine over the counter from medical shops. This results in missing important diagnoses of communicable diseases such as TB, Leprosy or Malaria.

PROGRAM DESCRIPTION

Resourceful migrant workers from various states working in the district have been identified, trained and deployed to serve as Migrant Link Workers to provide fellow workers information about health services and also to connect them to various services of not only the Department of Health Services but also other departments such as Labour and Skills or Legal Services Authority. It is for the first time in India that a state government has engaged migrant workers to provide services to their peers in similar lines to the services provided by ASHAs. The workers were recruited in January yand provided five-day training (during subsequent Sundays) in Maternal and child health (MCH), Family Planning (FP), Communicable disease (CD) and Non-Communicable disease (NCD), major legislations related to migrant workers and basic life support.

The workers were continuously mentored by NHM with the support of CSOs specialising in working with migrants. During COVID lockdown period, these link workers were of strategic advantage to the government in addressing the challenges faced by the migrant

workers in the district. The link workers were engaged to attend the calls by distressed migrant workers to the Corona Control Room as well as the Helpline established by the Department of Labour and Skills in the district. The link workers also were helpful in efficiently organising relief supplies and facilitating the return journey of migrant workers who wished to go back to their native places. NHM was also able to take up IEC campaigns with the help of the link workers. The link workers also helped the district administration in organising camps for migrant workers

PROGRAM OUTCOME

12 such workers, including men and women, have been deployed in Ernakulam district by NHM as of yet.

ANDHRA PRADESH

ANAEMIA MONITORING TOOL- STRONGER TOGETHER: MANAGING ANAEMIA WITH SIRA FRAMEWORK AND INTER-SECTORAL UNITY

PROBLEM STATEMENT

Anaemia remains a widespread yet often overlooked health concern with profound implications for both individual well-being and public health. Characterized by a deficiency of red blood cells or haemoglobin, it poses serious health risks and can stem from nutritional

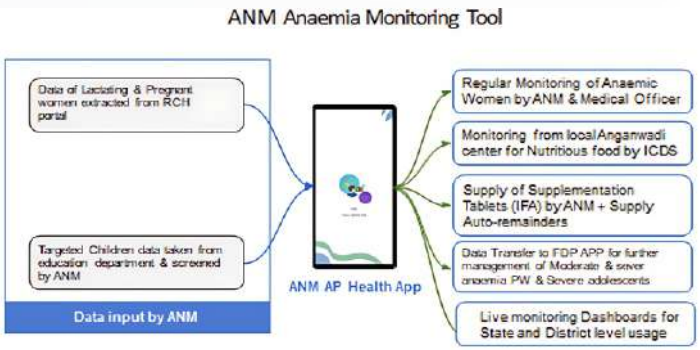
deficiencies, chronic diseases, and genetic factors. The absence of a systematic approach to monitoring and managing anaemia leads to delayed detection and intervention, increasing the risk of complications. Additionally, the lack of targeted data collection and analysis prevents the identification of high-risk groups and the formulation of effective prevention strategies. Addressing these challenges necessitates a comprehensive Anaemia Monitoring Tool that can systematically track cases, provide real-time insights into prevalence, and support evidence-based interventions.

PROGRAM DESCRIPTION

Andhra Pradesh has adopted a comprehensive approach to anaemia management under the Family Doctor Program (FDP), integrating data and services across multiple departments to ensure timely detection, intervention, and treatment. The state has developed the Anaemia Monitoring Tool, which enables systematic tracking of anaemia cases and facilitates real-time data collection, analysis, and targeted interventions. Pregnant women's data is integrated between the Health, Medical & Family Welfare (HMFW) and Women & Child Development (WCD) Departments through a Unique RCH ID, ensuring continuity of care. Auxiliary Nurse Midwives (ANMs) conduct monthly haemoglobin (Hb) level tests for pregnant women, entering the results in a mobile app to categorize cases as mild, moderate, or severe anaemia. The data is then shared with the WCD Department, enabling the provision of nutritious meals and Take-Home Nutrition Kits (YSR Sampoorna Poshana in rural areas and YSR Sampoorna Poshana in tribal areas). Additionally, ANMs distribute 60 Iron-Folic Acid (IFA) tablets per month to anaemic pregnant women to address iron deficiency.

