स्वास्थ्य एवं
परिवार कल्याण मंत्रालय
MINISTRY OF
HEALTH AND
FAMILY WELFARE

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

"Innovation and Inclusivity – Best Practices Shaping India's Health Future"






2026

10th NATIONAL SUMMIT ON GOOD AND REPLICABLE PRACTICES

BEST PRACTICES COMPENDIUM 2026

जगत प्रकाश नड्डा
JAGAT PRAKASH NADDA

सत्यमेव जयते

मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार
Minister
Health & Family Welfare
and Chemicals & Fertilizers
Government of India

MESSAGE

India stands at a defining moment in its journey towards becoming a *Viksit Bharat* by 2047. Guided by the visionary leadership of the Hon'ble Prime Minister, the Government of India is steadfastly prioritizing innovation, learning and knowledge sharing as foundational pillars for building a self-reliant (*Atmanirbhar*) nation. Significant efforts are underway to nurture an enabling innovation ecosystem that positions India as a global knowledge hub driven by science, technology and collaborative excellence.

The health sector is central to India's national vision, serving as a key driver of human development, innovation and evidence-based policymaking. By leveraging technology and promoting learning and knowledge exchange, it contributes significantly to strengthening health systems, improving outcomes and advancing sustainable development.

The Ministry of Health and Family Welfare has played a pivotal role in establishing a national platform for Good, Replicable and Innovative Health Practices, enabling States and Union Territories to adopt context specific solutions. This initiative strengthens programme effectiveness, fosters grassroots innovation and reinforces a shared commitment to responsive and inclusive health system strengthening through knowledge management. It is my privilege to present this Compendium of 10th edition of Best Practices and Innovations in the Public Healthcare System, reflecting India's decade long journey of transformation in public health innovation.

The National Summit has emerged as an important platform for knowledge sharing, enabling States and Union Territories to exchange field-driven solutions and learn from one another. This initiative reflects our collective commitment to leveraging knowledge and innovation for national progress. I therefore urge the States and UTs to adopt and prioritize localized solutions for addressing gaps effectively.

(Jagat Prakash Nadda)

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NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

सत्यमेव जयते

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

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

अनुप्रिया पटेल
ANUPRIYA PATEL

Message

It gives me immense pleasure to extend my heartfelt congratulations on the publication of this Compendium marking the 10th edition of the National Summit on Good, Replicable and Innovative Practices in the Public Health System. This volume stands as a fitting tribute to the spirit of innovation, dedication, and resilience demonstrated by our States and Union Territories in advancing the health and well-being of our citizens. Ministry of Health and Family Welfare has consistently emphasized the importance of context-specific and localized solutions to strengthen programme implementation. In this regard, a robust knowledge management platform such as this publication plays a vital role in documenting, disseminating, and institutionalizing best practices. It is encouraging to witness how States & UTs have emerged as leaders—identifying their unique challenges, piloting innovative solutions, and setting compelling examples for others to learn from and adapt. This compilation of best practices is a testimony to the transformative progress made across the country in addressing diverse public health challenges and further strengthening healthcare systems for optimum care.

In a time of rapidly evolving health needs, fostering a culture of knowledge sharing and cooperative learning is imperative. This Compendium brings together innovative, scalable, and impactful public health practices across the country, enabling cross learning and replication of proven approaches.

I am confident that the best practices documented in this volume will contribute significantly to building an equitable, resilient, and future-ready healthcare system—one that ensures healthy lives and well-being for every citizen of our nation. I commend all stakeholders involved in identifying, documenting, and implementing these exemplary practices. I am equally confident that this publication will inspire pride in our public health system, stimulate meaningful dialogue, encourage further innovation, and reinforce a nationwide movement toward excellence in public health.

(Anupriya Patel)

April 24, 2026
New Delhi.

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NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

प्रतापराव जाधव
PRATAPRAO JADHAV

सत्यमेव जयते

आज़ादी का अमृत काल

राज्य मंत्री (स्वतंत्र प्रभार)
आयुष मंत्रालय
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

The Government of India remains steadfast in its commitment to strengthening health systems across the country through inclusive, equitable, and cost-effective service delivery. The role of States and Union Territories in addressing local health challenges and reinforcing service delivery mechanisms has been instrumental in achieving sustained improvements in health outcomes.

At the same time, critical priorities remain—particularly bridging gaps in underserved and hard-to-reach areas, strengthening last-mile service delivery, and addressing communicable diseases among vulnerable populations subgroups. This compendium on 10th edition of Good Replicable and Innovative Practices in Public Health care system, brings forth practical innovative initiatives, targeted interventions, and scalable models adopted by States/UTs to respond effectively to context-specific health challenges.

The practices documented herein reflect sustained efforts to expand access, enhance quality of care, and build resilient health systems across all levels of service delivery. The compendium is envisaged as a platform for support cross-learning, enabling States and Union Territories to adapt and contextualize proven practices to further strengthen service delivery and advance equitable access to healthcare.

I encourage all stakeholders — policy makers, program managers, and health professionals—to actively engage with this resource and leverage its learnings to further strengthen health systems. I also place on record my appreciation for all those who have contributed to the development of this publication and look forward to its wide dissemination and effective use.

New Delhi.
24th April, 2026.

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

सत्यमेव जयते

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

Message

This best practice compendium brings together some of the most impactful and innovative initiatives undertaken across States and Union Territories in India. It reflects the commitment, resilience, and ingenuity of our healthcare professionals and policymakers, who continue to strengthen public health systems through adaptive and context specific solutions. It is my privilege to present this collection of exemplary efforts and their potential for wider replication.

The practices featured here represent a broad range of strategies to address critical healthcare challenges. From human resource innovations and efficient service delivery models to community led interventions that improve health outcomes, these initiatives demonstrate the transformative value of innovation in the public health sector. They also highlight how well-designed local solutions can deliver meaningful results and be scaled or adapted for wider impact.

I extend my sincere appreciation to all States and Union Territories for their active participation and valuable contribution. Through this collective exchange of knowledge and experience, we can further strengthen and build an even more responsive and resilient health system across the country.

Conceived as a reference resource for healthcare leaders, policymakers, practitioners, and researchers, this compendium is intended to encourage collaboration and the sharing of proven approaches—accelerating progress towards equitable, accessible, and high-quality care for all.

Together, let us build a future ready health system—people centered, technology enabled, and resilient—and I call upon all stakeholders to champion these best practices, invest in their scale up, and partner in delivering measurable improvements for every citizen.

Punya Salila

(Punya Salila Srivastava)

Date : 23.4.2026
Place : New Delhi

#StopObesity
टीबी हारेगा देश जीतेगा / TB Harega Desh Jeetega

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

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

MESSAGE

National Health Mission reaffirms its commitment to fostering innovation, evidence-based planning, and adaptive implementation as the foundation for sustained improvements in health outcomes and progress toward Universal Health Coverage.

India's public health ecosystem is anchored in strong policy frameworks and collaborative federalism which has enabled States and Union Territories to design and implement context-specific solutions that respond to diverse needs. NHM through its annual ***National Summit of Good and Replicable practices in Public Health care***, provides a common platform of Knowledge Management in Health systems strengthening. With rapid advances in digital health technologies, strengthened systems, and an expanding skilled workforce, the nation is well-positioned to accelerate healthcare delivery and achieve transformative outcomes. This ***Tenth Edition of Compendium of Best Practices*** reflects our collective resolve to translate knowledge into action, ensuring that India's health systems remain resilient, inclusive, and future-ready.

The success of India's health sector is driven by the ability of States/UTs to pilot innovative approaches, which, once proven effective and scalable, are replicated and adapted by other States, and also integrated into national programs. The continued documentation of such best practices provides an institutional mechanism for knowledge sharing and cross-learning, thereby strengthening resilience and fostering innovation across health system. NHM places priority on strengthening health systems by encouraging States/UT to design localized context specific solutions that address challenges with greater effectiveness. These innovations not only generate practical responses but also inspire learning, adaptation, and replication across the country. This approach reflects our commitment to decentralization and capacity building, fostering a problem-solving orientation. The establishment of the State Innovation Hub marks another step in this direction, enabling SHSRCs to proactively advance evidence-based learning and knowledge driven strategies that guide health systems. Together, these efforts reinforce resilience, inclusivity, and innovation as the foundation for India's health system.

This compendium reflects the resilience & innovation of India's health systems, showcasing localized solutions that address diverse challenges with greater effectiveness. By documenting and sharing these practices, NHM reinforces its commitment towards evidence-based learning. I appreciate the contribution and efforts of States/UTs, MoHFW/NHSRC team for documentation of these effective practices. It is my firm belief that this volume will inspire States/UTs to adapt, replicate, and scale successful models, advancing stronger health systems and contributing to the vision of ***Viksit Bharat***.

"Let us strive together towards learning by using this common platform of evidence generation and knowledge management for cross-learning, to adapt and replicate localized solutions rooted in inclusivity and innovation, ensuring affordable, accessible, and quality care for all, reaching every citizen till the last mile."

Dated: 28th April, 2026

(Aradhana Patnaik)

#StopObesity
टीवी हारेगा देश जीतेगा / TB Harega Desh Jeetega

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सत्यमेव जयते

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स्वास्थ्य एवं परिवार कल्याण मंत्रालय
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Message

Policies serve as the foundation upon which good practices and innovations under the National Health Mission (NHM) are conceived, nurtured, and scaled. By providing a clear framework of priorities, guiding principles, and accountability mechanisms, policies ensure that States and Union Territories can design context specific solutions while remaining aligned with national health objectives.

The NHM's emphasis on decentralization, evidence based planning, and adaptive implementation has created an enabling environment for innovation. Policies have institutionalized mechanisms such as the National Summit of Good and Replicable Practices in public health care, State Innovation Hubs, and community-based monitoring, which together strengthen the feedback loop between policy and practice. These platforms allow States/UTs to pilot new approaches, validate outcomes, and replicate successful models across diverse settings.

Through coherent policy direction, NHM has fostered collaboration among stakeholders i.e. policymakers, Programme managers, healthcare providers, and communities, ensuring that innovations are not isolated experiments but integrated into systemic improvements. Policies have also prioritized inclusivity and resilience, encouraging solutions that address last mile challenges, leverage digital technologies, and build local capacities.

Continuing these efforts, the 10th edition of Compendium of Good and Replicable Practices reflects how policy frameworks under NHM have catalyzed a culture of innovation and knowledge management. It presents a diverse set of initiatives undertaken by States and Union Territories to strengthen healthcare delivery across different contexts. These practices reflect sustained efforts to address local challenges through innovative and practical approaches, contributing to improved service delivery and health outcomes.

I acknowledge the contributions of States/UTs and teams within MoHFW and NHSRC for the efforts in documenting and disseminating these practices to provide valuable learning for strengthening healthcare delivery. This work exemplifies how sound policy, combined with innovation and collaboration, advances the vision of resilient and equitable health systems across the nation.

(Sibin C.)

Dated: 27th April, 2026

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ASSAM

UTTARAN - BEACON OF HOPE FOR MATERNAL AND CHILD HEALTH IN TEA GARDEN AREAS OF CACHAR

Problem Statement

The comparatively high incidence of Maternal & Child mortality among the Tea Garden communities of Cachar has necessitated that a comprehensive plan be made to reduce the mortality involving the concerned Govt. & Non-Govt. entities, and to build a robust monitoring mechanism to review the status.

Programme Description

A life cycle approach has been put in place involving the frontline workers and Tea Garden Management to improve health outcomes. The meaning of the term in English is moving "Uttaran" upwards or rising above, or promotion from the present status. By name, it reflects the effort to improve the present scenario. This is a holistic approach and amalgamation of comprehensive strategies for the reduction of Maternal & Child mortality in the tea gardens of Cachar, Assam. The project has multi-dimensional strategies, with existing institutional mechanisms being strengthened, and the capacity of the tea garden community is built up to promote health-seeking behaviour.

Strengthening of Institutional Mechanism:

Nodal Medical Officer by the Health & FW Dept. is elected for each of the Tea Gardens, who

is single point of contact (SPOC) for all Health-related matters for the Tea Garden communities. Strengthening of the service delivery of PPP-Tea Garden through regular review and support is done. Implementation of the Tea Garden Wage compensation scheme & Pradhan Mantri Matru Vandana Yojana (PMMVY) for pregnant women to ensure zero left out in all Tea Gardens of Cachar.

Convergence is ensured through the Education, Social Welfare and PHE department working together for implementation of WASH, to address problems related to nutritional anaemia, menstrual hygiene, Vit-A deficiency, and Deworming. Partnering done with MMU, Nehru Yuva Kendra Sangathan (NYKS), Blood bank of Silchar Medical College and Hospital (SMCH) and SM Dev Civil Hospital (SMDCH) to address the issue related to Maternal & Child Health.

Early identification and management of HRPW using the existing IT tool (MCTS), the Nodal Medical Officer, and PMU staff is done. Promotion of Voluntary Blood Donor Network and Family Donor Approach done through NYKS, Youth Wing of Tea Garden Union, Tea Garden Managements. Opening of "Help Desk for attending PW of Tea Garden areas" at SMCH and SM Dev Civil Hospital, Silchar.

No additional requirement of human resource. However, at each Garden Line, one Uttaran Committee is formed (informal), including- ASHA, AWW, Line Sardar, Bagan Panchayat, President/ Secretary of local Mohila Samiti, Mother-in-Laws and SHGs, etc. They would facilitate ASHAs in the mobilisation of reluctant beneficiaries and transportation voluntarily. Informal group discussions are held at the Tea Leaf Plucking sites by the Uttaran Group – which will have a positive impact by changing their health-seeking behaviour.

Programme Outcome

Since its inception, the initiative has got a good response and results at the community level. One Uttaran camp is organised at each of the tea gardens monthly, where RCH & Adolescent health services are provided free of cost. The maternal deaths have reduced in those gardens where Mission Uttaran is being implemented. Mission Uttaran continues to pave the way for a healthier, more empowered future. Through its comprehensive efforts, it is not just saving lives—it's igniting a revolution in maternal and child healthcare across the tea gardens.

Financial Implication

This initiative is totally voluntary. However, some provisions are there to seek support from philanthropic organisation, tea garden management, and District Administration.

Scalability

As this mission has certain positive sides, especially for tea estates, it may be scaled up in similar context settings, prioritizing vulnerable population sub-groups.

BIHAR

TRANSFORMING URBAN HEALTH: ADVANCING QUALITY THROUGH NQAS-CERTIFIED URBAN PRIMARY HEALTH CENTRES (UPHCs)

Problem Statement

The National Urban Health Mission (NUHM) in Bihar is dedicated to improving the quality of primary healthcare services for urban populations, with a particular emphasis on marginalised and vulnerable groups. However, ensuring consistent service quality at Urban Primary Health Centres (UPHCs) has been an ongoing challenge due to overburdened staff, limited resources, and infrastructure gaps. This has highlighted the need for a focused approach to institutionalise quality improvement practices at the facility level.

Programme Description

In 2023, the NUHM launched a focused Mission for NQAS Certification and selected 40 UPHCs in the first phase to undergo quality strengthening and prepare for NQAS. The goal of this mission is to institutionalise quality assurance practices within the daily operations of UPHCs, ensuring that services meet national benchmarks and are aligned with quality standards to improve patient satisfaction and facility utilisation.

This initiative focuses on establishing Quality Circles at each of the 40 selected UPHCs, comprising the District Urban Health Consultant, Medical Officer-In-Charge (MOIC), ANMs, pharmacists, and lab technicians. The circles meet bi-weekly to assess facility performance against NQAS checklists, identify service delivery gaps, implement corrective actions, and document progress, fostering internal accountability, ownership, and continuous quality improvement at the facility level and enhance facility readiness for state and national-level assessments. The initiative was implemented without any additional expenditure on human resources, utilizing the existing UPHC workforce including MOs, ANMs, Pharmacists, Lab Technicians, DEOs, and ASHAs for quality improvement activities, self-assessments, documentation, and patient engagement. Health staff are trained on the 8 areas of concern under NQAS and carry out regular self-assessments using standardised checklists.

The key strategies include Capacity Building Workshops, Inter-Assessor cum SPT Training, monthly self-assessment exercises, weekly review meetings for gap identification and micro-planning, peer learning through cross-facility exposure visits, Excel-based KPI tracking dashboards, supportive supervision through regular on-site mentoring visits, and institutionalised patient feedback and record audits through exit interviews and periodic service record review.

Programme Outcome

This mission has made a significant contribution towards enhancing the quality of services in urban healthcare settings. Among the 40 UPHCs selected in the first phase, 62.5% UPHCs successfully achieved certification. Of these, 9 UPHCs received National-level NQAS certification, while 16 UPHCs were certified at the State level. In addition, 7 more UPHCs have formally applied for National NQAS assessment, reflecting sustained momentum and commitment to quality improvement across urban health facilities in Bihar. Post-certification, certified UPHCs have exhibited tangible improvements in service delivery, including improved patient experience, enhanced infection prevention and control practices, better documentation and record-keeping, higher staff engagement and accountability, and increased community trust and service utilisation. These outcomes reflect a shift towards a culture of continuous quality improvement and more standardised, responsive, and patient-centric care.

Among key indicators, the average NQAS score (internal assessment) improved from 60% to 87%. Average patient satisfaction improved from 3.1 to 4.5 (scale 1–5). Average infection control compliance improved from low to high. Average availability of essential drugs increased from 65% to 95%. Average availability of essential diagnostics increased from 35% to 55%. Average patient waiting time reduced from 45 minutes to 20 minutes. Service delivery indicators also showed substantial improvement. OPD increased by 75.81%, hypertension screening increased by 85.90%, diabetes screening increased by 97.37%, ANC registration increased by 107.22%, four or more ANC visits increased by 70.95%, and immunisation increased by 78.34%.

Financial Implication

No additional cost implications were incurred, and low cost tools were utilised.

Scalability

The success of this initiative across 40 UPHCs demonstrates strong potential for scale-up across urban health facilities in Bihar and beyond. The model relies on existing human resources, simple monitoring tools, and low-cost quality improvement practices, making it scalable, sustainable, and replicable for strengthening quality of care and achieving NQAS certification.

CHHATTISGARH

SUPPORT OF BIHAN IN FILARIA ELIMINATION PROGRAMME & MALARIA FREE CHHATTISGARH CAMPAIGN

Problem Statement:

In Chhattisgarh, it was observed that despite good overall coverage of Mass Drug Administration (MDA) of around 68%, a persistent 30–32% population was left out due to refusal or migration, which posed a challenge to the target of Lymphatic Filariasis elimination by 2027. The highly forested districts of Bastar Division (Bastar, Bijapur, Dantewada, Kanker, Kondagaon, Narayapur and Sukma) are inhabited predominantly by tribal population and contributes to high burden of Malaria cases in the State. The average API (Cases/1000 population/year) was 16.49 and ranged from 3.02 to 53.14 in 2018. These seven districts constitute 11.50% population of the State and contributed 83% of the positive cases in year 2024. The transmission is persistent due to asymptomatic carrier of malarial parasite among tribal population. With an increased focus on disease elimination, need for interventions that are effective at reducing transmission of filariasis & malaria in different settings were implemented.

Programme Description

To strengthen social mobilisation for MDA, the State Health Department partnered with BIHAN (State Rural Livelihood Mission) to engage Cluster Level Federations (CLFs) and Self Help Groups (SHGs) at the grassroots. An incentive amount was approved by NHM and directly transferred to CLF accounts. It was mutually agreed that CLFs would conduct mobilisation and sensitisation activities,

which would be monitored and reported by Project Resource Persons (PRPs). BIHAN deployed 212 PRPs across 61 blocks in 17 districts, each supporting one CLF, and provided capacity building, monitoring, and field support throughout the drive while District Vector Borne Disease (VBD) team facilitated orientation of these PRPs. Key activities undertaken by CLF members included; orientation and mobilisation through SHGs, schools, Anganwadi centres, Public Distribution System (PDS) dealers and PRI members, community outreach using wall writings, school sensitisation (98,847 students in 1,685 schools), and oath-taking ceremonies at SHGs and during community meetings.