For moderate and severe anaemia cases, the Family Doctor Program plays a pivotal role. ANMs forward case details to Family Doctors via the Family Doctor App, who then conduct further examinations and prescribe treatment, including Iron Sucrose injections or referrals

for blood transfusions at higher centers if necessary. Family Doctors also counsel patients on nutrition and diet, while ANMs coordinate treatment administration. A dedicated free transport service, Thalli Bidda Express, ensures that pregnant women can access Primary and Community Health Centres (AAM-PHCs/CHCs) for treatment without financial burden. The state has adopted a "Consistent Rhythm" approach, fostering synergy between HMFW, WCD, School Education, and Village & Ward Secretariat Departments to reduce anaemia prevalence, particularly among pregnant women and adolescent girls. The SIRA framework (Surveillance, Information, Response, Analysis) was implemented to track progress, with live dashboards providing real-time insights to State Officers, District Collectors, and DM&HOs for monitoring, evaluation, and corrective action. The ANM AP Health Android App supports screening of pregnant and lactating women every month and adolescents, children, and women of reproductive age every six months, along with real-time supply chain management of IFA supplements, auto-reminders for ANMs and Medical Officers, and live dashboards for state and district-level monitoring.



PROGRAM OUTCOME

On average, 3,73,304 pregnant women are screened monthly with their anaemic status uploaded in the portal. Additionally, the details of anaemic pregnant women were shared with the WCD, triggering alerts for the provision of additional nutrition supplements, ensuring intersectoral convergence for comprehensive care.

The anaemia prevalence for pregnant women has reduced from 53.7% (NFHS-5 2019-21) to 32.69 % in FY 2024-25 (till January, 2025) and for adolescent girls from 60.10% (NFHS-5) to 34.3% in FY 2024-25. The state has completed 50% of the screening for target population as of January 2025. The impact of the Anaemia Monitoring Tool has been remarkable, leading to a substantial decline in anaemia prevalence among pregnant women and adolescent girls.

FINANCIAL IMPLICATION

Supported under the state fund

SCALABILITY

By incorporating nutrition-based initiatives, utilizing local resources, and enhancing digital monitoring, Andhra Pradesh has successfully established a strong and scalable framework to reduce anaemia rates and improve maternal and child health outcome.

HARYANA

ANAEMIA ELIMINATION WEEK – A STEP FORWARD TO COMBAT ANAEMIA IN HARYANA

PROBLEM STATEMENT

Anaemia is a critical public health problem particularly affecting women and children, with far-reaching consequences such as reduced cognitive function, increased vulnerability to infections, and lower physical fitness, which in turn hampers daily tasks and work productivity. In spite of high per capita income in Haryana, anaemia prevalence across all age groups (excluding adolescent boys) remains higher than the national average, according to

the NFHS 5 (2020-21). To address this, the state has committed to achieving the AMB target of reducing anaemia by 3 percentage points annually. As part of this effort, Haryana observed a dedicated "Anaemia Elimination Week" (AEW) every quarter to implement mandatory Hb testing during outpatient visits in public health facilities, ensuring early detection and intervention to reduce anaemia and improve overall health outcomes.

PROGRAM DESCRIPTION

Executive orders, guidance notes, and SOPs were issued to districts, leading to the successful conduct of four Anemia Elimination Weeks in May and November 2022 and February and June 2023. From AEW learnings, a 100-day anemia prevalence reduction campaign was initiated between June to September 2024 as a part of same initiate. A state NHM-developed Anaemia Tracking Web Portal facilitates real-time data entry for Hb testing, capturing demographic details, beneficiary categories, Hb testing status, and treatment or referral updates. Each beneficiary is assigned a unique ID, enabling seamless tracking of follow-up Hb tests and improvement status. Opportunistic Hb Testing mandated in public health facility OPDs, prioritizing gynecology and pediatric departments.

Districts ensured the availability of Hb testing logistics, consumables, and IFA stock at all health facilities, with designated nodal and LT in-charges for the AMH (Anaemia Mukt Haryana) program. All testing data was uploaded to the anaemia tracking portal in real-time, enabling effective monitoring and follow-up. T3+T (Test-Treat-Talk-Track) camps were organized at schools and Anganwadi centers (AWCs) by RBSK teams, and at the community and SHC-AAM level by ANMs and CHOs. Dedicated anaemia clinics were set up at all public health facilities, staffed by medical officers (MOs), ANMs, and LTs. Severely anaemic cases were referred and managed at higher public health facilities such as SDH, DH, and FRUs. While prophylactic and therapeutic treatment was being ensured for all identified individuals, ASHAs were also provided an incentive for follow up in her catchment area. Awareness and mobilization efforts were carried out through ASHAs and AWWs, ensuring broad community engagement and support.

PROGRAM OUTCOME

Anaemia prevalence declined from 59.3% in FY 2022-23 to 51.5% in FY 2024-25, marking a 7.8 percentage point reduction. Over 33 lakh beneficiaries were screened in FY 2024-25, including opportunistic testing in OPDs and 16 lakhs were found anaemic irrespective of severity. Treatment was provided to 11 lakhs and 50,000 identified severe anaemia cases were managed at District Hospital. Referral rate dropped from 20.1% from FY 2022-23 to 7% in FY 2024-25, indicating improved service quality at Point of Care sites.

FINANCIAL IMPLICATION

No additional HR cost is associated as existing HR and service delivery platforms are utilized. NHM PIP budget is being utilized for procurement of drugs, consumables, training and IEC etc. Under the Atal Abhiyan state scheme, ₹50,000 per district was allocated to support launch events, mobility, and contingencies.

SCALABILITY

The dedicated AEW has proven to be highly scalable, with the potential for expansion across the entire state and to other states with minimal additional resources. Building on the success of AEW, the state has developed a blueprint for a high-impact, 100-day anaemia control campaign. Additionally, there is feasibility to expand anaemia testing camps to private schools in a phased manner, further broadening the reach and impact of the initiative.

MEGHALAYA

MEGHALAYA DRONE DELIVERY NETWORK (MDDN)

PROBLEM STATEMENT

Meghalaya's public health supply chain faces significant logistical challenges, particularly in delivering essential healthcare items to hard-to-reach health facilities. With only 36.02% of the State's roads being surfaced (Basic Road Statistics Report, 2017-18)—the second lowest percentage in the country—poor road infrastructure, difficult terrain, natural disasters, and security threats further strain an already overburdened healthcare system. This results in increased vulnerability for children and mothers, especially since nearly 79% of Meghalaya's

population resides in rural areas (Census 2011). The prolonged turnaround time for delivering medicines to remote health facilities has led to low availability of medical supplies, sometimes resulting in patient deaths during transfers.

PROGRAM DESCRIPTION

A pilot test for drone-based healthcare logistics was successfully conducted on 26th November 2021. The test flights, which transported medical supplies from a Civil Hospital to two Primary Health Centres (AAM-PHCs) in the remote West Khasi Hills District, demonstrated the feasibility of using drones to overcome geographical barriers. With this proof of concept established, the Government of Meghalaya constructed a dedicated Drone Station at Jengjal Sub-divisional Hospital in West Garo Hillsto serve as a central hub, and enable the transportation of medical supplies to rural health facilities within a 50 km radius. The model follows a Hub-and-Spoke system, where Jengjal SDH functions as the permanent hub, while 12 AAM-PHCs, 12 AAM-SHC and 1 CHC in difficult to reach areas have been designated as spokes (As of Feb 2025). Financially, operations run on a 'per kg per km' cost basis, ensuring cost-effectiveness. Technologically, the drones are equipped with Beyond Visual Line of Sight (BVLOS) capability, allowing them to operate over long distances without direct human control. Socially, the initiative ensures the continuous availability of essential medicines at remote health facilities, reducing delays in treatment. Existing health personnel at these activated facilities are trained to handle the loading and unloading of packages, while skilled pilots from the State's drone partner, operate and maintain the drones.