Malaria free Chhattisgarh campaign was carried out in 7 aspirational districts of Bastar division. After observing the continuous decline in Malaria cases, Campaign was implemented widely in districts of other divisions. The main objectives of the campaign were-to reduce morbidity & mortality due to malaria in the State & especially in tribal predominant high endemic blocks with special focus on pregnant women, lactating mother and under 5 children in high endemic pockets by diagnosing symptomatic and asymptomatic malaria cases to ensure complete treatment

The 1st round was carried out in January-February 2020. Schools, Ashram, hostel, pota cabins and paramilitary camps and hard to reach areas were covered during the campaign by the team members. IEC through miking, banner, poster, display of hoardings, folk media, mashal rally etc. were carried out to create awareness in the community.

The main attraction of the campaign was the door-to-door visits by the survey team members consisting of Health Workers and Mitanins, who screened all members of the family using Rapid Diagnostic Test and if found positive, were given complete treatment, & treatment card was provided to the patient for case follow-up. LLIN monitoring and source reduction activities were also carried out. Inter-sectoral coordination with allied departments was ensured to make the campaign successfully.

Programme Outcome

The direct CLF engagement in MDA campaign enabled last-mile connectivity, enhanced Directly Observed Therapy (DOT), and significantly improved drug uptake in hard-to-reach areas. Refusal conversion of 68,135 refusals, 53,213 were converted, with 39,218 conversions attributed directly to SHG efforts.

There has been a widespread impact of Malaria Free Bastar and Malaria free Chhattisgarh campaigns. In 1st round (2020), the test positivity rate as 4.60%, which declined to 0.46% in 11th round (2025). The Annual Parasite Incidence (API) was 5.21 in 2015, which declined to 0.98 in 2024. The Annual Parasite incidence of Bastar Division was 27.40 in 2015, which has declined to 7.11 in 2024. In Bastar division 71.09% reduction of Malaria cases in 2024 was reported compared to 2015.

Financial Implications

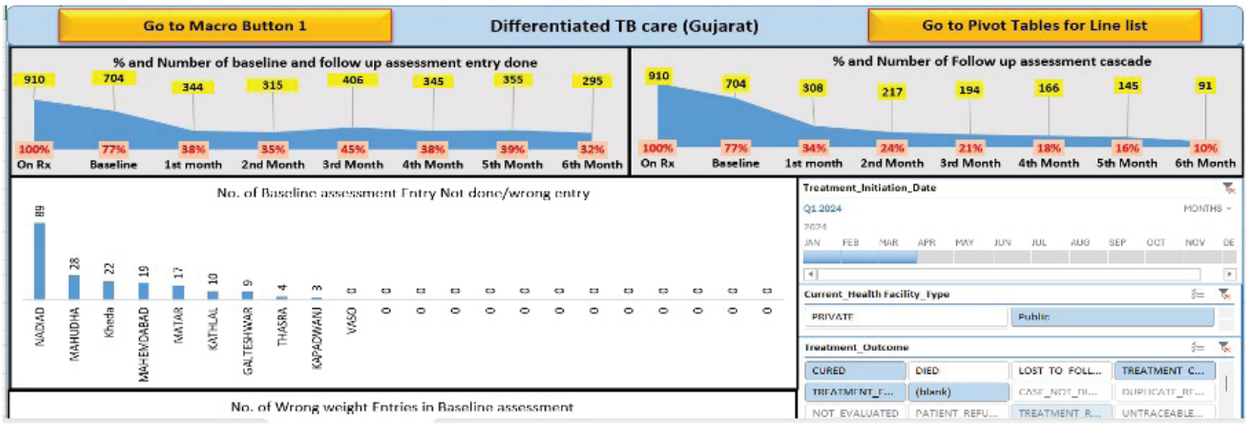
Existing resources including approvals under NHM were utilised to undertake the activities.

Scalability

This collaborative model between Health and Rural Development departments demonstrates a scalable and sustainable approach in control and elimination of Lymphatic Filariasis and Malaria through strengthening community participation in public health programmes.

GUJARAT

STATE'S INITIATIVE TO REDUCE TB DEATHS – REVIEW, PROTOCOL AND FOLLOW-UP SYSTEM



Problem Statement

India aims to eliminate tuberculosis (TB) ahead of the global SDG target of 2030 with key objectives of 80% reduction in TB Incidence and 90% reduction in TB Mortality. The Department of Health & Family Welfare in Gujarat has implemented focused interventions to reduce TB mortality through a structured review mechanism, a state-specific treatment and follow-up protocol, and monitoring of high-risk TB patients through Aarogya Samiksha Kendra (ASK).

Programme Description

The State initiated and operationalised three key innovations to reduce TB deaths: TB death audit review mechanism, a state-specific TB treatment and follow-up protocol, and monitoring of high-risk TB patients through Aarogya Samiksha Kendra (ASK). Monthly review meetings are conducted with Medical Colleges and District TB Officers under the Chairmanship of PS Health, followed by district-level monthly meetings. Training of all Peripheral Health Institute (PHI) Medical Officers for TB death audit has been completed, with data collection using Google forms and Excel tools since

2023. Verbal autopsy is conducted by the concerned PHC Medical Officer and Taluka Health Officer with support from local staff, and 80%–90% of deaths are re-visited and verified by DTO.

The State Government has issued a revised protocol for identification of more vulnerable individuals among detected TB cases for comprehensive evaluation of comorbidities before initiating anti-TB treatment, including periodic follow-up at 15 days, every month, and after 6, 9 and 15 months. PHI MOs, CHOs, and Medical College faculties were trained, and the protocol was implemented in all 41 districts. A referral matrix for CHO was developed, along with state and district dashboards for tracking high-risk TB patient referrals and hospital admissions. Follow-up is conducted through monthly review by PS Health and weekly follow-up by the State TB Cell team.

Aarogya Samiksha Kendra conducts proactive follow-up calls for high-risk TB patients at treatment initiation, 15th day, 2nd month, 4th month, 6th month, and post-treatment follow-up at 3 months. Calls are made to monitor adherence and progress, identify side effects, assess outcomes, and provide counselling and support. Referral and admission protocols ensure timely access to higher-level health facilities through linkages with district health officials. ASK is operated through 100 trained tele-callers, counsellors, and paramedics, supported by advanced call center infrastructure.

Programme Outcome

Following these initiatives, a significant reduction in absolute number of deaths as well as in death rate among total notified TB Cases was reported. In April 2024, the TB deaths reported were 4.5% of the total notified patients, which reduced to 3.7% in the first quarter of 2025-26. A major reduction was also observed among vulnerable categories, with decreases of 23% in HIV-positive individuals, 34% in those with diabetes mellitus, and 24% in individuals with low BMI. Among 41 NTEP districts, the number of districts having death rate >5% reduced from 17 to 9, between April 2024 and April 2025 respectively.

Financial Implication

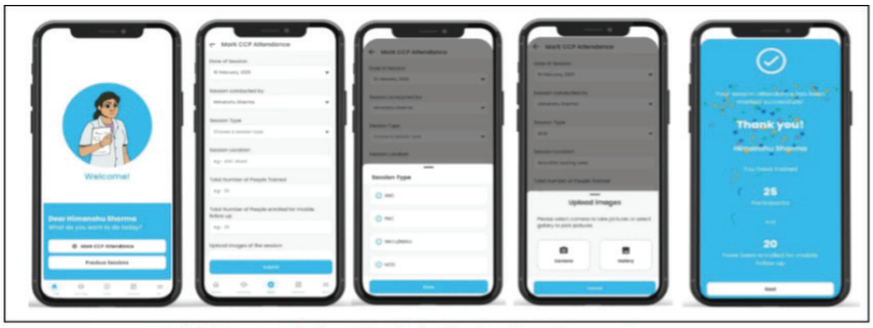
There are no additional financial implications, as this is built on existing routine programme interventions. The death review component is also part of routine activities but has been further strengthened under this initiative. Additionally, the Arogya Samiksha Kendra utilises the existing 104/108 services, which have been redesigned.

Scalability

The intervention is scalable and sustainable. Its expansion is expected to reduce inter-district disparities and improve health outcomes among TB patients.

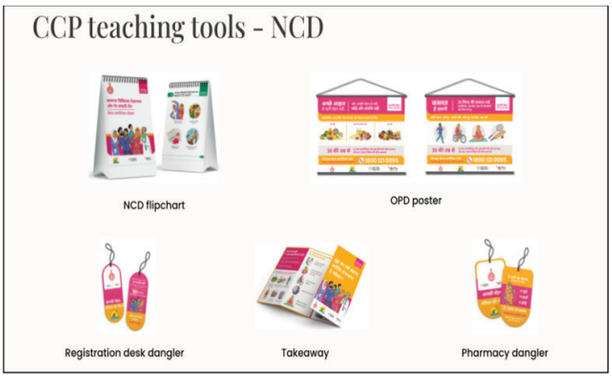
HARYANA

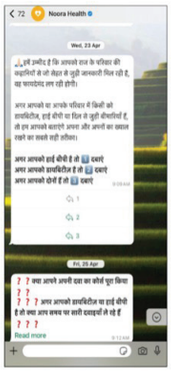
ADVANCING HEALTH SYSTEM RESILIENCE THROUGH CAREGIVER EDUCATION: HARYANA'S NCD CCP MODEL



"Health Educator Platform" for the facility-level CCP intervention

"CCP session taken by Nursing officer in the NCD Clinic, CHC Barara, District-Ambala"





Problem Statement

In Haryana, the rising burden of Non-Communicable Diseases (NCDs) such as diabetes, hypertension, heart disease and stroke presents a major public health challenge requiring long-term care and adherence. While government services provide treatment access, ongoing management and follow-up largely depend on family caregivers across both rural and urban households. As per NFHS - 5, hypertension and diabetes are significant concerns in the state, with numbers slightly above national average. Along with this, risk factors for NCDs including alcohol, tobacco consumption and obesity are also widely prevalent in the state.

Programme Description

Recognising the growing challenge of NCD burden in the state, the Health Department initiated efforts to empower patients and their caregivers with essential knowledge and skills to combat the conditions. A Care Companion Programme (CCP) in Haryana was proposed through NHM PIP in FY 2024-26, to support family members of patients visiting health facilities by educating them on NCD prevention and management.

For patients with NCDs (diabetes, hypertension, heart disease), the CCP improves outcomes through awareness and behaviour change. Nurses at NCD clinics in DHs, SDHs, CHCs and medical wards run regular education sessions and train family caregivers for home care. A WhatsApp service reinforces practices with guidance, reminders and health tips. The State Health Department also builds NCD staff capacity through structured training with technical support, and has developed IEC materials (posters, flipcharts) for NCD care.

The Mobile Care Companion Service (MCCS) is a WhatsApp-based messaging and support service for patients with NCDs and their caregivers. Using SBCC principles, it sends verified, easy-to-understand health information to improve disease management and healthy behaviours. Enrolled users receive weekly, language-specific messages (text, images, videos) on medication adherence, healthy lifestyles and check-ups, and can ask questions answered by qualified healthcare professionals.

As part of this effort, CCPP builds upon the existing public health workforce, without the need to create new posts. The programme also contributes to strengthening leadership within the health system by identifying and training selected nurses as Master Trainers (MTs). These MTs subsequently build the capacity of other nurses and healthcare workers through ongoing training, mentorship, and supportive supervision, ensuring sustained implementation and quality of the initiative. Regular supportive supervision and feedback, supported by technical partners, ensure programme quality and timely resolution of challenges.

Programme Outcome

With programme was expanding to cover NCD services across 188 health facilities in Haryana, (22 DHs, 32 SDHs, and 120 CHCs), 375 staff nurses have been trained as MTs. The MTs have subsequently built the capacity of more than 1,100 staff nurses, enabling them to serve as family health educators under the programme. Between February and April 2025, 60,424 patients and caregivers were trained on basic yet critical health practices and behaviours. The NCD Care Companion Health Educator Application has been developed to support nurses in documenting CCP sessions, monitoring their impact, and accessing educational resources digitally. In addition, a state-level dashboard has been created to enable real-time tracking and monitoring of interventions.

Financial Implication

The cost implication for the innovation was minimal. For the training of nurses, the average cost of training per nurse comes out to be around Rs. 362 as per Haryana govt. norms. The cost for printing the IEC materials was Rs 24,81,500/-, as approved in the NHM RoP for FY 2024-25. The costs related to engagement of design-thinking experts, facility needs assessment (both one-time activities), programme design and development, as well as ongoing WhatsApp operations, are being supported and borne by the technical partners, and the operationalisation cost comes around Rs 20,650/- per facility. Overall, the estimated cost of training an individual was around Rs 2.5/- per person.

Scalability

The activity has the potential to be replicated and scaled up for effective implementation.

JAMMU AND KASHMIR

CAPACITY BUILDING INITIATIVES - SUPPLY CHAIN MANAGEMENT AND SUCCESS STORY

Problem Statement

In Jammu & Kashmir, the public health supply chain was fragmented and poorly coordinated across departments. Different departments were responsible for different segments of the system, but they were not functioning as an integrated whole. There was no structured platform for regular joint review of data, planning, or problem-solving among J&K Medical Supplies Corporation Limited (JKMSCL) and Directorate of Health Services (DHS) departments. As a result, stock visibility across levels remained weak, the digital Drug and Vaccine Distribution Management System (DVDMS) was underutilised, and supply delays created stock-outs in some facilities while others faced overstocking. These inefficiencies directly affected service delivery and patient care at the last mile. Additionally, due to absence of a dedicated professional supply chain cadre; pharmacists, store officers, and programme managers were managing logistics without formal training in inventory management, resulting in inconsistent planning, limited accountability, and weak performance monitoring.

Programme Description

To address these systemic gaps, a Supply Chain Management Team (SCMT) was formally established as a governance and coordination mechanism. The SCMT brought together representatives from JKMSCL, NHM J&K, the DHS J&K divisions, and all regional drug warehouses.

The SCMT began meeting quarterly to review key performance indicators (KPIs) related to supply chain management. These meetings created a common platform where stakeholders could discuss progress, identify bottlenecks, assign responsibilities, and document action points. The team focused on reviewing and monitoring demand forecasting, order placement tracking, distribution scheduling, warehouse operations, inventory levels of essential drugs (EDL 2022), and utilisation of DVDMS. It also monitored legal compliance related to procurement and supplier agreements.

Importantly, this structure did not require new hiring or additional financial outlay. Existing personnel were assigned defined roles and responsibilities within a structured review system.

Alongside governance reform, a comprehensive capacity-building initiative was implemented to strengthen the skills of the existing supply chain workforce. A Training Needs Assessment (TNA) was conducted across all levels of the system to identify gaps. Based on this assessment, two modular Learning Resource Packages (LRPs) were developed. One focused on public procurement and compliance under General Financial Rules (GFR) 2017, while the other covered end-to-end supply chain management, including demand forecasting, inventory management, warehouse operations, expiry management, and effective use of DVDMS.

Training was delivered through a Training of Trainers (ToT) model. Two intensive two-day sessions were conducted in Jammu and Srinagar, engaging 194 participants through both in-person and virtual formats. These participants included medical officers, pharmacists, and store in-charges from all 20 districts and regional warehouses. An additional 25 senior JKMSCL officials received specialised procurement training. Beyond the ToTs, 2049 AAM-HSC staff were trained on the DVDMS mobile application. The training approach emphasised simulation-based and scenario-driven learning rather than traditional lectures. Participants engaged in role-play exercises, mock exercises, and real-world problem-solving. IEC materials and ready reckoners were developed to provide simple, step-by-step operational guidance at facilities and warehouses. Exposure visits allowed officials to observe private-sector best practices in warehousing and digital inventory systems.

To institutionalise long-term capacity building, NHM J&K initiated collaboration with IIM Jammu to establish a Centre of Excellence for Public Health SCM. The Centre aims to certify future trainings, develop advanced modules, and support ongoing research and innovation in SCM.

Programme Outcome

The intervention led to measurable improvements across several indicators. DVDMS utilisation showed steady and significant growth. In August, utilisation stood at 27%. It increased to 31% in September and 34% in October. Following structured coordination and training interventions, DVDMS reach increased to 100% facility mapping up to AAM-PHC level, and utilisation rose to 82% by May 2025 and 89% by July 2025.

Facility mapping and de-duplication were also addressed. Earlier discrepancies showed 373 facilities reported by NHM but 473 reflected in DVDMS, indicating duplication. Corrective action was initiated, and 2,501 AAM-SHCs were mapped into the system. Another significant outcome was the optimisation of demand forecasting for programme drugs. Previously, certain programmatic medicines were being procured both by NHM and DHS, leading to duplication. After discussion within the SCMT, the demand was rationalised for FY 2024–25. This resulted in a 44% reduction in quantity ordered and a 47% reduction in procurement cost. The total cost reduced from approximately INR 1,03,85,740.94 to INR 49,00,479.76, representing substantial savings without compromising service delivery.

Capacity-building efforts also showed measurable learning gains. Pre- and post-training assessments demonstrated a 42% improvement in knowledge scores among participants, indicating that the training was not merely procedural but led to meaningful skill enhancement.

Financial Implication

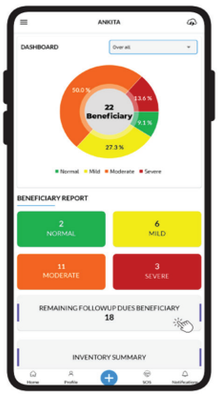
The formation of the SCMT had no additional financial implication. The initiative relied entirely on existing human resources within the health system.

Scalability

The model demonstrates strong potential for replication in other states and regions. Its core strength lies in structured coordination, clearly defined KPIs, regular review mechanisms, and capacity building of existing staff. The Training of Trainers model ensures sustainability through internal knowledge transfer. Modular learning packages, ready reckoners, and IEC materials allow easy customisation to local contexts.

JHARKHAND

BRIDGING DATA AND ACTION: THE AMB T4 APP



Problem Statement

Despite the availability of Point-of-Care testing through digital haemoglobinometers and comprehensive funding support, the health system lacks an effective mechanism to report testing volumes, categorise individuals by anaemia severity, and systematically track them through referral, treatment, and follow-up until complete recovery. The absence of real-time, comprehensive digital tracking remains the primary barrier to ensuring continuous care and maximizing programme impact.

Programme Description

The digital initiative aims to enhance the Anaemia Mukt Bharat (AMB) programme's efficiency and impact through comprehensive database development by establishing a robust database of AMB beneficiaries across diverse geographies and age groups, real-time digital reporting by strengthening digital systems to enable instantaneous data collection, analysis, and dissemination,

enhanced monitoring systems by improving case tracking through regular monthly progress reporting and systematic follow-up, community engagement by facilitating IEC material sharing through accessible digital platforms, and supply chain optimisation by supporting effective inventory and supply chain management for anaemia interventions. The AMB Mobile Application operationalises the T4 approach, which includes (i) Test by providing streamlined tools for anaemia screening and diagnostic support, (ii) Treat by offering comprehensive treatment information and healthcare facility directories, (iii) Track by enabling systematic monitoring of haemoglobin status and treatment progress using IFA supplements, FCM, or IV Iron Sucrose as prescribed by GOI AMB guidelines, and (iv) Talk by delivering targeted awareness campaigns about anaemia causes, prevention, and management strategies. The AMB Mobile Application directly addresses core AMB programme objectives through continuous monitoring, targeted interventions, community strengthening and proactive management.

Programme Outcome

Since the inception of the programme, 11,07,771 beneficiaries have been registered, with 13.4 lakh haemoglobin tests recorded. Around 8,000 severe and moderate anaemic cases have also been successfully referred to secondary health facilities including FRUs and DHs. A total of 8,689 recoveries to non-anaemic status have also been documented.

Financial Implication

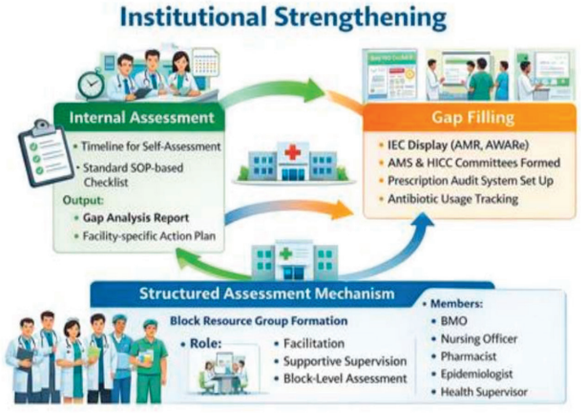
No additional cost implication.

Scalability

Can be scaled up across States & UTs.

KERALA

AMARAM - ALAPPUZHA MODEL OF ANTIBIOTIC RESISTANCE AWARENESS AND MITIGATION VISION



Problem Statement:

Antimicrobial Resistance (AMR) poses a significant public health challenge with implications beyond the health sector, impacting animal health, agriculture, food safety, and overall socio-economic development. There is a need to promote rational use of antibiotics, strengthen infection prevention practices, and enhance awareness among both healthcare providers and communities. In alignment with the One Health approach, there is a recognised requirement for coordinated, multi-sectoral interventions and improved community engagement to address irrational antibiotic usage and strengthen surveillance and stewardship mechanisms across sectors.

Programme Description:

AMARAM (Alappuzha Model of Antibiotic Resistance Awareness and Mitigation) is a comprehensive initiative aimed at developing an AMR-smart district through antibiotic-smart hospitals and antibiotic-literate communities under the One Health approach. The programme focuses on promoting rational antibiotic use, strengthening institutional mechanisms, and enabling community participation through coordinated multi-sectoral action. Aligned with the Kerala Antimicrobial Resistance Strategic Action Plan (KARSAP), the initiative focuses on awareness, surveillance, infection prevention and control, optimised antibiotic use, and intersectoral collaboration. It aims to transform health facilities into Antibiotic-Smart Hospitals, enhance antibiotic literacy, and strengthen interdepartmental coordination.

Key components include capacity building of healthcare providers (doctors, nurses, pharmacists) on antibiotic stewardship, and establishment and strengthening of antimicrobial stewardship and Infection Prevention and Control (IPC) committees at facility and block levels. Antibiotic literacy is promoted through IEC dissemination and awareness programmes across schools, Anganwadis, and community platforms, with engagement of local bodies, NGOs, and community groups to encourage responsible antibiotic use. A multi-sectoral coordination mechanism is operationalised through a district-level AMR Task Force involving departments such as Health, Veterinary, Education, Food Safety, Drug Control, Agriculture, Animal Husbandry, Fisheries, and Environment, with regular review and data-sharing under the One Health framework.

Key interventions include strengthening hospital IPC practices, adherence to along with prescription audits, vaccination of healthcare staff, and promotion of rational antibiotic use. Community-level actions include public awareness campaigns, handwashing facilities, and social media outreach. Pharmacy-level interventions include awareness for pharmacists and collection of unused/expired medicines through community mechanisms. Surveillance is strengthened through laboratory capacity building (hub-and-spoke model) and development of a district AMR data repository. Sustainability is ensured through integration of AMR activities into routine health and allied sector programmes, including promotion of safe farming and biosecurity practices. The programme is implemented in phases, with twelve Local Self-Government Departments (LSGDs) covered in Phase I. Monitoring includes periodic reviews, institutional documentation, and pre- and post-intervention assessments, with recognition of best-performing institutions and corrective actions based on findings.

Programme Outcome:

Implementation of AMARAM has enabled systematic monitoring and evaluation of antimicrobial resistance interventions across health facilities and communities. As part of World Antimicrobial Awareness Week (WAAW) 2024, all health institutions actively implemented AMARAM activities, and institutions demonstrating exemplary best practices were formally recognised at the state level.

The programme has established a structured review mechanism, wherein corrective actions and necessary modifications are undertaken based on monitoring outcomes, strengthening quality of implementation. During Phase I, 12 selected LSGDs implemented both hospital-based and community-based interventions in collaboration with line departments, demonstrating operationalisation of the One Health approach at the local level.

Financial Implication:

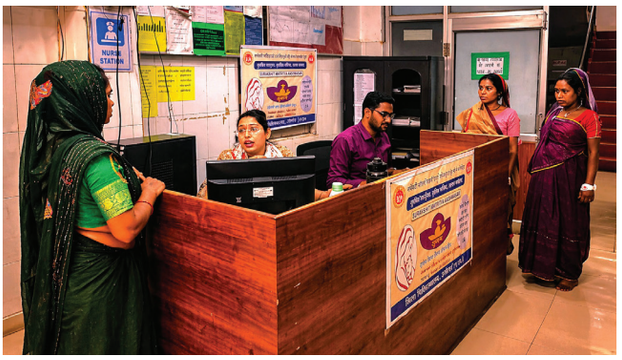
The programme is supported through Local Self-Government Institution (LSGI) project funds and communicable disease prevention funds.

Scalability:

The initiative is scalable.

MADHYA PRADESH

SUMAN ICCC AND DISTRICT SUMAN HELP DESK INITIATIVE FOR ASSURING TIMELY MNCH SERVICE DELIVERY



Problem Statement

As per SRS 2021-23, Madhya Pradesh has 3rd highest MMR (142). Ensuring the timely and quality of ANC services to Pregnant Women remains a major challenge in the state. To address these gaps, SUMAN (Surakshit Matritva Aashwashan) scheme was launched by Government of India on 10th October 2019 with a goal to achieve zero preventable mortality and morbidity for the pregnant women and newborn. In state, the achievement of the objectives of the SUMAN programme are being envisaged through RCH ANMOL M.P. portal.

Programme Description

The state has established an Integrated Command and Control Centre (ICCC) under SUMAN programme to institutionalise the mechanisms for tracking the Maternal, Neonatal and Child Health (MNCH) services delivered by health services providers and validating the services received by beneficiaries, which includes conditional cash transfers (CCTs) and delivering awareness messages to the beneficiaries. The programme includes intensive follow-up of MNCH services; assured pre-referral information to higher centre; mechanisms for addressing grievances; ensuring 100% reporting and follow-up of Maternal and Infant Deaths; and evidence-based planning of the programmes.

The conceptual framework of SUMAN integrates the ICCC and District Help Desks with the RCH Portal and MP ANMOL system to strengthen beneficiary tracking and service delivery in MP. Beneficiary and provider information from the RCH Portal is shared with tele callers for follow-up and gap identification. State ICCC monitors high-risk cases, due services, and programme performance, while district help desks track missed services, referrals, and beneficiaries requiring attention. ANMs, CHOs, Medical Officers, and Gynaecologists enter service data into MP ANMOL portal and facility modules. Combined data analysis enables state and district officials to take timely corrective actions, improving maternal and child health service coverage and accountability.

For the ICCC and district SUMAN helpdesk, a 20 seater call centre has been established, where 40 tele callers, 3 supervisors and one manager is posted at the ICCC. Additionally, one supervisor and one tele caller is also posted in all 62 facilities of SUMAN help Desk. An orientation was conducted for all the relevant staff on SUMAN ICCC and help desk related activities.

Programme Outcome

Every month, more than 50,000 calls are made to High Risk Pregnant Women (HRPW) from SUMAN ICCC, and on average 30,000-35,000 HRPW are being tracked through SUMAN ICCC. Around 4,000 ANMs and 5,000 CHOs are monitored for service delivery during VHNDs and ANC clinics monthly. The performance of gynaecologists, DHOs, DPMs, and BPMs is tracked through SUMAN ICCC. Logistics availability at VHND and ANC sites is reviewed via district SUMAN Help Desk (DSHD). Additionally, reporting and management of HRPWs have improved significantly on the RCH portal following the implementation of SUMAN ICCC and DSHD systems. More than 3.5 lakh HRPWs were tracked from SUMAN ICCC in FY 2024-25 out of approximately 4 lakh identified HRPW. Additionally, More than 60,000 HRPWs have received services after follow-up from DSHD.

Financial Implication

Operational cost of ICCC and District SUMAN Help Desk is approximately around INR 23 Lakhs per month, as approved in RoP.

Scalability

The innovation has potential for scale up across other states, through existing NHM and other mechanisms.

MAHARASHTRA

MATRUSNEH

Problem Statement

Nandurbar is a tribal district in Maharashtra that reports high maternal and child mortality rates. There is a high prevalence of home deliveries, particularly in Dhadgaon and Akkalkuwa blocks, which contribute significantly to maternal and neonatal mortality. Maternal and child death reviews indicate that the majority of delays were 'Type-1' delays occurring at the decision-making level. In this context, a need for focused intervention was felt to promote institutional deliveries and prevent avoidable maternal and neonatal deaths.

Programme Description

To streamline institutional deliveries in Nandurbar district, the 'Lakshya-84 Days' campaign was launched on 1st September 2023. The programme aimed at covering antenatal pregnant women from 42 days before the expected date of delivery to 42 days after delivery, thereby covering a critical 84-day continuum around childbirth. During this period, pregnant and lactating women were followed through routine and additional home visits by Medical Officers (MOs), CHOs, ANMs and ASHAs to ensure 100 % institutional deliveries.

The intervention was specifically strengthened in Dhadgaon and Akkalkuwa blocks where the prevalence of home deliveries was higher. Structured home visit planning was undertaken for

systematic tracking and follow-up of beneficiaries. The programme aims to provide quality antenatal and postnatal services to mothers and children, strengthen referral services, promote utilisation of Maherghar facility services, and reduce home deliveries to zero %. It also seeks to reduce maternal, infant and child mortality indicators in the district. The existing human resources in the form of ASHAs, ANMs, CHOs and MOs were utilised for implementation, and capacity building of staff was conducted through training sessions and meetings for effective execution of the programme.

Programme Outcome

Following the launch of the programme on 1st September 2023, measurable improvements were observed. The prevalence of home deliveries reduced from 8 % in FY 2022–23 to 3 % in FY 2023–24 and further to 1.5 % in FY 2024–25 (till October 2024). Maternal deaths declined from 46 in FY 2022–23 to 37 in FY 2023–24 and further to 27 in FY 2024–25 (till November 2024). Child deaths reduced from 812 in FY 2022–23 to 666 in FY 2023–24 and further to 442 in FY 2024–25 (till November 2024).

Financial Implication

No additional costs incurred.

Scalability

The MatruSneh Programme utilises existing system resources and is therefore suitable for scaling up at larger levels within the state.

ODISHA

COMPREHENSIVE GERIATRIC CARE CAMPS UNDER URBAN HEALTH SYSTEM

Problem Statement

India's demographic landscape is changing rapidly with an increasing proportion of elderly population. By 2030, nearly 16% of India's population will be above 60 years, resulting in higher demand for age-sensitive health and social care services. Urbanisation, migration and the breakdown of traditional joint family systems have left many elderly persons isolated and dependent with limited social support. Weakened immunity and multiple chronic conditions make older adults highly vulnerable to non-communicable diseases (NCDs), geriatric syndromes, and mental health issues.

Recognising these challenges, Odisha initiated a comprehensive geriatric care package through regular health camps at Urban Primary Health Centres (UPHCs) and selected Urban Ayushman Aarogya Mandir (UAAMs) to improve access to integrated, elderly-friendly services.

Programme Description

Odisha's geriatric care model goes beyond existing national guidelines through dedicated geriatric care days with a structured schedule of camps every 1st Saturday in the facility and 4th Saturday in the operational areas. Services combine screening, diagnosis, treatment, referral, physiotherapy, yoga, and mental wellness, with systematic education of caregivers on nutrition, mobility, and daily health needs. Social engagement activities such as quiz, essay, poetry, plantation drives, and storytelling address loneliness and promote active ageing. The model includes digital integration through line listing and ABHA ID generation for each elderly beneficiary for continuity of care, and camps are extended to parks, community centres, and old age homes. Specialist OPDs and referrals are integrated with UPHC/UAAM services.

Programme Outcome

Since its launch on 7th December 2024, 1,272 geriatric camps have been organised and 56,880 elderly beneficiaries mobilised. A total of 55,640 beneficiaries were screened for NCDs, 28,624 attended wellness sessions, 51,848 lab tests were conducted, 12,632 attended physiotherapy sessions, 15,362 received nutrition counselling, 55,184 received free essential drugs, 29,024 accessed specialist OPD services, 1,496 were referred for higher-level care, and 3,208 elderly aged 70+ received Ayushman Vaya Vandana Cards.

Financial Implication

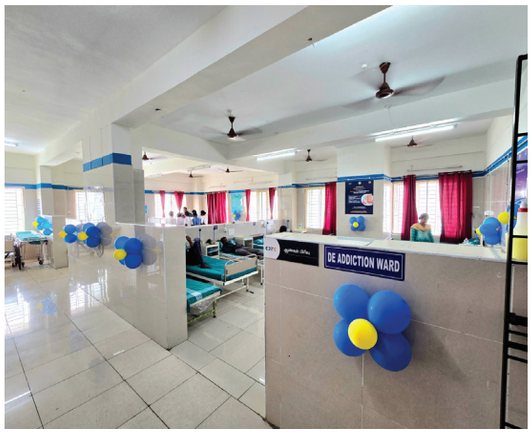
The programme has been designed to be low-cost and resource-leveraged with Rs 2,000 per camp (1st Saturday) and Rs 5,000 per outreach camp (4th Saturday). IEC/BCC activities and geriatric health card printing were supported under UAAM XV-FC grants, using existing workforce and infrastructure of UPHCs and UAAMs.

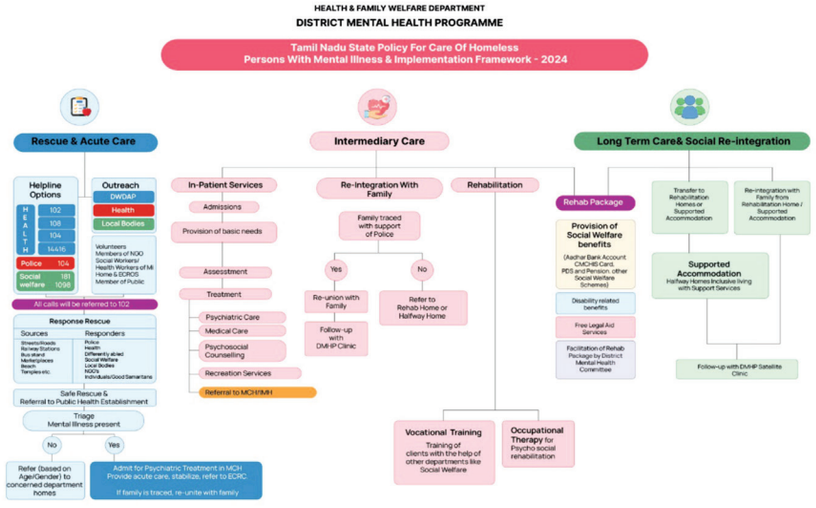
Scalability

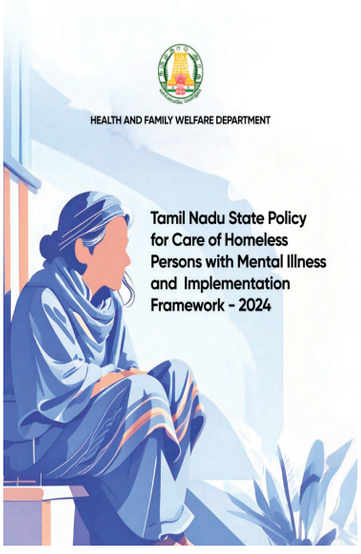
This initiative has proven effective, affordable, and scalable, making it a strong initiative for replication in India given the ongoing demographic transition towards an ageing society.

TAMIL NADU

MANAM PROGRAM - AN INITIATIVE TO PROMOTE MENTAL HEALTH; KALANGARAI MAIYAM TAMIL NADU'S STRATEGY FOR ADDRESSING DRUG ABUSE & COMPREHENSIVE MENTAL HEALTH CARE FRAMEWORK FOR HOMELESS PERSONS WITH MENTAL ILLNESS (HPWMI): A POLICY DRIVEN APPROACH







Problem Statement

Tamil Nadu faces a dual challenge of rising mental health concerns among students and widespread substance abuse across the population. Suicide rates in the state have consistently remained above the national average, with 16,883 suicides reported in 2020. Students accounted for 8.2% of total

suicide deaths in India, and Tamil Nadu contributed 7.4% of these cases. College years represent a critical developmental phase, yet stigma, family expectations, academic stress, and lack of structured support often leave psychological distress unnoticed. At the same time, substance use disorders remain a major public health challenge. NFHS-5 data shows that 25.4% of men in Tamil Nadu aged 15 years and above consume alcohol and 20.1% use some form of tobacco, while the Magnitude of Substance Abuse in India 2019 report ranked Tamil Nadu third nationally, with 37 lakh individuals needing help for alcohol problems. Together, these realities highlight the urgent need for a proactive, structured framework that promotes mental well-being and ensures timely, accessible psychological and deaddiction support.

Programme Description

To address these challenges, the Government of Tamil Nadu introduced two complementary initiatives. The first is the MaNaM Programme (Mananala Nallaatharavu Mandram), a Mind Health Support Forum established across all Government Medical Colleges. The programme promotes student well-being through awareness, early identification of distress, peer support, and accessible institutional care. Each college has a governance structure comprising Peer Ambassadors trained in mental health awareness and basic peer support, Faculty Facilitators serving as mentors, Monitoring Committees led by senior administrators, and Empowerment Committees coordinating activities. Weekly awareness sessions on stress management, coping skills, and lifestyle promotion are conducted, alongside creative engagement activities such as music, art, dance, and cooking. A dedicated MaNaM helpline (18005997627) is operated by Psychiatry departments, and monthly meetings provide safe spaces for students to openly discuss concerns.

The second initiative is Kalangarai Maiyam (meaning "Lighthouse"), a state-wide strategy to address substance abuse through a three-tier model of deaddiction services under the Department of Health and Family Welfare. Comprehensive Deaddiction and Rehabilitation Centres (CDRCs) were launched in 25 Medical College Hospitals in February 2025. These centres provide a continuum of care across primary, secondary, and tertiary levels, ensuring accessibility and integration. Services include outpatient and inpatient care, emergency interventions, pharmacotherapy for detoxification, psychological and relapse prevention interventions, psychosocial rehabilitation, laboratory services, and structured follow-up. Strong inter-departmental coordination involving Health, Education, Police, Social Welfare, and DDRO ensures community outreach and referral facilitation.

Programme Outcome

Between April 2024 and March 2025, the MaNaM Programme established 37 clubs across Government Medical Colleges, conducting 1,389 meetings and awareness activities, with 1,18,840 students participating. Importantly, 1,644 students accessed psychological support, including counselling and stress management services, demonstrating increased awareness and help-seeking behaviour. Between March and June 2025, Kalangarai Maiyam recorded 37,632 outpatient (OP) services and 3,070 inpatient admissions, reflecting strong demand and effectiveness of the deaddiction centres.

Financial Implication

For Kalangarai Maiyam, the Government sanctioned a total of Rs.15,81,84,500 for the establishment of 25 deaddiction centres, with each centre costing Rs. 63,27,380. This includes human resource costs (42 Contract staff & 14 Psychiatrists), medicines, diet supplementation, training, contingencies, furniture, linen, and equipment. Each centre is staffed with psychiatrists, counsellors, psychiatric social workers, nurses, and support staff. For MaNaM, no additional cost implication has been incurred.