PROGRAM OUTCOME

The initiative has demonstrated its effectiveness in healthcare logistics through extensive trials, showcasing consistency, precision, and reliable delivery. One of the most significant impacts has been the drastic reduction in delivery time, cutting down transportation from 3-

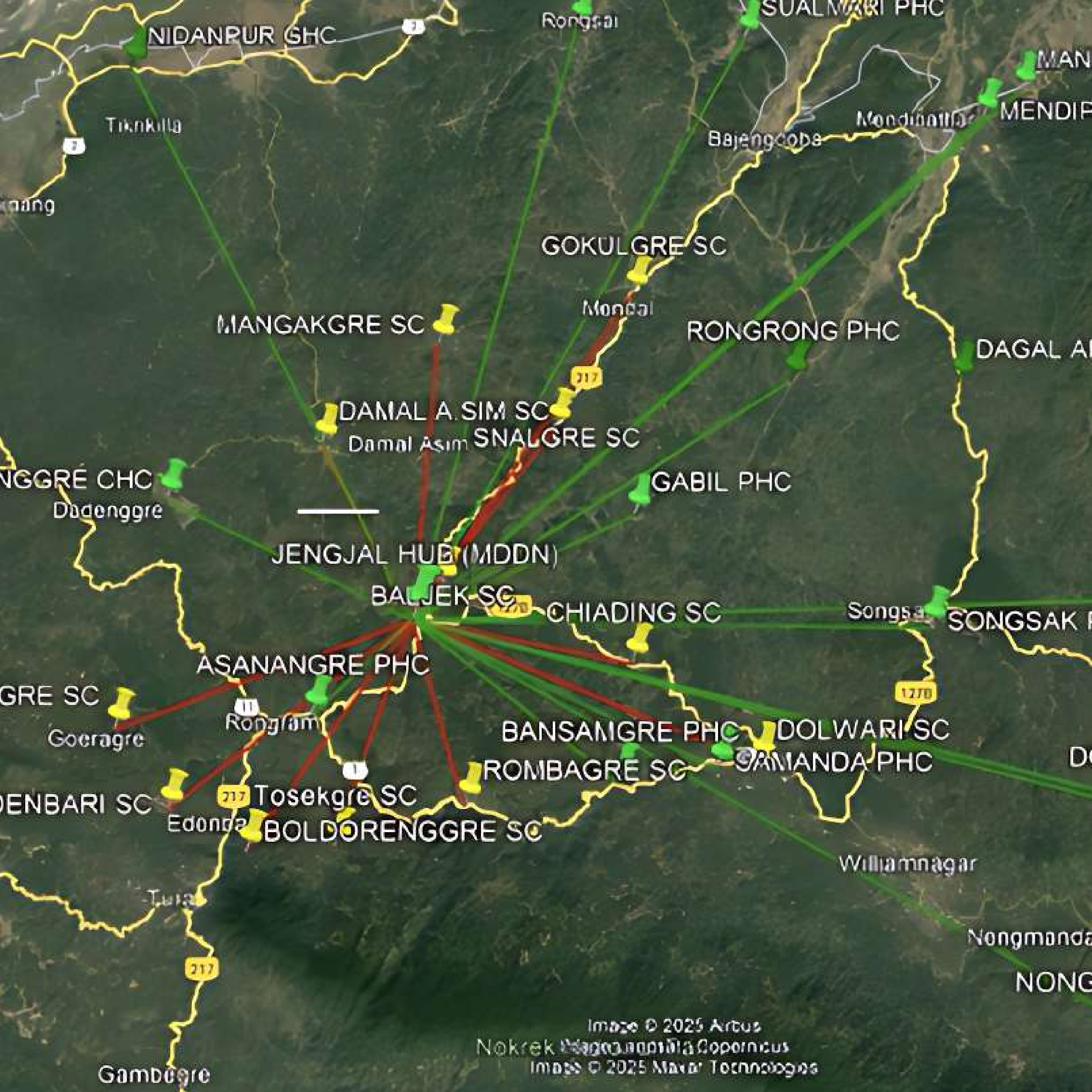
4 hours by road to just 30 minutes one way. Additionally, the project has successfully implemented reverse logistics, enabling the swift transportation of blood samples for testing, with reports being shared within an hour of collection. As of February 2025, the project has completed 566 flights, covering an aerial distance of 14,915.35 Km to deliver 5,75,053gm of payload.

FINANCIAL IMPLICATION

The drone model/system operates on a cost of INR 75 per kg per km, with an average payload capacity of around 2 kg.

SCALABILITY

The initiative would be effective to facilitate public health logistics in AAM- SHCs, and remote AAM-PHCs with limited emergency payloads and for diagnostics reverse logistics; provided the weather conditions and aviation rules are favourable for drone use. The model is beneficial especially for emergency logistics, as witnessed during the pandemic.



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