Scalability

MaNaM has already been implemented across all Government Medical Colleges, with plans to expand to all colleges statewide, thereby extending structured mental health support to a much larger student population. Kalangarai Maiyam has demonstrated scalability through SOP-driven, community-supported, and cost-effective service delivery, making it a replicable model for other states. Both initiatives are sustainable, scalable and replicable as they build on existing infrastructure and community participation.

UTTAR PRADESH

6-DAYS OBSERVERSHIP TRAINING OF NBSU STAFF NURSES AND MEDICAL OFFICERS AT DISTRICTS LEVEL SNCU & ENHANCING THE KNOWLEDGE AND SKILLS OF FAMILY PLANNING COUNSELLORS THROUGH CASE-BASED LEARNING

Problem Statement

Ensuring quality newborn care at Newborn Stabilisation Units (NBSUs) required strengthening of provider capacity, as existing 3-day classroom training was found insufficient to build skills and confidence for service delivery.

In addition, gaps were identified in condition-specific counselling skills among family planning counsellors, despite prior integrated training, indicating the need for continued capacity building through practical and context-based learning approaches.

Programme Description

To address these gaps, two capacity-building interventions were implemented in Uttar Pradesh:

The first is a 6-day Observership training for NBSU Staff Nurses and Medical Officers at district-level SNCUs, designed as a one-time practical training for providers who had completed classroom-based NBSU training. The observership includes structured rotations across labour room, OPD/postnatal

ward, and SNCU, with a focus on hands-on skill development in newborn care. A guidance note, defined mentor-mentee framework, logbook, and key indicators were developed to standardise training. Districts prepared micro plans linking SNCUs with NBSUs, and SNCU-trained providers served as mentors. Regular reviews at district level were conducted to track implementation and quality of care.

The second intervention focuses on enhancing the knowledge and skills of family planning counsellors through case-based learning. A state-wide, WhatsApp-based platform was used to conduct weekly case study discussions for 217 counsellors across the state. Case scenarios based on real-life experiences were shared, followed by responses from counsellors and consolidation of correct answers by the state. A monitoring mechanism through weekly dashboards tracked participation and engagement.

Programme Outcome

Under the NBSU observership training, a total of 46 Medical Officers and 222 Staff Nurses (268 providers) from 125 facilities across 22 districts were trained between October 2024 and February 2025. More than 75 percent of participants reported achieving the intended exposure across newborn care procedures, including observed cases, supervised performance, and independent practice. However, gaps remained in independent performance of selected procedures and variation across districts.

The case-based learning initiative led to improvements in counselling quality, including better understanding of practical challenges, increased confidence in counselling across family planning methods, improved communication skills, and more standardised service delivery. A total of 13 case studies covering condition-based counselling scenarios were completed as part of the initiative, with ongoing implementation planned until 31st March 2026. Feedback from the field highlighted the usefulness of the initiative in enhancing practical knowledge and improving counselling effectiveness.

Financial Implication

For the NBSU Observership training, budget provisions include travel allowance, daily allowance, food, honorarium, and contingency. The total cost per batch of 4 trainees for 6 days is Rs. 26,900, with an average cost of Rs.1,121 per participant per day. The total estimated cost for training is Rs 2.23 Cr. No additional costs were incurred for the case-based learning initiative.

Scalability

The NBSU Observership training is being scaled across districts with learnings from 22 districts, with a focus on developing a pool of trainers, increasing participation of medical officers, strengthening skills of staff nurses, and ensuring uniform quality of training through linkage with ongoing mentoring programmes. The case-based learning initiative is being implemented as a continuous state-wide activity with planned coverage of multiple case scenarios until March 2026 and ongoing monitoring of counsellor participation.

ASSAM

CENTRALISED PROCUREMENT SYSTEM IN ASSAM: A MODEL OF EFFICIENCY AND TRANSPARENCY IN STRENGTHENING SUPPLY CHAIN MANAGEMENT

Problem Statement

Assam's healthcare supply chain faced challenges in ensuring timely availability of quality-assured medicines and medical commodities. Major issues included frequent stock-outs of essential medicines leading to unavailability, delays is procurement cycles causing delayed receipt of drugs & a visible lack of quality assurance and supplier accountability. Additionally, a fragmented system of procurement created inefficiency and limited transparency in the procurement process.

Programme Description

The centralised procurement system in Assam was established to improve the efficiency and transparency of the healthcare supply chain through Assam Medical Services Corporation Limited (AMSCL). AMSCL is an ISO 9001:2015 certified organisation helping the State Government in Supply chain Management and procurement of essential medical Commodities in the State of Assam. The procurement of drugs, consumables, and medical equipment has been centralised through a transparent e-procurement system platform. This system not only accelerates procurement cycles but also ensures adherence to stringent quality standards, with products certified by National Accreditation Board for Testing and Calibration Laboratories (NABL). It mitigates delays, reduces redundancy, and enhances cost-efficiency.

The State has empanelled approximately around 197 manufacturers through a 3-year framework agreement, with each essential drug list (EDL) backed by L1, L2, and L3 suppliers to ensure regular uninterrupted supply. Limited tenders are floated among these empanelled suppliers to secure the best rates. Additionally, rate contracts have been established for consumables, surgical items, chemicals, and sutures to streamline procurement. The procurement process is guided by well-

defined procedures, including risk identification and control, procurement, quality control, finance, change management, and responsibility and authority matrix.

Procurement decisions are based on analysis of average monthly consumption data from the DVDMS. A 6-month buffer stock is maintained at district warehouses, with procurement initiated when stock levels fall below 4 months. Limited tenders are issued among empanelled bidders, with the L1 bidder notified after careful examination and justification of rates. L2 and L3 bidders and other can participate in supply if they match the L1 price, promoting competition and ensuring quality and timely supplies. Suppliers face penalties for delayed delivery, ensuring timely supplies. AMSCL has established an online Material Receipt Certificate (MRC) system to ensure timely payment to vendors within 15 days of MRC provided all the necessary valid documents are submitted. Suppliers directly dispatch commodities to District Warehouses based on purchase orders, streamlining the delivery process.

Programme Outcomes

This system in place has enabled consistence inventory levels across facilities, reduced stock outs and shortages, timely delivery from supplier, improved vendor performance, quality compliance, pricing advantage and reduced delivery lead time with optimised cost.

Financial Implications

No additional cost implications.

Scalability

This innovative model can be scaled up to other states, with each state having its own tailored dashboards and DVDMS to track procurement. By combining centralised procurement based on consumption rates with decentralised last-mile delivery, an efficient and responsive supply chain architecture can be created. This adaptable model can be customised to suit the specific needs of each state, enabling widespread implementation and impact.

BIHAR

DIGITISATION OF HEALTH SERVICES THROUGH DVDMS ADOPTION

Problem Statement

Bihar faces challenges with supply chain management, resulting in inadequate availability of essential drugs across health facilities. Operational inefficiency including manual data entry and data silos leads to errors and delays in the procurement processes. Furthermore, the absence of real-time inventory visibility and a push-based distribution system creates frequent stock-out episodes. The lack of transparency and accountability also leads to lowered trust and an overall poor experience for the patients.

Programme Description

The implementation of DVDMS in Bihar has been customised to align with Bihar-specific operational and user requirements, ensuring high adoption and usability across all levels of healthcare facilities. DVDMS is actively utilised across MCHs, DHs, SDHs, RHs, CHCs, AAM-PHCs/UPHCs and AAM-SHCs. To bring the availability of drugs and medical commodities across all Public Health Facilities open to public domain, a QR code based drug availability initiative has been taken up in a phased rollout from DHs to PHCs level in Phase I and from UPHC, APHCs to all AAM- SHCs level in Phase II.

Key features include transparency in drug availability and distribution through QR code for public domain, customised digital modules aligned with Bihar workflows, end-to-end supply chain integration covering indenting, issuing stock, procurement, quality testing, NSQ alerts, write-offs and programme-specific stock, real-time alerts and notifications through automated SMS for Not of Standard Quality (NSQ) and expired or near-expiry drugs, integration with BHAVYA (HMIS), facility-level dashboards, phased rollout, and data-driven planning and budgeting. A tailored

and structured capacity building approach was adopted including targeted user training for pharmacists, data entry personnel, CHOs, ANMs, and facility in-charges, periodic refresher sessions, development of learning resources such as user manuals, SOPs, handouts and visual aids, and field-level handholding with supportive supervision during rollout phases.

Programme Outcome

The intervention has significantly strengthened the public health supply chain. Bihar stands 1st among all states as per MoHFW DVDMS dashboard. All AAM facilities use the DVDMS mobile application for indenting and issuing of medicines, and 100% of facilities are operational on DVDMS enabling statewide digital inventory visibility. Customised dashboards empower district and state officials to make informed decisions and monitor stock levels, usage and compliance, with improved procurement and quality monitoring through purchase orders and test reports managed directly through DVDMS. These outcomes have improved efficiency, transparency, and accountability of the drug supply chain, thereby enhancing overall functionality of the health system.

Financial Implication

No additional financial implications.

Scalability

Implementation of DVDMS in Bihar has transformed its public health supply chain through digitisation and data-driven practices. The integrated, scalable, and adaptive model demonstrates how digital infrastructure can enhance operational efficiency, improve drug availability, and support better patient outcomes. Bihar's approach serves as a replicable model for other states and health systems.

CHHATTISGARH

"CHIRAYU DAY" (EVERY THURSDAY) UNDER RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

Problem Statement

In Chhattisgarh, a significant number of children remain undiagnosed for birth defects, deficiencies, diseases, and developmental delays due to gaps in early screening and awareness. Limited community awareness often results in poor participation and delayed care-seeking behaviour. Additionally, there are gaps in referral linkages and follow-up of identified cases to higher-level facilities, compounded by shortages of trained manpower and inconsistent availability of screening tools and equipment.

Programme Description

Chirayu Day is beneficial for children identified for their health condition for early detection and free treatment and management including surgeries at secondary and tertiary level, along with early intervention services and follow-up care at district level. On Chirayu Day, the RBSK team takes identified children suffering from various diseases to Medical Colleges, District Hospitals and District Early Intervention Centres (DEICs) in an RBSK vehicle, where they are properly examined and treated by medical experts, and dropped home after conservative or surgical management.

On this day, paediatricians, orthopaedics, physiotherapist, audiologist, ENT specialists, eye surgeon, speech therapist and other specialists are present for treatment. Chirayu Day is also observed addressing key health concerns, i.e. AAM-SHCs for vitamin A deficiency, PHC for skin conditions, CHC for goitre/dental conditions, and Medical College and District Hospital for surgical management like club foot. Chirayu Day enables many children to avail full benefits of various health schemes of the government under NHM.

The RBSK team includes a Male & Female Ayush MO, 1 Pharmacist and 1 ANM, supported by specialists, doctors and staff from Medical Colleges, DH, CHC, UCHC, UPHC, AAM- PHC and SHC. All RBSK teams are trained on quality screening and the process of referral and management of children identified by the RBSK team, including use of standardised tools and formats for assessment.

Programme Outcome

In FY 2024–25, a total of 74,590 children were screened during Chirayu Day. Out of these, 72,347 (96.9%) children were treated and 1,600 children were referred to other higher centres.

Financial Implication

It is a cost-effective outreach model using existing infrastructure, HR and mobility budget, with high return in terms of timely referral and management of children identified by RBSK team and improved quality of life.

Scalability

The initiative supporting early detection and intervention, comprehensive specialist care to children identified by the RBSK team, and effective interdepartmental coordination. This initiative is highly scalable and replicable.

CHHATTISGARH

STRENGTHENING WOMEN'S MENTAL HEALTH THROUGH MENOPAUSE COUNSELLING

Problem Statement

Menopause-related mental health issues are under-addressed in urban healthcare systems. Women often suffer in silence due to hormonal changes, social stigma, and lack of awareness. In Chhattisgarh, structured mental health support is particularly limited within UPHCs and UCHCs. The Menopause Counselling Centre model was designed to bridge this critical gap in care.

Programme Description

The model establishes Menopause Counselling Centres within existing urban health facilities (UCHCs/UPHCs) to integrate psychological and physical care for menopausal women. This service is the first-ever menopause specific mental health service in urban public health in Chhattisgarh, which integrates yoga, diet, and lifestyle counselling with routine clinical checkups and community-based support groups guided by trained counsellors. Existing human resources, including Medical Officers, ANMs, and counsellors of UCHCs/UPHCs are involved. Newly engaged human resources are trained psychologists or counsellors for menopause-related mental health concerns and Yoga instructors and dieticians for lifestyle interventions. Special training modules were developed for healthcare providers on menopause-related psychological and physical symptoms. Capacity building also includes on skill enhancement workshops for counsellors, medical officers, and frontline workers and training in yoga and diet counselling related to menopause management.

Programme Outcome

A total of 413 women accessed counselling services, which led to reductions in symptoms of anxiety, depression, and sleep disorders. This engagement also encouraged greater participation in health screenings and lifestyle workshops, thereby strengthening community trust in public health services. Importantly, the initiative established a patient-centred care model that integrates mental health into urban healthcare settings.

Financial Implication

The programme primarily involves conducting training sessions. It is estimated as low-cost and includes only IEC. This is a high-impact model that strategically leverages existing infrastructure.

Scalability

The model can be replicated across other UCHCs/UPHCs by utilizing existing HR and infrastructure. It can be easily integrated into the National Health Mission's ongoing mental health and non-communicable disease (NCD) frameworks. The approach holds potential for expansion through digital counselling platforms for remote urban areas.

CHHATTISGARH

FAST-TRACKING NI-KSHAY POSHAN YOJANA BENEFITS THROUGH CENTRALISED DBT PAYMENT SYSTEM & NUTRITIONAL COUNSELLING FOR TB PATIENTS THROUGH NUTRITION REHABILITATION CENTRE

Problem Statement

Under the National Tuberculosis Elimination Programme in Chhattisgarh, delays in disbursement of financial incentives under the Ni-kshay Poshan Yojana (NPY) were observed due to multiple approval layers, dependency on fund availability at the district level, and fragmented processing systems. These delays affected timely nutritional support to tuberculosis patients, which is critical for improving treatment outcomes.

In addition, tuberculosis patients in districts faced challenges related to inadequate nutritional intake and lack of structured counselling support. Given the high burden of tuberculosis and its impact on patient health, there was a need to strengthen nutritional counselling and promote appropriate dietary practices to improve recovery and treatment adherence.

Programme Description

To address delays in benefit disbursement, a centralised Direct Benefit Transfer (DBT) payment system under the NPY was implemented in Chhattisgarh. Under the existing system, benefits were processed at the Tuberculosis Unit level and required multiple levels of approval at the district level prior to disbursement. The intervention shifted the approval authority to the state level, enabling centralised processing of payments through the Public Financial Management System and integration with Nikshay. This reform was implemented through coordination between the State TB Cell, Central TB Division, State Finance Department, and associated technical teams, with standard operating procedures followed to clear pending cases and streamline fund flow processes .

Simultaneously, nutritional counselling for tuberculosis patients was strengthened through Nutrition Rehabilitation Centres (NRCs) in Durg district. From January 2025 onwards, structured counselling sessions have been conducted twice weekly, where TB patients are advised on protein-rich diets including locally available foods such as rice, jaggery, and green vegetables. Counselling is provided by trained personnel at the NRC, who also distribute diet charts and educate patients on the importance of nutrition alongside medication. The intervention also includes efforts to address patient-specific concerns, adverse drug effects, and linkage with Nikshay Mitra support where required. Both interventions were implemented using existing programme platforms and human resources, with no additional HR.

Programme Outcome

The centralised DBT system has resulted in a significant reduction in delays associated with benefit disbursement. The average turnaround time from creation of benefit to Public Financial Management System (PFMS) acknowledgment reduced from approximately 61 days to 26 days, while the total time from creation to final payment reduced from approximately 78 days to 47 days during the course of implementation. The system also enabled clearance of backlog payments and improved real-time monitoring and transparency through integrated dashboards.

The nutritional counselling intervention has reached 161 tuberculosis patients to date through structured sessions at the Nutrition Rehabilitation Centre. Following the introduction of counselling, a reduction in tuberculosis patient deaths was observed from 75 deaths during January to June 2024 to 53 deaths during the same period in 2025. Improvements in patient weight and overall health parameters, including general condition and nutritional indicators, have also been reported following adherence to dietary advice.

Financial Implication

The centralised DBT system was implemented without any additional financial cost, as it optimised existing financial management systems and processes. Similarly, nutritional counselling was delivered through existing Nutrition Rehabilitation Centres using available human resources and infrastructure. Both interventions therefore did not require additional financial investment and were implemented within existing programme budget.

Scalability

The centralised Direct Benefit Transfer model demonstrates potential for replication across other states, as it standardises approval processes, eliminates the need for district-level fund allocation, and improves efficiency and accountability in financial disbursement. The model supports better treatment adherence and programme performance through timely financial support to patients.

The integration of nutritional counselling into existing Nutrition Rehabilitation Centres provides a scalable approach to strengthening patient support services. The intervention leverages existing infrastructure and can be expanded to other districts to improve nutritional status, reduce mortality, and enhance overall treatment outcomes among tuberculosis patients.

DELHI

PATH TOWARDS ZERO HOME DELIVERIES: ADDRESSING MARGINALIZED POPULATIONS DELHI'S INSTITUTIONAL BIRTH MOVEMENT



Problem Statement

Home deliveries continue to occur in Delhi, accounting for approximately 8 percent as per NFHS-5 and around 8,000 cases (approximately 3%) as per HMIS 2022-23. These are often associated with non-reported and high-risk pregnancies, migration, socio-cultural barriers, and health system constraints, necessitating a focused, mission-mode approach to ensure universal access to safe institutional childbirth.

Programme Description

To address the continued occurrence of home deliveries, the Directorate of Family Welfare, Government of NCT of Delhi, launched the Sansthagat Prasav Abhiyan in 2023 as a mission-mode initiative aimed at achieving 100 percent institutional deliveries. The approach was based on detailed data analysis, identification of root causes, and implementation of targeted interventions across districts. The implementation followed a phased, stepwise methodology. Initially, root cause analysis was undertaken at the state level, identifying key issues such as availability of ambulances and behaviour of healthcare staff. These were addressed through targeted interventions including strengthening services in peripheral facilities and conducting Respectful Maternity Care (RMC) workshops.

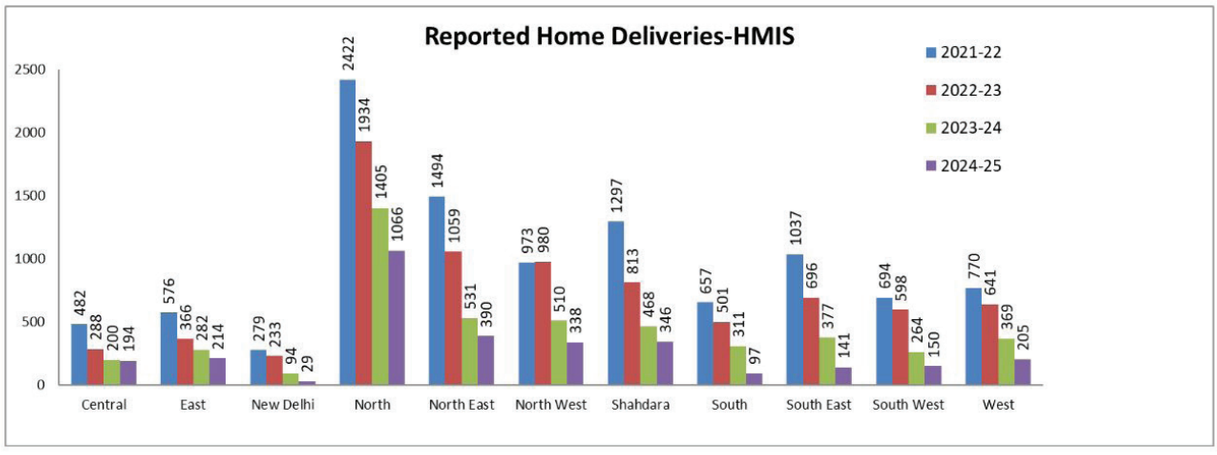
High-burden districts and clusters with high incidence of home deliveries were identified using HMIS and survey data and categorised as "hotspots." Districts were required to undertake detailed analysis and implement targeted corrective measures. Home delivery audits were institutionalised, wherein each case was reported, reviewed, and followed up to ensure postnatal care and preventive action for future cases.

A combination of general and targeted interventions was implemented, including strengthening reporting mechanisms, enhancing accountability through line-listing and audit proformas, improving referral linkages, and ensuring supportive supervision through regular reviews. Community-level interventions included beneficiary engagement through field visits, Garbhini Parivar Sammelan, and targeted IEC activities to improve awareness and birth preparedness.

System strengthening measures included improved availability and positioning of CATS ambulances, establishment of ASHA help desks at delivery points, strengthening referral systems through cluster meetings, and capacity building of healthcare providers. Engagement with private practitioners and community influencers such as local leaders and traditional birth attendants was also undertaken to improve outreach and trust.

Programme Outcome

The implementation of the mission-mode approach has resulted in a sustained decline in home deliveries across all districts, as reflected in HMIS data. The reduction has been achieved through coordinated efforts of district officials, programme officers, and frontline workers, supported by continuous monitoring, targeted interventions, and community engagement.



Financial Implications

No additional financial implication.

Scalability

The initiative demonstrates a model based on good governance, real-time data use, targeted area-based interventions, community mobilisation, public and private engagement, respectful maternity care, and strengthened referral and transport systems. The approach serves as a scalable model for other states and urban centres aiming to reduce home deliveries and ensure safe and dignified childbirth for women.

GOA

EARLY DETECTION OF LUNG CANCER THROUGH AI-ENABLED CHEST X-RAY SCREENING




Problem Statement

Lung cancer is one of the leading causes of cancer-related mortality, largely due to late diagnosis. In many cases, early lung nodules are missed or misinterpreted, and symptoms are often mistaken for tuberculosis or other respiratory conditions. Conventional diagnostic pathways involve multiple referrals, delayed imaging, and fragmented follow-up, resulting in loss of valuable time before treatment initiation. Recognising the need for earlier detection and streamlined diagnostic pathways, the Directorate of Health Services, Government of Goa, initiated an AI-enabled screening programme to strengthen early identification of lung cancer through digital chest X-ray analysis and coordinated referral mechanisms.

Programme Description

Launched in February 2024, the initiative integrates artificial intelligence into routine chest X-ray screening across public health facilities. Using the qXR AI tool, digital chest X-rays are analysed for lung nodules and other abnormalities, generating malignancy risk scores that help clinicians identify high-risk cases. Patients flagged by the system are referred for confirmatory diagnostics such as Low Dose CT, CT scan, or biopsy, ensuring early clinical evaluation and treatment planning. The cloud-based AI platform integrates with existing digital X-ray systems and allows real-time analysis, enabling clinicians to make faster, evidence-based decisions. The programme has been deployed across multiple primary, secondary, and district-level facilities in Goa, supported by structured referral pathways, clinical coordination, and continuous monitoring mechanisms to ensure timely follow-up of suspected cases.

Programme Outcome

The AI-enabled screening model has strengthened early detection capacity within the public health system. More than 20,000 chest X rays have been analysed since implementation, with more than 800 suspected nodules identified and 16 lung cancer cases confirmed at earlier stages since July 2025. The streamlined referral pathway has reduced the number of visits required for diagnosis and shortened the time taken to reach confirmatory testing. By improving triage and clinical decision-making, the initiative has helped reduce delays in treatment initiation and enhanced continuity of care for high-risk patients. The programme also demonstrates how digital technologies can augment clinical capacity, improve diagnostic accuracy, and strengthen cancer care pathways in resource-constrained settings.

Financial Implication

The intervention leverages existing digital X-ray infrastructure and cloud-based AI platforms, making it cost-efficient. By reducing unnecessary referrals, repeated imaging, and delayed diagnosis, the approach has the potential to optimise resource utilisation while improving patient outcomes.

Scalability

The Goa experience illustrates how artificial intelligence can be integrated into routine public health workflows without major structural changes. The model is adaptable to other states with digital radiography facilities and can be extended to detect additional lung conditions beyond cancer. By combining technology, clinical coordination, and referral linkages, the initiative offers a replicable pathway for strengthening early cancer detection within the public health system.

GUJARAT

GOOD, REPLICABLE & INNOVATIVE PRACTICES (GRIP) SUMMIT – A PLATFORM FOR INNOVATION & BEST PRACTICES

Problem Statement

Despite various healthcare initiatives in Gujarat, there remains a significant gap in the identification, dissemination, and replication of innovative and effective practices across the state. Often, impactful innovations remain localised without mechanisms for scaling or knowledge sharing. Recognizing this, there is a need for a platform that captures, evaluates, and promotes good, replicable, and innovative practices within the public healthcare system to improve service delivery and outcomes.

Programme Description

The Government of Gujarat has been at the forefront in fostering a culture of innovation. To institutionalise these efforts and acknowledge the innovative practices in health system, the state of Gujarat through State Health System Resource Centre – Gujarat (SHSRC - G) initiated the GRIP State Summit, replicating the National Summit on Good, Replicable & Innovative practices, conducted by MoHFW. This summit aims to showcase innovative practices in healthcare implemented across Gujarat, provide a platform for health professionals, administrators, and educators to exchange

knowledge and experiences and endorse standout innovations through a competitive evaluation process.

Good practices are invited in the first quarter of the year from all districts, corporations, and medical colleges, district hospital and sub district hospital across the state. A Technical Screening Committee of 7 members, constituted of Faculties of Medical College, Key health stakeholders, including NGOs is constituted for evaluation and selection of the best practices, which are given a score out of 75 marks based on predefined parameters. The selected best practices are evaluated by a jury of 3-4 members, and the best practices receiving maximum marks are awarded the GRIP Award in Public Health.

Programme Outcome

As of 2025, 2 GRIP State Summits have been conducted. In the first summit, a total of 73 best practices were received, out of which 29 were shortlisted for the summit. A total of 300 participants attended the summit, and 8 practices were awarded the GRIP award. In the second summit, a total of 63 practices were submitted, out of which 25 were shortlisted under 4 domains. Additionally, 18 best practices were shortlisted under 2 domains for Poster Exhibition. For the GRIP award, 8 best practices and additionally 4 best practices from the Poster exhibition were selected. A total of 450 participants attended the summit. The third State Summit was also announced in early 2025. The State also conducted Regional GRIP summits across 5 regions in Gujarat, following the model of the State Summit.

The State has also released two compendiums of the Good, Replicable and Innovative practices from the 2 summits conducted, which is a repository of the submitted best practices showcased in the summit.

Out of the submitted best practices in the two summits, 14 from the Public Health domain and 10 from the Medical Education domain were shortlisted for expert scrutiny and consideration for further scale-up, based on their feasibility for implementation at the State or Regional level. Subsequently, two expert committees—one each for Public Health and Medical Education—were constituted to review, evaluate, and assess the scalability potential of these best practices. The process to examine their replicability has also been initiated.

Institutionalisation of GRIP across Gujarat at State and Regional levels promotes structured knowledge sharing among public health, medical, and administrative stakeholders. Through comprehensive documentation, dissemination, and strategic scaling of high-impact innovations, the initiative strengthens replication potential while fostering a sustained culture of innovation and continuous improvement in health service delivery statewide.

Financial Implication

No additional cost implications since the initiative has been implemented from the budget approved in NHM RoP.

Scalability

The innovation has potential for scalability across the States/UTs using the existing NHM resources and mechanisms.

GUJARAT

SWASTHYA PARISHAD – DIALOGUES FOR HEALTHIER GUJARAT

Problem Statement

Strengthening public health outcomes requires not only technical interventions but also strong governance, community engagement, and inter-sectoral collaboration. Traditionally, health planning processes have been largely administrative, with limited institutional platforms for structured dialogue between policymakers, communities, and frontline stakeholders. Recognising the need for participatory decision-making and policy reform grounded in field realities, the Government of Gujarat established the Swasthya Parishad platform to institutionalise structured dialogue on health priorities at both district and state levels.

Programme Description

Swasthya Parishad is designed as an inclusive governance platform bringing together public representatives, administrators, community leaders, private providers, academia, civil society, and external1 partners to collectively deliberate on key health challenges and propose actionable solutions. The initiative was formally adopted through a Government Resolution in March 2024, creating district- and state-level committees to guide planning, implementation, and monitoring. District Parishads are conducted as annual events chaired by District Collectors, where priority health issues are discussed through structured sessions supported by evidence and field data.

Recommendations emerging from these deliberations are consolidated into action plans with clearly assigned responsibilities and timelines. The State Health Systems Resource Centre (SHSRC), Gujarat acts as the nodal agency for coordination, monitoring, and follow-up of agreed actions. The first phase of implementation covered five districts with diverse socio-geographic contexts, followed by the first state-level Swasthya Parishad held in January 2025, which brought together over 150 stakeholders across sectors to deliberate on maternal health, malnutrition, adolescent well-being, and non-communicable diseases.

Programme Outcome

The Swasthya Parishad initiative has strengthened the visibility of key public health concerns and created a structured mechanism for multi-sectoral dialogue and collaborative problem solving. District-level consultations have generated locally relevant action plans addressing issues such as maternal mortality, malnutrition, vector-borne diseases, adolescent health, and service delivery gaps. At the state level, the process led to the formulation of a comprehensive roadmap with actionable recommendations involving multiple departments and partners. Independent documentation of the initiative has highlighted its potential to improve community ownership, strengthen convergence across sectors, and enhance responsiveness of health planning to ground realities.

Financial Implication

The initiative primarily utilises existing administrative platforms, programme structures, and institutional mechanisms. Costs are largely limited to organisation of events and coordination activities, making the model financially feasible and sustainable for continued implementation and expansion.

Scalability

The model is highly replicable across States/UTs, as it builds on existing administrative systems and community engagement frameworks. Institutionalising such platforms can support evidence-based policy making, improve inter-departmental coordination, and foster citizen-centred health systems.

HIMACHAL PRADESH

EQUIPPING FAMILY CAREGIVERS TO PROVIDE QUALITY CARE FOR ANTENATAL AND POSTNATAL MOTHERS AND THEIR INFANTS BY LEVERAGING EXISTING HEALTHCARE WORKFORCE

Problem Statement

In Himachal Pradesh's remote and tribal areas, many families lack knowledge to provide safe home-based care for pregnant women, new mothers, and newborn babies. Despite more institutional deliveries, there is lack of adequate guidance on essential prenatal/postnatal practices, danger signs, and timely care-seeking. Limited time for structured counselling in facilities leaves a gap in continuity of care at home, contributing to preventable maternal and newborn complications.

Programme Description

The Care Companion Programme (CCP) was introduced in December 2022 across 31 high-delivery facilities in 10 districts of Himachal Pradesh, covering about 85 percent of the state's delivery load. The programme was integrated into the existing Maternal Health Programme and used the current infrastructure and staff, without hiring additional personnel. The central idea was to transform the hospital stay into a meaningful learning opportunity for pregnant women, postnatal mothers, and their caregivers.

A Training of Trainers model was adopted, where selected staff nurses from Antenatal Care (ANC), Postnatal Care (PNC), and Sick Newborn Care Units (SNCU) wards were trained as master trainers, who would train other staff within their facilities. They were provided with modules, demonstration models, and educational materials to conduct structured sessions. During these sessions, nurses interacted directly with mothers and family members in the OPDs, MCH wing and Wards, explaining essential practices such as completing at least four antenatal check-ups, taking iron and folic acid tablets regularly, initiating breastfeeding within one hour of birth, practicing exclusive breastfeeding, maintaining dry cord care, performing skin-to-skin care for newborns, and recognizing danger signs.

Pre- and post-session knowledge assessments were conducted in five facilities using structured questionnaires, with records captured in the Internal Management Information System. Families were linked to a toll-free WhatsApp Mobile Care Companion Service (MCCS number: 18002039711) for ongoing ANC, PNC and infant care support. Follow up calls with assessed beneficiaries checked adoption of practices at home, where pregnant women were contacted within 15 days of their Expected Date of Delivery, and postnatal and SNCU beneficiaries were followed up on or after 42 days after delivery. All findings were systematically documented in the internal MIS to support ongoing monitoring and analysis.

Programme Outcome

The programme reached a large number of people within a relatively short time. From December 2022 to March 2025, 1,86,878 beneficiaries and caregivers were trained through 10,846 sessions. A total of 47,505 beneficiaries were connected to the mobile support service (MCCS), and 6,730 (1656 ANC, 3740 PNC, 1334 SNCU) were followed up telephonically to assess the impact of CCP.

Knowledge levels improved significantly. As per internal MIS (from Dec 2022 to Mar 2025), among those assessed in five facilities, there was a 37 percent improvement in knowledge among ANC beneficiaries, 32 percent among PNC beneficiaries, and 37 percent among caregivers in SNCUs. Follow-up results showed positive changes in behavioural outcomes. A large majority of pregnant women completed more than four antenatal check-ups. In the ANC group, 24.7% of beneficiaries were identified as high-risk, and continued monitoring ensured appropriate care. Additionally, 72% of infants were born with a healthy birth weight above 2.5 kg, and 92.8% initiated breastfeeding within the first hour of birth. Among PNC and SNCU beneficiaries, 92.9% of mothers were exclusively breastfeeding, while 97.4% practiced correct umbilical cord care. Kangaroo Mother Care (KMC) was adopted by more than 70% of caregivers in PNC cases and 84.2% in SNCU cases. Importantly, the readmission rate in SNCU remained low at 5%, indicating improved newborn care practices at home.

As per HMIS data, the proportion of pregnant women receiving four or more antenatal check-ups increased from 79% in FY 2022–23 (baseline year) to 93% in FY 2024–25, reflecting a 14% improvement over two years. The percentage of women receiving the full course of 180 Iron and Folic Acid (IFA) tablets rose by 2%, while early initiation of breastfeeding within one hour improved from 91% to 95%, marking a 4% increase. According to PMSMA portal data, detection of High-Risk Pregnancies increased from 16% in FY 2023–24 to 21% in FY 2024–25. Additionally, antenatal footfall at PMSMA clinics rose by 33% within one year of the intervention.

Financial Implication

No additional cost was required for implementing the programme.

Scalability

The programme is embedded within the existing Maternal Health framework and leverages current infrastructure and human resources, enabling seamless implementation without requiring additional inputs, thus making it scalable and replicable.

JHARKHAND

STRENGTHENING HOME VISITS IN JHARKHAND (INTEGRATED HBNC & HBYC MODULE, JOINT VISITS INVOLVING AWWS AND VISIT WISE TRACKING OF EACH CHILD)




Problem Statement

Home visits by frontline workers under Home Based Newborn Care (HBNC), Home Based Young Child Care (HBYC) and Poshan 2.0 are critical for maternal, newborn, and child health, nutrition, and early childhood development. However, HBNC and HBYC were conceptualised as two separate segments. This separation created the need for a more consolidated and structured approach. There was a requirement to ensure quality and uniformity of home visits. Coordination between ASHAs, AWWs, and supervisors needed strengthening. There was also a need for better tracking and planning of child-based services.

Programme Description

The initiative introduces a consolidated approach through an Integrated Home Visit Module (IHVM). Its key components are:-

1. Integrated Home Visit Module (IHVM): A structured module combining HBNC and HBYC which brings together the essence of existing resources. Ensuring quality and standardisation of home visits
2. Focus Areas of Visits: Child health, nutrition, early childhood development, maternal support.
3. Joint Home Visits: Conducted by ASHA and AWW together. It ensures structured service delivery which benefits both caregivers and service providers
4. Digital Child-Based Tracking: Developed a mechanism for real-time tracking of each child which improves planning and coordination between: ASHA & AWW, ASHA Facilitator & supervisors

Programme Outcome

This initiative ensures quality of each home visit conducted promoting a structured and integrated service delivery which strengthens coordination between ASHA, AWW, and supervisors. It also enables child-based real-time tracking, improving planning and follow-up. Overall improvement of the delivery of services related to: Child health, nutrition, early childhood development, maternal support.

Financial Implications

The initiative leverages existing frontline workers (ASHAs and AWWs) from the Health and Women and Child Development departments, resulting in no additional financial burden on the state. The approach suggests optimisation of existing resources rather than creation of separate systems.

Scalability

The innovation is already implemented at state level in Jharkhand ,designed as a consolidated and structured module (IHVM) with no additional cost to the state, making it replicable .

KARNATAKA

FORMATION & EMPOWERMENT OF MEDICAL BOARDS FOR LATE TERM ABORTIONS

Problem Statement

The amendment to the Medical Termination of Pregnancy (MTP) Act, 2021 enabled termination of pregnancy beyond 24 weeks in cases of serious foetal abnormalities through approval by designated Medical Boards. Prior to this, women were required to seek judicial approval, often resulting in delays, emotional distress, and limited access to safe and timely services. There was a need to operationalise the provisions of the amended MTP Act through institutional mechanisms to ensure timely, safe, and ethical access to abortion services, particularly cases identified at later gestational stages.

Programme description

Karnataka operationalised the MTP (Amendment) Act, 2021 by establishing Medical Boards to streamline access to safe, ethical, and medically approved abortion services beyond 24 weeks. A total of 35 Medical Boards has been constituted across 31 districts (including 5 in Bengaluru Urban), located at Medical Colleges and District Hospitals, each comprising a Gynaecologist (Chairperson), Paediatrician, Radiologist/Sonologist, and Anaesthetist, as per statutory provisions. The Department of Health & Family Welfare oversees implementation and operational coordination undertaken by district health officials and facility administrators. A digital communication platform (WhatsApp group) has been established to enable real-time coordination, case-based discussions, dissemination of guidelines, and cross-learning among Medical Board members, facilitating timely decision-making and expert support.

Capacity building has been undertaken through statewide orientation sessions for Medical Board members, service providers, and postgraduate trainees, covering provisions of the MTP Act, roles and responsibilities, and documentation requirements. Service strengthening measures include issuance of official circulars to public and private providers, empanelment of MTP facilities through the eKalyani portal, and regular facility inspections to ensure infrastructure readiness, legal compliance, and proper documentation.

Community engagement is facilitated through training of ASHAs and frontline workers to promote awareness and early referrals, along with dissemination of information through professional platforms (OBG Society meetings) and public health observances (International Safe Abortion Day and World Population Day). A structured monitoring mechanism has been instituted through a standardised monthly reporting system capturing cases reviewed, approvals and rejections, and clinical outcomes. Regular site visits, supportive supervision, and identification of high-performing Boards for replication further strengthen implementation and accountability.

Programme Outcome

Following the operationalisation of Medical Boards, Karnataka has significantly strengthened access to timely and medically approved services. Between October 2023 and March 2025, a total of 415 cases were reviewed, of which 383 cases (92%) were approved, and 32 cases (8%) were denied based on medical considerations.

Phase-wise trends indicate that 90 cases were reviewed between October 2023 and March 2024 (with 5 denials), and 325 cases between April 2024 and March 2025 (with 27 denials), reflecting increased utilisation of the mechanism. On average, approximately 23 cases per month received approval for termination, indicating improved access to safe and timely services. Denied cases are systematically tracked, with some cases seeking judicial recourse, while others are counselled to continue pregnancy based on clinical assessment.

Scalability

The structured institutional mechanism for Medical Boards, supported by standardised protocols, digital coordination platforms, and capacity-building initiatives, demonstrates potential for replication across other states.

KARNATAKA

ASHAKIRANA - A SPECTACLE OF HOPE

Problem statement

Blindness and vision impairment remain significant public health challenges in India. According to the National Programme for Control of Blindness and Visual Impairment (NPCBVI), the primary causes of blindness are cataract (66.2%), followed by uncorrected refractive errors (18.6%), glaucoma (6.7%), and diabetic retinopathy (3.3%). To address this, Karnataka launched the Ashakirana Programme to conduct massive eye health awareness and screen campaigns targeting cataract and refractive errors, the two most common and preventable causes of blindness.

Programme description

Ashakirana was initially launched in a phased manner and is now transitioning into a sustainable model through infrastructure integration and policy redesign. The initiative emphasises community participation, with ASHAs conducting door-to-door campaigns for primary screening

and mobilisation, and Refractionists and Male Health Workers conducting secondary screening and facilitating service delivery. In Phase III, the programme has moved beyond camp-based screening to an institutionalised approach with the establishment of permanent Vision Centres in District Hospitals (DHs), Taluk Hospitals (THs), Community Health Centres (CHCs), and Medical College Hospitals. ASHAs and Community Health Officers (CHOs) continue to conduct preliminary screening during routine household visits and refer suspected cases to these Vision Centres for detailed examination and management. Cataract patients are referred to the nearest government hospitals or NPCBVI-recognised NGOs for surgical intervention, while other eye conditions are referred to tertiary care hospitals or empanelled NGOs for specialised treatment.

All spectacle distribution is systematically tracked through a dedicated mobile application to ensure transparency and accountability. The programme aims to conduct large-scale eye health awareness activities focusing on cataract and refractive errors, screen individuals across all age groups, and provide free spectacles to those in need. It also facilitates cataract surgeries and other necessary treatments at no cost, while promoting community-level awareness on eye care and the prevention of visual impairment. Each Vision Centre is equipped with Information, Education, and Communication (IEC) materials related to eye health and includes a dedicated spectacles dispensing counter. The mobile application further strengthens real-time monitoring by integrating with SATS/UIDAI for accurate beneficiary identification, incorporating drop-down indicators to minimise data entry errors in refraction values, enabling photo documentation before and after spectacle delivery, providing geo-tagged tracking of distribution, and sending SMS alerts to ensure continuous updates throughout the service delivery process.

Programme outcome

In Phase I (FY 2022–23), implemented in Chikkaballapura, Chamarajanagara, Haveri, and Kalaburgi, 68.21 lakh individuals were primarily screened, 10.82 lakh underwent secondary screening, 2.70 lakh spectacles were distributed, and 59,842 cataract surgeries were conducted.

In Phase II (FY 2023–24), across Chitradurga, Mandya, Raichur, and Uttara Kannada, 72.15 lakh individuals were primarily screened, 13.65 lakh received secondary screening, 1.60 lakh spectacles were distributed (in progress), and 45,267 cataract surgeries were performed.

In Phase III (FY 2024–25), 81,217 individuals received free spectacles following eye examinations, and 93,800 cataract surgeries were conducted.

Financial Implication

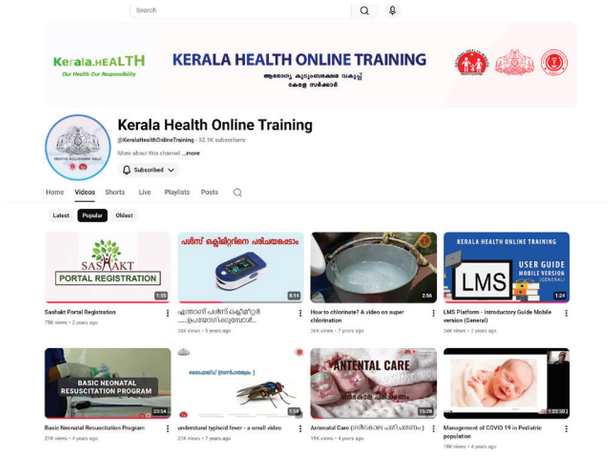
The program has received substantial financial support under NHM across various phases for cataract surgeries and for the distribution of free spectacles to school children and elderly persons, with partial State contribution towards free spectacles distribution for the 19–39 age group. Overall, approximately Rs. 150 Cr has been approved under NHM across Phases I–IV, along with about Rs. 4.92 Cr as State share. There are no additional cost implications for the activity.

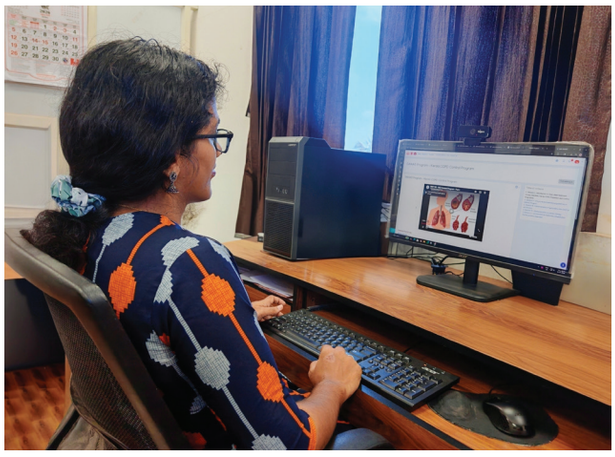
Scalability

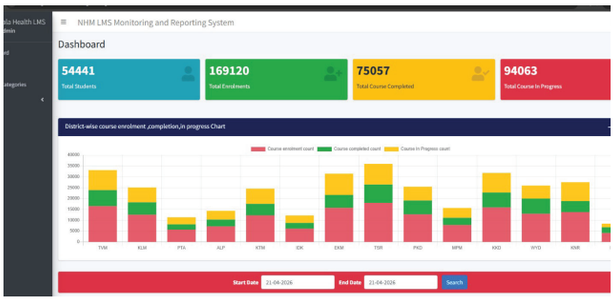
Ashakirana is a scalable and replicable model in comprehensive eye care, combining community engagement, technology integration, and institutional strengthening. It has significantly improved early detection, treatment coverage, and quality of life among underserved populations.

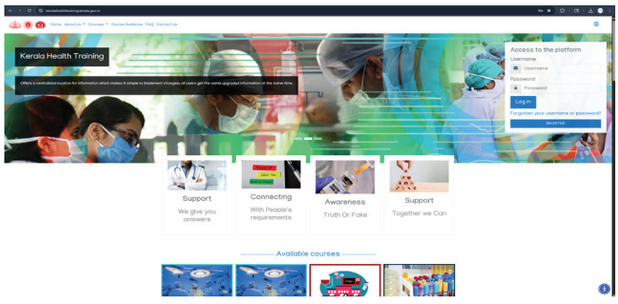
KERALA

LEARNING MANAGEMENT SYSTEM & KERALA HEALTH ONLINE TRAINING









Problem Statement

The health system relied predominantly on in-person training approaches, which required extensive coordination, logistics, and recurring expenditure, resulting in limited training coverage and challenges in ensuring uniform dissemination of information across districts. Disruptions during the COVID-19 pandemic further affected the continuity of capacity building. There was also a need for accessible platforms to disseminate standardised training and public health information to healthcare workers and the wider community, including those in remote and underserved areas.

Programme Description

To address these challenges, the State Training Division under NHM Kerala established an integrated digital learning ecosystem comprising a centralised Learning Management System (LMS) and the Kerala Health Online Training YouTube Channel.

The LMS, developed in 2020 in collaboration with the Department of Health Services and C-DIT, is a Moodle-based platform designed to deliver structured, standardised, and measurable training

to healthcare professionals. The platform follows a uniform course delivery pathway comprising pre-assessment, modular training content, post-assessment, and automated certification based on defined performance criteria. It provides round-the-clock access, enabling self-paced learning, and is supported by real-time monitoring dashboards for tracking participation, performance, and training gaps at district and state levels. The LMS hosts a comprehensive repository of courses spanning clinical, public health, administrative, and programmatic domains and has been institutionalised as the official platform for mandatory trainings, including Community Health Officer capacity building.

Complementing the LMS, the Kerala Health Online Training YouTube Channel was launched as an open-access digital platform to support wider dissemination of training content and public health awareness. The channel hosts a structured repository of training modules, demonstration videos, expert sessions, and IEC/BCC materials catering to both healthcare professionals and the general public. Content is made available in Malayalam and English to ensure inclusiveness and is accessible without any login requirement, thereby enabling widespread reach.

Together, these platforms form a comprehensive and synergistic digital training ecosystem, combining structured certification-based learning with large-scale, accessible dissemination of health knowledge and awareness content.

Programme Outcome

The implementation of the integrated digital learning ecosystem has resulted in substantial scale and utilisation across the state. The LMS has enrolled over 53,000 healthcare professionals and offers more than 138 structured courses, with 50,316 enrollments and 63,451 certifications issued to date. It has enabled the institutionalisation of mandatory trainings, including multiple batches of Community Health Officer training with digital certification. The Kerala Health Online Training YouTube Channel has further strengthened outreach and engagement, with 830 training and awareness videos uploaded, 12,60,463 cumulative views, and 31.8 thousand subscribers as of December 2025.

Financial Implication

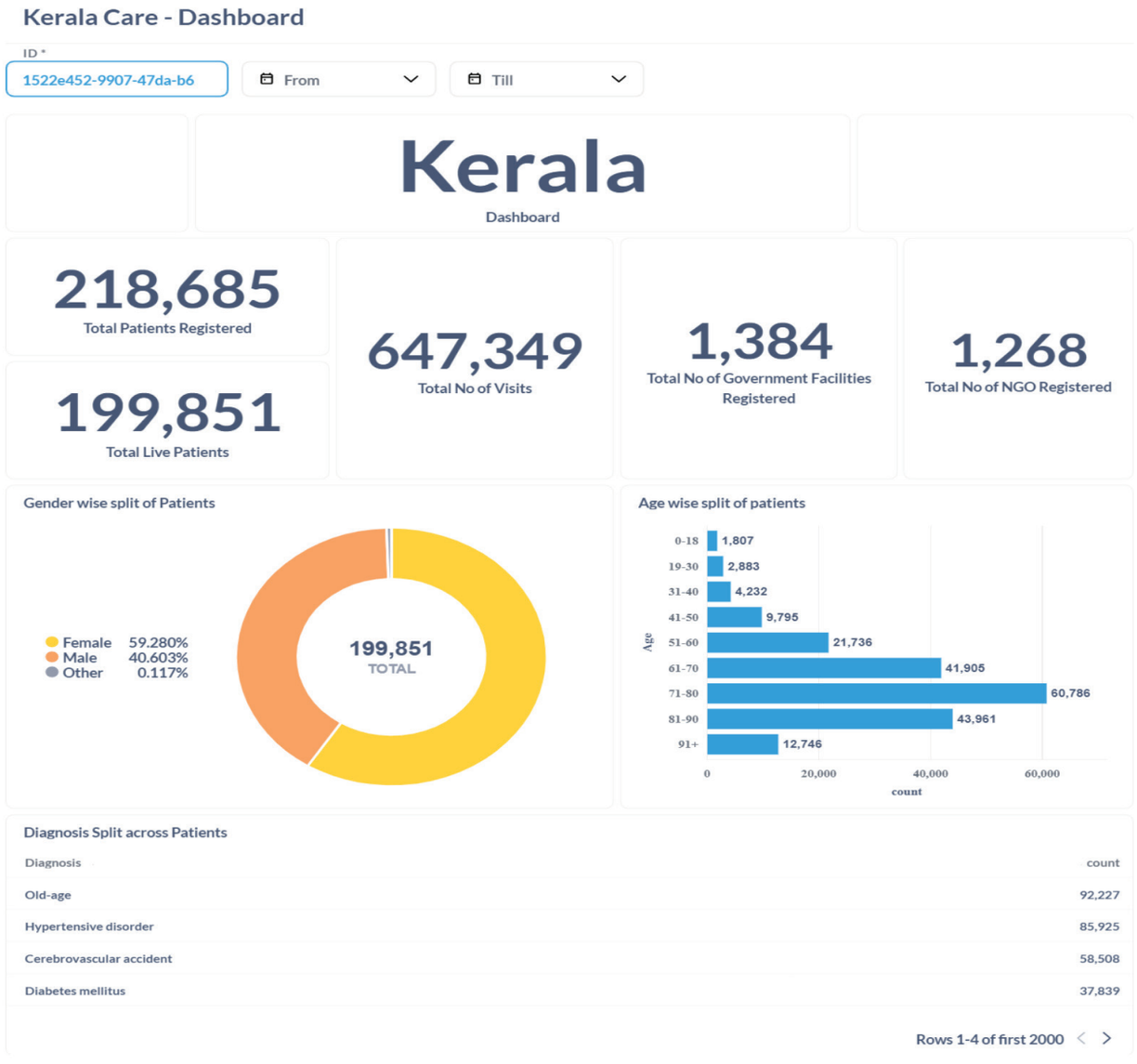
The initiative represents a cost-effective approach to large-scale capacity building. The use of YouTube as a hosting platform eliminates infrastructure and dissemination costs, while the LMS has been developed through institutional collaboration with C-DIT, while leveraging existing technical and administrative resources. The shift from physical to digital training has significantly reduced expenditure related to travel, logistics, venue arrangements, and manpower deployment.

Scalability

The initiative enables scalable dissemination of training and awareness of content through digital platforms. The use of YouTube allows rapid expansion without additional cost, while the LMS supports continuous addition of courses and training modules. The platform ensures accessibility across all districts, including remote, tribal, and aspirational areas, overcoming geographical and logistical barriers to training. As part of a broader digital learning ecosystem, integration with other platforms and adoption of blended learning approaches further supports expansion and sustained capacity building.

KERALA

KERALA CARE - DIGITAL PLATFORM FOR PALLIATIVE CARE



Problem Statement

It is estimated that 0.6% of Kerala's population is bedridden due to various health conditions. Additionally, another 2% of the population, though not confined to bed, suffers from Serious Health Sufferings (SHS) due to long-term illnesses. The Universal Palliative Care Programme focuses on the coordination of palliative care services available at various levels. To support this coordination, the state has conceptualized a Palliative Care Grid, named Kerala Care, as a digital platform to streamline palliative care activities.

Programme Description

The Kerala Palliative Care Grid, a groundbreaking online system designed to ensure comprehensive care for bedbound and homebound persons by fostering collaboration between government and NGO/CBO palliative care units, was launched by the Hon'ble Chief Minister on June 28, 2025. The grid is designed to be a one-stop solution for addressing the physical, psychological and social issues of persons living with serious health-related suffering. This innovation digitises and streamlines palliative care delivery by enabling patient registration and management, including Electronic Health Records (EHRs) and the recording of home visits and patient encounters, scheduling and rescheduling appointments for healthcare providers and assignment & management of volunteers for patient support & home visits. It raises and processes requests for clinical care, social support, comfort devices, medicines, and financial aid. It is also used for structured user creation and role-based access control for administrators, programme managers, medical officers, nurses, and volunteers across the state, district, and local self-government (LSGD) levels.

The digital platform targets to improve engagement and access for the following stakeholders in palliative care: healthcare Professionals, community volunteers, palliative care units, and administrators. Through the platform, patients and caregivers get benefits for registration, appointment scheduling, and better coordination.

Programme Outcome

A total of 2,18,685 patients have been registered on the Kerala Palliative Care Grid platform since its inception. Of the registered patients, 1,99,851 were alive, 59% among them were female, and 40.60% were male. Most of the registered patients were in the 71-80 years of age group. In the dashboard, 1384 government facilities and 1268 NGOs were registered to provide comprehensive palliative services.

Financial Implication

As an open-source system, Kerala Care powers the Grid, reduces proprietary software costs, and contributes to the overall cost-effectiveness of implementing and maintaining the digital infrastructure.

Scalability

The Kerala Care digital platform demonstrates potential for scalability across other states and UTs due to its open-source architecture, and cost effective design.

MADHYA PRADESH

USE OF DECISION SUPPORT SYSTEM FOR ASSESSMENT AND TREATMENT OF UNDER - FIVE CHILDREN

Problem Statement

Madhya Pradesh has achieved significant reductions in child mortality; however, further acceleration is required to meet the Sustainable Development Goals (SDGs). While facility-based interventions have improved outcomes, persistent challenges remain in the timely identification and management of critically ill children at the community level. Under the Integrated Management of Neonatal and Childhood Illness (IMNCI) programme, frontline workers often face difficulties in accessing and effectively using physical chart booklets for assessment, which affects confidence and consistency in clinical decision-making. There was therefore a need for a structured, user-friendly digital solution to strengthen early identification, appropriate classification, and timely referral of children under five years of age.

Programme Description

The Child Health Division of NHM Madhya Pradesh developed a mobile-based Decision Support System (DSS) to support Community Health Officers (CHOs), ANMs, and RBSK Medical Officers in delivering standardised child health services as per IMNCI protocols. The tool was introduced

statewide during the SAANS Abhiyan and is designed as an Android-based application that operates offline, ensuring accessibility even in low-connectivity settings.

The DSS provides step-by-step guidance for integrated child assessment, ensuring that no referral opportunity is missed. The algorithms embedded in the system were prepared and reviewed by the state technical group to maintain clinical accuracy and protocol adherence. The application supports community screening and case management at Ayushman Arogya Mandir (AAM) by generating real-time clinical suggestions and capturing patient-level data. It systematically identifies high-risk cases by alerting frontline workers to danger signs and guiding pre-referral management. The tool also facilitates referral linkages to higher facilities and tracks follow-up of children at both community and facility levels. A real-time dynamic dashboard has been developed for programme managers to enable monitoring, review, and follow-up.

The initiative was implemented using existing human resources without recruitment of additional staff. Capacity building was undertaken through a cascading training model at state, district, and block levels using existing training platforms and virtual sessions. Divisional and district programme consultants were oriented for field-level handholding support. Technical guidelines, instructional videos, and posters were developed to facilitate adoption, and the DSS has been integrated into the child health training module for CHOs.

Programme Outcome

A mixed-method assessment conducted during the pilot phase demonstrated the potential of the application to support frontline workers in clinical decision-making. Since April 2022, more than 80,000 children under five years of age in Madhya Pradesh have been assessed using the DSS. Among the total assessments, 61.62% were conducted by ANMs and 35.61% by CHOs, with male and female children assessed in nearly equal proportions. Of the sick children assessed, 83.5% were managed at AAMs, while 16.5 % were identified as high-risk cases. Among those identified as high-risk, 65.83% were referred to higher facilities. Among children below two months of age, high-risk cases were identified, with 64 % referred. A substantial proportion of young infants were identified with low weight (73.8%) and feeding problems, and possible serious bacterial infections were detected in 94% of all bacterial infection cases. Among children aged 2 months to 59 months, general danger signs were identified in 2.3 % of cases, 6.93% of children presented with cough or difficulty breathing, out of which 31.25% had signs of pneumonia, and 20.17% were identified with malnutrition and anaemia. Vaccination verification indicated that 98 % of children had updated MCP cards and 92 % were age-appropriately vaccinated. The initiative has strengthened systematic assessment, improved adherence to IMNCI protocols, enhanced identification of high-risk conditions, and supported timely referral and follow-up mechanisms, thereby reinforcing primary healthcare service quality.

Financial Implication

The DSS was developed using open-source software at low cost. No additional human resources were required for implementation, as existing frontline workers were trained to use the application. The primary recurring expenditure relates to server maintenance, making the initiative financially sustainable within existing programme structures.

Scalability

The DSS has been implemented statewide in Madhya Pradesh and is designed for scalability with minimal additional capacity-building and maintenance costs. Given its low-cost, standardised clinical algorithms, and established monitoring dashboard, the initiative is suitable for replication at the national level.

MADHYA PRADESH

ADDRESSING OBESITY IN ADOLESCENTS AND YOUTH

Problem Statement

Madhya Pradesh has been witnessing a steady rise in overweight and obesity among adolescents and young people, emerging as a significant public health concern that demands timely and structured action. Adolescence is a critical developmental stage during which lifelong habits related to diet, physical activity, and self-care are formed, and when unhealthy weight gain begins during this period and remains unaddressed, it substantially increases the risk of chronic conditions such as diabetes, hypertension, and cardiovascular diseases in adulthood. A major systemic gap contributing to this challenge was the absence of routine screening, early identification, and structured monitoring mechanisms, resulting in many weight-related concerns going unnoticed until they progressed into more serious health complications. Compounding this issue, stigma

around body image and weight often discouraged adolescents from openly discussing their concerns or seeking appropriate guidance.

Programme Description

The response was a comprehensive, multi-sectoral strategy in which multiple departments and platforms worked together in a coordinated way. The model strategically leverages existing service delivery platforms across schools, colleges, communities, and primary healthcare settings to ensure wide coverage, sustainability, and continuity of care.

A key pillar of the initiative is the network of Adolescent Friendly Health Clinics, known as Umang Health Centers, established in 339 health facilities. These centers provide counselling services and clinical management through Medical Officers, with routine BMI screening conducted for every adolescent client. Those identified as overweight or obese receive personalised guidance on nutrition and physical activity in a supportive and confidential environment, ensuring early detection and structured follow-up. The approach is further strengthened through the "Saathiya" programme, where trained peer educators and members of the "Saathiya Brigade" lead village-level awareness activities that promote healthy eating, active lifestyles, and positive health-seeking behaviour. Counsellors also conduct structured sessions in schools, colleges, and hostels focusing on balanced nutrition, regular physical activity, and the long-term risks of obesity, while BMI screening is integrated into both facility-based services and comprehensive school health programmes to enable timely identification in educational and clinical settings.

Community outreach is expanded through Community Health Officers (CHOs) at Ayushman Arogya Mandir, who engage youth beyond formal education systems and conduct BMI and Haemoglobin screenings to assess overall health status. Rashtriya Bal Swasthya Karyakram (RBSK) teams incorporate BMI screening and awareness on healthy weight into routine school health initiatives, while the AB-Umang School Health and Wellness Programme trains teachers as Health and Wellness Ambassadors to conduct regular sessions and encourage students to seek support for weight-related concerns or anaemia.

Implementation is supported by a structured network of counsellors, peer educators, Saathiya Brigade members, CHOs, RBSK teams, and trained teachers, all strengthened through tailored capacity-building efforts covering nutrition, BMI assessment, adolescent psychology, communication skills, screening protocols, and referral pathways to ensure coordinated and youth-friendly delivery.

Programme Outcome

In FY 2024–25, a total of 7,84,510 adolescents were screened for BMI. Among them, 11,157 were identified as overweight (BMI 25.0–29.9) and 4,552 as obese (BMI ≥30), bringing the total number of overweight and obese adolescents to 15,709, representing 2.00% of those screened. All 15,709 adolescents identified received counselling services, including structured weight management support, personalised physical activity guidance, and clinical care wherever necessary. Of those identified, 11.74% (1,310 out of 11,157) of overweight adolescents and 12.98% (591 out of 4,552) of obese adolescents have successfully converted to a healthy weight, while the remaining 13,808 adolescents continue to remain in regular follow-up and counselling support to achieve sustained improvement.

This progress has been strengthened by strong peer and school engagement. A total of 32,120 peer educators conducted village-level awareness sessions, promoting healthy lifestyle practices and improving community awareness. In parallel, over 22,010 trained teachers served as Health and Wellness Ambassadors, delivering structured health and wellness sessions within schools.

Financial Implication

All activities were implemented through existing government programmes. No additional costs were incurred.

Scalability

The intervention holds strong potential for replication because it is embedded within existing health and education systems. By strategically utilizing schools, peer networks, and primary healthcare facilities, it establishes a coordinated and sustainable framework that can be adapted to varied regional and socio-cultural contexts.

MADHYA PRADESH

LEVERAGING PANCHAYATI RAJ DEPARTMENT PLATFORM FOR STRENGTHENING THE SERVICES AT AYUSHMAN AROGYA MANDIR THROUGH INTERDEPARTMENTAL CONVERGENCE

Problem Statement

Madhya Pradesh has a well-established three-tier Panchayati Raj system at the Gram, Block, and District levels. These institutions already play a major role in connecting villagers to government schemes and improving social and economic conditions. However, while health services were provided through AAM, there was a gap in community awareness and engagement. Many villagers were not fully aware of the range of services available at AAM. Even when services existed, community mobilisation and consistent communication were needed to improve uptake. There was also a need to bring health related awareness initiatives closer to the community, using trusted local leadership such as the Sarpanch and Gram Sabha platforms. The challenge was not the absence of services, but how to strengthen their reach and acceptance. This required better coordination between departments and a structured way to integrate health topics into existing community platforms.

Programme Description

To address this, the Department of Health and the Panchayat Raj Department worked together through an interdepartmental convergence model. Instead of creating a new structure, they used the existing Gram Sabha platform to bring health discussions directly to the community.

The first step was to formally include health topics in Special Gram Sabhas. These Gram Sabhas were organised on important national days such as Gandhi Jayanti, Independence Day, Republic Day, Ambedkar Jayanti, and Women's Day. Agendas were carefully designed at the state level to ensure that key health services and schemes were clearly explained.

Detailed agenda points were shared with Sarpanches so that communication with the community would be clear and consistent. Health topics included antenatal care services at AAM, screening for non-communicable diseases, availability of drugs and diagnostic services, tuberculosis screening and treatment, and Ayushman Arogya Shivir health camps.

Community Health Officers (CHOs) working at Ayushman Arogya Mandir were oriented to actively participate in these Gram Sabhas. They collaborated with the Sarpanch, discussed the agenda items, and explained the services available at the local health facility. This created a direct link between the health system and the community.

More than 9,000 CHOs were involved in this collaboration. Their participation ensured that discussions were not only informational but also practical, allowing villagers to ask questions and understand how to access services.

Programme Outcome

The collaboration led to the inclusion of health agendas in five Special Gram Sabhas organised during the financial year 2024–25. Out of 22,741 Gram Panchayats in MP, Special Gram Sabhas were organised in 18,391 Gram Panchayats across 52 districts, where health topics were discussed with the community. Key health services were highlighted during these meetings, including antenatal care, non-communicable disease screening, tuberculosis screening and treatment, drug and diagnostic services, and Ayushman Arogya Shivir activities. This effort increased footfall at AAM, meaning more people started visiting these facilities for services. The collaboration also strengthened Jan Arogya Samitis at the Ayushman Arogya Mandir level. As community discussions increased, trust in local health facilities improved. This helped create stronger community ownership and engagement around health services.

Financial Implication

Funds were leveraged from the Department of Panchayat Raj, as the Gram Sabhas were already being organised at the Gram Panchayat level. No separate or additional financial structure was created specifically for this initiative.

Scalability

The model shows strong potential for scale-up and sustainability because it uses an already established and trusted community platform. Since the approach relies on interdepartmental coordination rather than new infrastructure, it can be replicated in other districts and states with similar Panchayati Raj systems. By strengthening the role of Panchayats in health awareness and linking them closely with AAM, the model creates a sustainable pathway for improving community health engagement.

MADHYA PRADESH

BEST PRACTICES UNDER NATIONAL SICKLE CELL ANAEMIA ELIMINATION MISSION (NSCAEM)

भोपाल में आयोजित राज्यस्तरीय कार्यशाला में एक्सपर्ट के रूप में आमंत्रित की गईं डॉ. बीनू सिंह

सिकल सेल एनीमिया के 12 नमूनों का संग्रहण कर चुका रीवा का एक्सीलेंस सेंटर

- मेडिकल कालेज में जेनेटिक लैब की जल्द शुरूआत होगी: डीन

नवस्वदेश ■ रीवा

सिकल सेल एनीमिया पर 3 अप्रैल को भोपाल में राज्यस्तरीय कार्यशाला का आयोजन किया जा रहा है जिसमें एक्सपर्ट के तौर पर श्यामशाह मेडिकल कालेज रीवा की डॉ. बीनू सिंह को विशेषज्ञ के रूप में आमंत्रित किया गया है। डॉ. बीनू सिंह प्रदेश के पहले शासकीय सेंटर ऑफ एक्सीलेंस फॉर प्री-नेटल डायग्नोसिस ऑफ हीमोग्लोबिनपैथी केन्द्र रीवा की परियोजनजा प्रमुख हैं, को आमंत्रित किया गया है।

डॉ. बीनू सिंह प्रदेश के पहले शासकीय सेंटर ऑफ एक्सीलेंस फॉर प्री-नेटल डायग्नोसिस ऑफ हीमोग्लोबीनपैथी के शुरूआत करने एवं उसके संचालन से संबंधित अपने अनुभव को साझा करेंगी। प्रदेश का पहला शासकीय 'सेंटर ऑफ एक्सीलेंस फॉर प्री-नेटल डायग्नोसिस ऑफ हीमोग्लोबिनपैथी' श्यामशाह मेडिकल कालेज रीवा में है। चिकित्सा महाविद्यालय रीवा के अधिष्ठाता डॉ. सुनील अग्रवाल के अनुसार इस सेंटर ऑफ एक्सीलेंस के द्वितीय फेज में जल्द ही जेनेटिक लैब शुरू करने के लिए राष्ट्र स्वास्थ्य मिशन भोपाल द्वारा आश्वासन दिया गया है। विन्ध्य क्षेत्रवासियों को भविष्य में इसका फायदा होगा। उन्होंने बताया कि एक्सीलेंस सेंटर का विधिवत् शुभारंभ उपमुख्यमंत्री राजेन्द्र शुक्ल द्वारा जनजातीय गौरव दिवस के मौके पर 15 नवम्बर 2024 को किया गया था। शुभारंभ से लेकर अब तक में कुल 12 नमूनों का सफल संग्रहण किया जाकर संबंधी जांच केन्द्र में नमूनों को प्रेषित किया गया है।

विशेष भूमिका निभा रहा केन्द्र

डीन डॉ. अग्रवाल के अनुसार जनजातीय क्षेत्रों में रक्तजनित विकारों के लिए विशेष भूमिका बिरसा मुण्डा उत्कृष्ट संस्थान रीवा निभा रहा है। विन्ध्य क्षेत्र के सीधी, शहडोल, उमरिया, अनूपपुर, सिंगरौली आदि जिलों में निवासरत जनजातियों में अनुवांशिक रूप से रक्तजनित विकारों का चिन्हांकन किया गया है जिसमें सिकल सेल एनीमिया प्रमुख है। बिरसा मुण्डा सेंटर ऑफ एक्सीलेंस फॉर प्री-नेटल डायग्नोसिस ऑफ हीमोग्लोबिनपैथी में 1 जनवरी 2025 को पहला नूना सफलतापूर्वक किया गया जिसे डॉ. बीनू सिंह के द्वारा स्वयं ही संग्रहित किया गया। सेंटर से नमूनों का संग्रहण कर उसे मानक शोध केन्द्र भोपाल पहुंचाने का कार्य राष्ट्रीय स्वास्थ्य मिशन भोपाल से अनुबंधित एनजीओ संकल्प इंडिया फाउंडेशन के माध्यम से किया गया। उल्लेखनीय है कि रीवा केन्द्र का भ्रमण 12 दिसम्बर 2024 को राज्यपाल मंगुभाई पटेल द्वारा किया गया था।

Problem statement

Madhya Pradesh, especially its tribal-dominated regions such as Sidhi, Shahdol, Dindori, Anuppur and Singrauli, carries a high burden of haemoglobinopathies, including Sickle Cell Disease (SCD). Tribal populations constitute 21.1% of the state's population, highlighting the vulnerability and scale of the problem. Despite national-level mandates, prenatal diagnosis remained largely unavailable in public facilities, resulting in missed opportunities for early detection, counselling, and management. The National Sickle Cell Anaemia Elimination Mission(NSCAEM) advocates for integrating screening and prenatal diagnostic services within routine pregnancy care. However, early efforts in MP, including a pilot in 2021 across two high-burden districts, revealed key systemic challenges. Screening during this phase relied on solubility tests and High-Performance Liquid Chromatography (HPLC), which were limited by operational inefficiencies, high costs, diagnostic inaccuracies, and poor accessibility in remote areas.

Programme description

MP has adopted an integrated approach to Sickle Cell Disease (SCD), combining strengthened facility-based diagnostics with large-scale community screening. The Centre of Excellence (CoE) was launched on January 1, 2025, under NHM MP, with support from the State Haemoglobinopathies Mission, Directorate of Medical Education, and Maternal Health Division-NHM MP. The CoE established at medical college in Rewa serves as a referral hub for adjoining districts. The CoE provides prenatal diagnosis through amniocentesis and chorionic villus sampling (CVS), supported by basic OT and ultrasound facilities, along with comprehensive counselling. Sample processing and molecular testing are coordinated through a hub-and-spoke model with mobile-based case tracking and active district-level patient mobilisation. The state has established protocols for high-risk SCD pregnancies, ensuring early detection, monitoring, referrals, and follow-up.

State has also taken proactive steps in developing specific guidelines for screening and management of Sickle Cell Disease to reduce maternal mortality, pregnancy-related complications, and prevent the birth of children with SCD. To further strengthen community engagement, the proposal designates NCC cadets as "Sickle Cell Mitra" across tribal districts under the NCC MP Directorate to support awareness generation and provide genetic counselling to identified carriers and patients, contributing to SCD elimination efforts. At the community level, MP scaled up screening from 9 lakh to 1 crore using rapid, cost-effective POCT kits. A transparent Service Tender model with rigorous evaluation and demonstration stages ensured quality, feasibility, and efficient large-scale implementation. Trained teams used the Sickle Cell App to screen high-risk groups, including tribal populations and pregnant women. Supply strengthening and multi-tiered monitoring improved screening quality and programme efficiency.

Programme Outcome

The Centre demonstrated the feasibility of public-sector prenatal diagnostics while highlighting the need for early counselling and timely testing. At the population level, MP ensured POCT availability up to L1 facilities and became the first state to screen over 1 crore individuals, supported by digital tools like the Sickle Cell App for real-time monitoring and improved decision-making, while also ensuring access to Hydroxyurea—establishing a scalable, data-driven model aligned to eliminate SCD by 2047.

Financial Implications

Initial costs included ultrasound equipment, HR training, and facility setup, with recurring expenses for personnel, consumables, and logistics supported by NHM and external partners. A cost-efficient procurement model enabled screening at Rs.101 per test (service tender) and Rs. 40.88 per POCT kit, reducing confirmatory testing costs from Rs. 480 (HPLC) and ensuring overall financial efficiency.

Scalability

MP's SCD initiative presents a strong, replicable model for other high-burden states by integrating facility-based care with large-scale screening. The Centre of Excellence functions as both a referral and training hub, strengthening capacity and patient-centric care. Key scale-up strategies include deploying genetic counsellors, strengthening referral and transport systems, and establishing regional genetic labs in tribal areas. Integration with antenatal care and community outreach, along with inclusion of genetics in medical education, further supports sustainability. Overall, it offers a scalable, evidence-based pathway aligned with India's goal of eliminating SCD by 2047.

MADHYA PRADESH

AROGYA KI OOR: TRIBAL IMMUNISATION CAMPAIGN

Problem Statement

Despite progress in immunisation coverage, certain tribal and remote villages show alarmingly low rates due to geographical inaccessibility, cultural hesitancy, inadequate health infrastructure, and limited communication effectiveness. A village-specific, data-driven approach is needed to identify root causes and tailor strategies to each village's needs. A targeted approach was introduced in 125/ 1342 priority villages with historically low coverage and challenges like geographical isolation, vaccine hesitancy, inaccessibility, seasonal migration and other seasonal disruptions. By comparing immunisation status with population data, gap identification and measuring the effectiveness of current strategies to improve immunisation rates was aimed.

Programme Description

The Root Assessment involves comprehensive data collection across key determinants influencing immunisation coverage in 125 selected villages. It examines health workforce capacity and training needs, vaccine availability, monitoring and tracking mechanisms, community motivation, and strategies to address vaccine hesitancy. The assessment also reviews micro-planning processes and transportation or mobility challenges affecting service delivery. In addition, community-level information is gathered, including population estimates, the number of children requiring immunisation, history of recent epidemics, cultural or social resistance to vaccination, and feedback from community members regarding barriers and concerns. This structured approach helps identify gaps and informs targeted, context-specific interventions to strengthen immunisation coverage and programme effectiveness at the local level.

Collaboration with the Forest Department improves access to remote villages by identifying alternative routes and ensuring safe passage for health teams, while enabling community engagement. Integrating immunisation services with Tendu Patta Phads leverages seasonal gathering points to reach tribal children, promote awareness, and provide on-site vaccination through trusted community mobilisation mechanisms. The Kasth Labhansh system, a participatory forest management initiative, provides a strategic opportunity for public health interventions. During timber distribution events, healthcare services like immunisation can be delivered to tribal and forest-fringe communities, addressing challenges in accessing healthcare facilities in remote regions. The Early Morning Vigil initiative mobilises health workers early morning to vaccinate migrant families' children before work, preventing missed immunisations during critical periods. To address vaccine hesitancy, the Udan Tribal Counsellors initiative engages youth volunteers from the National Service Scheme (NSS) belonging to local tribal communities. Through door-to-door outreach, participation in VHSND activities, and Gram Sabha meetings, these counsellors promote immunisation awareness and actively dispel myths, misconceptions, and fears, helping build trust and improve vaccine acceptance. Regular review and monitoring exercises are carried out by the health officials in the villages.

Programme Outcome

As part of a larger strategy to improve routine immunisation coverage across 125 identified villages, Bhawanipur (Total Population: 992, Total Households: 136, 0-5 yr children: 115) was selected as the pilot village to assess the feasibility and effectiveness of targeted interventions in remote and high-resistance areas. Before the intervention in the pilot village, the vaccination coverage was 47%, which increased to 89% after the intervention was carried out. After the pilot, the intervention was carried out in 9 more villages, which showed increase in vaccination coverage between 8% and 42%.

Financial Implication

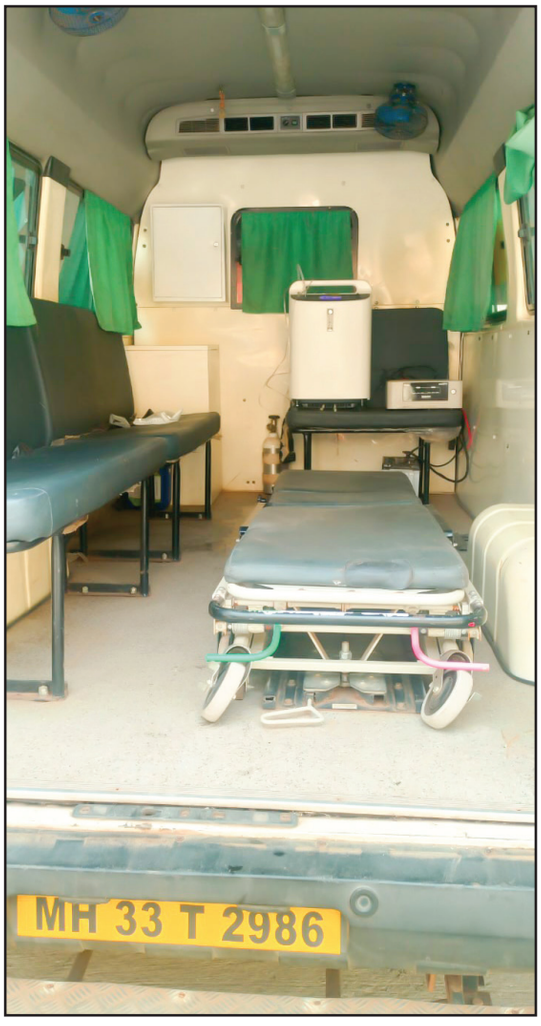
No additional cost implications.

Scalability

The innovation can be scaled up across the tribal districts in the country using existing NHM resources and mechanisms.

MAHARASHTRA

CUSTOMISATION OF OXYGEN CONCENTRATOR IN AMBULANCE



Problem Statement

Timely access to oxygen during medical emergencies is a critical determinant of survival, particularly for maternal, neonatal, and other acute respiratory conditions. Despite the expansion of ambulance services under initiatives such as Janani Shishu Suraksha Karyakram (JSSK) and Janani Suraksha Yojana (JSY), significant gaps persist in ensuring uninterrupted oxygen supply during patient transport.

In many ambulances, oxygen cylinders are either inadequately filled, unavailable, or not replaced in time, leading to critical shortages during emergencies. This challenge is more pronounced in

rural and remote areas, where distances to higher referral facilities are longer and dependence on ambulance-based stabilisation is higher. As a result, patients often experience worsening respiratory distress enroute, compromising clinical outcomes and increasing the risk of mortality.

Additionally, reliance on manual handling and refilling of oxygen cylinders introduces operational inefficiencies and human errors. The lack of continuous oxygen availability in transit undermines the effectiveness of pre-hospital emergency care, which is essential for reducing maternal and child mortality. These systemic gaps highlight the need for a reliable, sustainable, and technology-driven solution to ensure uninterrupted oxygen access during patient transport.

Programme Description

To address the critical gap in oxygen availability during ambulance transport, the State Health Systems Resource Centre (SHSRC), Maharashtra has proposed and initiated a pilot intervention focused on the customisation of ambulances with oxygen concentrators.

This model involves equipping ambulances with oxygen concentrators (OCs), which are medical devices capable of extracting oxygen from ambient air and delivering medical-grade oxygen with a purity of approximately 93% (±3%). Unlike traditional oxygen cylinders, concentrators provide a continuous and reliable oxygen supply, eliminating dependency on refilling logistics.

To operationalise this, ambulances are being retrofitted with essential electrical infrastructure, including a high-capacity inverter (1800 watts) and an additional backup battery (12V, 200 Ah), ensuring uninterrupted power supply for the concentrator during transit. This customisation also enables the use of other electrical medical equipment such as nebulisers, thereby enhancing the scope of pre-hospital respiratory care.

The intervention is currently being implemented as a pilot, with the objective of demonstrating feasibility, effectiveness, and operational sustainability in real-world settings, particularly in resource-constrained and rural areas.

Programme Outcome

As the initiative is in its pilot phase (initiated in April 2025), outcome assessment is primarily focused on demonstrating feasibility and early effectiveness. The intervention is expected to significantly improve the reliability of oxygen delivery during patient transport, thereby reducing the risk of hypoxia-related complications.

The availability of continuous oxygen supply within ambulances enhances pre-hospital stabilisation, particularly for high-risk groups such as pregnant women, newborns, and patients with respiratory distress. It also reduces dependence on facility-based oxygen sources and minimises delays caused by cylinder shortages or logistical constraints.

Additionally, the integration of oxygen concentrators enables the use of supportive respiratory therapies such as nebulisation, further strengthening emergency care during transit. Over time, this is anticipated to contribute to improved referral outcomes, reduced emergency complications, and enhanced patient survival rates.

Financial Implication

The intervention is designed to be cost-effective, with a one-time investment required for ambulance customisation. The estimated cost per ambulance ranges between Rs. 45,000 to Rs. 50,000. This includes procurement and installation of an inverter (1800 watts), an additional backup battery (12V, 200 Ah), and associated fittings required to support the oxygen concentrator.

Compared to the recurring costs and logistical challenges associated with oxygen cylinder refilling and maintenance, this model offers a sustainable alternative with lower long-term operational burden. The reduction in emergency complications and improved patient outcomes further justify the investment from a health systems perspective.

Scalability

The model demonstrates strong potential for scalability across Maharashtra and other states, particularly within existing ambulance networks under national health programmes. SHSRCs where functional can play a critical role. Its integration does not require major structural changes but rather a standardised retrofit approach that can be replicated across ambulance fleets.

ODISHA

MOBILIZING COMMUNITY STRUCTURES FOR URBAN HEALTH: PARTNERING WITH RESIDENT WELFARE ASSOCIATIONS (RWA) IN ODISHA, INDIA AND COMMUNITY-BASED SURVEILLANCE (CBS) MODEL IN URBAN ODISHA: A DIGITAL, COMMUNITY-DRIVEN APPROACH FOR EARLY DETECTION OF PUBLIC HEALTH EVENTS

a) Community Structures for Urban Health

Problem Statement

Urban health programmes in India, particularly under the National Urban Health Mission (NUHM), have conventionally targeted slum populations due to their visibility and socioeconomic vulnerabilities. However, experiences during the COVID-19 pandemic and outbreaks of diseases like dengue and jaundice in Odisha highlighted an overlooked challenge: non-slum urban populations residing in apartments and gated colonies are increasingly vulnerable but remain largely outside the purview of public health outreach. A sense of detachment from public health facilities and a predisposition towards private providers further aggravate the situation, leading to higher out-of-pocket expenditures (OOPE) and poor health outcomes. Recognizing these gaps, the Government of Odisha, under NUHM, initiated a community engagement model to formally integrate Resident Welfare Associations (RWAs) into the public health delivery system with an objective to provide equitable and inclusive health coverage to all urban citizens.

Programme Description

The programme aims to establish structured partnerships between RWAs and Urban Health Facilities (UPHCs/UCHCs) to extend the coverage and quality of health services in non-slum urban areas. The approach is participatory, inclusive, and built on community trust. Urban Local Bodies (ULBs) prepare a comprehensive list of RWAs. Health Workers (Female) under the UPHC obtain this list and create a line list of households and residents within their operational areas. Health teams conduct initial and periodic meetings with RWAs, apartment residents, and Ward Corporators. Members from Jan Arogya Samitis (JAS) are involved to anchor the initiative within the community platform. These meetings identify the specific health care needs and promote awareness about free services available at government health institutions. RWAs nominate a nodal point person and volunteers to work with health teams. Selected residents are designated as Drug Administrators, assisting during campaigns like Mass Drug Administration (MDA). RWAs maintain a First Aid Box stocked with essential medicines from the UPHC. Plans to establish satellite clinics in large apartments are being considered to reduce travel time and OOPE

Activities are planned in collaboration with RWAs including; NCD Screening and cancer screening camps, Immunisation Sessions organised within society premises, counselling and referral services for senior citizens. Urban Health, Sanitation, and Nutrition Days (UHSND) are Observed to promote holistic health practices.

While NUHM guidelines emphasise slum coverage and community engagement through MAS (Mahila Arogya Samiti), this model systematically integrates RWAs, a non-traditional stakeholder into public health service delivery, develops tailored micro plans based on community-specific needs in non-slum populations. RWA volunteers are trained in health schemes, availability of Govt. services

Programme Outcomes

This pioneering initiative in Odisha represents a shift in urban health delivery, from a slum- centric approach to a whole-population model that ensures equity and inclusiveness. By tapping into community-based governance structures like RWAs, the state has successfully demonstrated a scalable, sustainable, and cost-effective model that brings public health services closer to previously under-reached communities. It stands as a replicable best practice for other Indian states aiming to strengthen urban health. Increased uptake of NCD screening, ANC/PNC services, immunisation among apartment dwellers, enhanced community participation in UHSNDs and vector control activities, reduced OOPE by offering diagnostics, checkups, and medicines within community premises are the outcomes of this initiative.

Financial Implications

No additional funds were required; as existing budget was leveraged for all activities.

Scalability

The model is easily replicable in cities and towns across India with growing apartment based housing. It complements existing NUHM structures and can be integrated into City Health Plans. The strategy can evolve into more comprehensive urban outreach models, incorporating telemedicine,

satellite clinics, and preventive health packages. Digital MIS tools in such interventions can inform city-wide disease burden mapping and service planning.

b) Community-Based Surveillance (CBS) Model

Problem Statement

Public health surveillance in India has traditionally relied on facility-based passive reporting systems. However, the recent pandemic underscored critical limitations in early detection and response capacities at the community level. Urban areas, in particular, faced compounded challenges due to dense populations, frequent mobility, and fragmented health-seeking behaviour. To strengthen disease surveillance and improve the timeliness of outbreak response, a Community-Based Surveillance (CBS) model was conceptualised and piloted in urban areas of Jharsuguda district, Odisha.

Programme Description

The CBS Model is a community-led, technology-enabled innovation that introduces proactive surveillance through participatory structures. While the existing IDSP framework primarily depends on facility-based data and formal reporting, the CBS model expands this approach by directly empowering community platforms to digitally report health events in real time. Members of MAS, JAS, Ward Kalyan Samiti,, and youth groups are trained to identify and report early warning symptoms using a mobile- based CBS application or a QR code-enabled web interface. The CBS app is linked to the IDSP-IHIP community reporting system, ensuring data convergence and institutional alignment. Reported events are monitored by Medical Officers (MOs) at UPHCs, who verify the information through field health workers and escalate confirmed potential outbreaks to the District Surveillance Unit (DSU). A web-based CBS Dashboard with heat maps, spot maps, and trend charts provides state and district health authorities with visual, real- time insights on disease patterns for data-driven decision-making.

The CBS model leverages existing human resources within the community and health system while introducing a clear structure for accountability and data flow. This structured linkage ensures that the community remains the first line of detection, while UPHCs and DSUs act as the first line of response.

Financial Implications

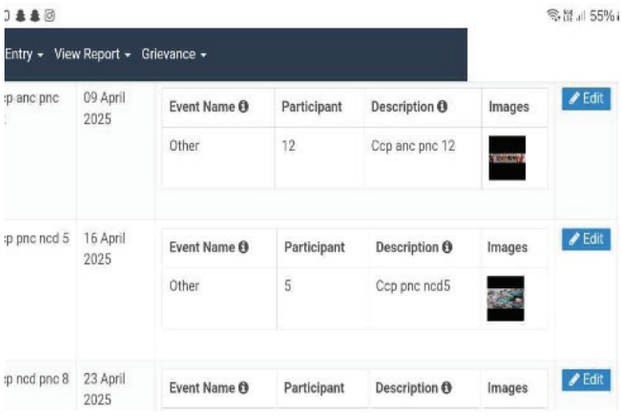
The CBS model was designed to be low-cost and scalable, primarily using existing community Structures, Digital infrastructure and the health care workforce.

Scalability

The CBS model offers a replicable and scalable solution for both urban and rural contexts, especially in resource-constrained settings. Its Integration with IDSP-IHIP allows state wide scalability without additional infrastructure. The model can be expanded to cover vector-borne diseases, environmental hazards, and NCD risk reporting. With digital literacy improving and local governance structures (ULBs, RWAs, SHGs) increasingly engaged, CBS can evolve into a citizen-led health intelligence system across Odisha and beyond.

PUNJAB

STRENGTHENING COMMUNITY WELLNESS THROUGH STRUCTURED CAREGIVER EDUCATION: ENHANCING WELLNESS ACTIVITIES AT AYUSHMAN AROGYA KENDRAS (AAKs)



Problem Statement

The Care Companion Programme (CCP), an initiative by the Government of Punjab, aims to strengthen community-level health education and improve patient outcomes through structured, skill-based training for patients and caregivers. The programme is active in 23 District Hospitals, 41 Sub-Divisional Hospitals, and over 200 Ayushman Arogya Kendras across Moga and Ferozepur districts. Despite existing health infrastructure, NFHS-5 data reveal critical gaps in maternal and child health- Only 62.3% of mothers had ≥4 antenatal care visits, 45.4% consumed iron-folic acid for 100+ days during pregnancy and 57.5% of women (15–49 years) are anaemic.

Further, Non-Communicable Diseases (NCDs) are a growing concern- 8.9% of the population has diabetes—well above the national average of 6.7%, 35.8% of adults aged 30+ are hypertensive, often undiagnosed or poorly managed. Poor diets, low physical activity, and limited awareness worsen these trends. These indicators highlight the need for sustained health education and behaviour change. CCP addresses this by delivering culturally contextual, community-based health education through trained staff, improving outcomes in maternal and child health and contributing to NCD

prevention and control at the community level.

Programme Description

The Care Companion Programme (CCP) enhances wellness sessions at Ayushman Arogya Kendras (AAKs) by empowering caregivers with essential health knowledge and skills. Based on the principle that families play a key role in health outcomes, CCP equips caregivers—mothers, fathers, and other family members—to support recovery and promote preventive care.

To strengthen wellness activities, the Care Companion Programme (CCP) builds upon the existing public health workforce at Ayushman Arogya Kendras (AAKs), especially Community Health Officers (CHOs). Rather than adding new personnel, CCP equips CHOs to become effective health educators through focused training. Their established community presence enables consistent and culturally sensitive communication. Their familiarity with local needs allows for customised health messaging. Moreover, a "master trainer" model fosters peer-led training and mentorship, promoting sustainability, leadership, and accountability within the system. CCP uses a hybrid training model, combining digital and in-person formats to ensure scalable and quality implementation across the state.

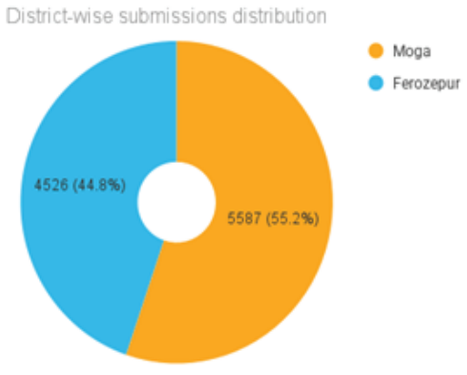
Phase 1 - Virtual Orientation: It is the first touchpoint where CHOs are introduced to CCP objectives, tools, and the Mobile Care Companion Service through a virtual session. A structured training manual supported learning to enhance programme understanding.

Phase 2 - In-Person Training of Trainers (ToT): Trainers facilitated ToT sessions, emphasizing hands-on use of CCP materials, planning wellness sessions and reporting through the AAM portal. Using Participatory methods encourages peer learning and offers relevant solutions to improve implementation in the field.

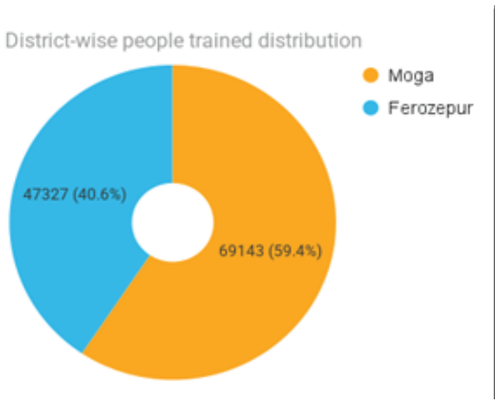
This blended approach ensures high coverage, deeper engagement, and supports AAK's vision of preventive and participatory health care.

Programme Outcome

From 19 April 2024 to 31 March 2025, wellness sessions through CCP were implemented at Ayushman Arogya Kendras in the aspirational districts of Ferozepur and Moga, Punjab. During this period, 10,113 valid wellness sessions were conducted by CHOs, training a total of 116,470 patients and caregivers, as recorded on the AAM portal under the "Wellness Activity" section.



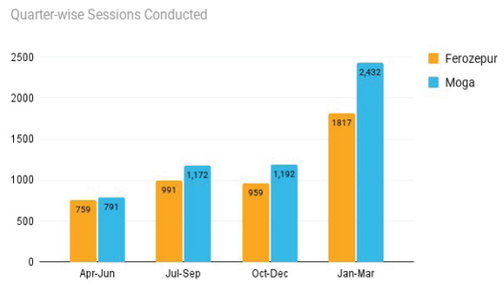
Graph 1 : District wise wellness activities



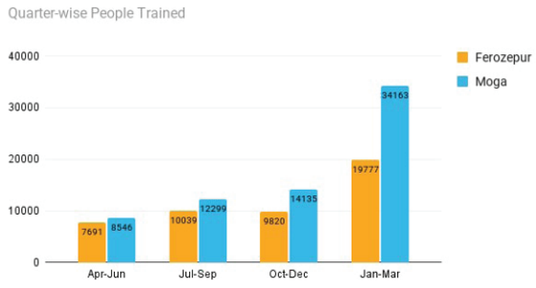
Graph 2: District wise people trained

Graphs 1 and 2 present district-wise session counts and beneficiary numbers, demonstrating strong adoption and coverage of CCP-led wellness activities across both districts.

The CCP integration has enhanced the use of the HWC-AAM portal through real-time tracking of wellness sessions, leading to improved data quality, regular reviews, and broader district-level participation.



Graph 3: Quarter wise sessions conducted



Graph 4: Quarter wise people trained

Graphs 3 and 4 illustrate a steady quarter-wise increase in both sessions conducted and individuals trained, highlighting growing programme momentum.

In parallel, the Mobile Care Companion Service (MCCS) has ensured post-facility engagement, supporting continuity of care. From 2019 to March 2025, 146,859 users enrolled in MCCS, with 93,855 queries resolved, reinforcing health messages and sustaining caregiver support beyond clinical settings.

Financial Implication

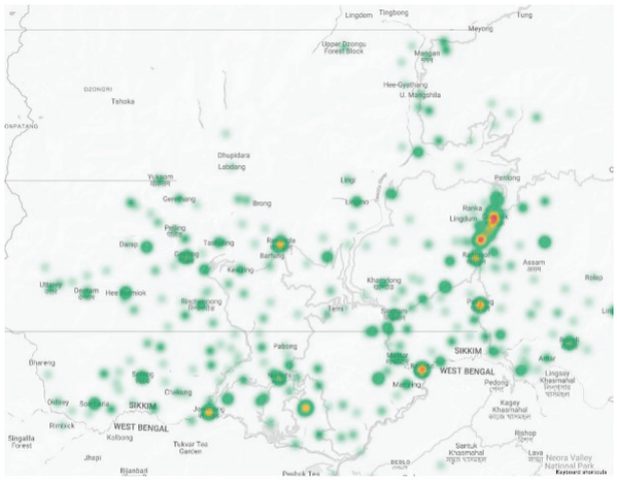
The budget required for the implementation of the CCP is minimal as it is focused on capacity building and training of the existing healthcare staff only to strengthen the healthcare systems. The approximate cost per Ayushman Arogya Kendra (AAK) is INR 1,901 per annum, covering training (INR 626) and printing counselling tools (INR 1,275) per AAK. Training cost includes venue, meals, welcome kits, and incidental costs for a one-day, non-residential training for one batch of around 45 CHOs, while printing costs cover one set of counselling tools, including MCH and NCD flipcharts, for each AAK.

Scalability

The programme was piloted in six district hospitals for maternal and newborn care and scaled to all 23 district, 41 sub-divisional hospitals and 196 Ayushman Arogya Kendras (AAKs) in Punjab. With continued national integration, CCP's modular design can be scaled across states, adapted to various health conditions and serve as a key driver of preventive, people-centred care especially in rural and underserved areas.

SIKKIM

LEVERAGING GEOSPATIAL MAPPING BASED ACTIVE CASE FINDING FOR EARLY TB DIAGNOSIS IN A HILLY INDIAN STATE



Problem statement

The need to strengthen tuberculosis (TB) control measures is particularly critical in geographically challenging regions such as the mountainous state of Sikkim. Reliance on conventional passive case detection results in missed diagnoses among at-risk and marginalised populations, thereby sustaining transmission. Active Case Finding (ACF) is recognised as a key strategy for early identification and timely initiation of treatment. The practice aims to address these gaps by using geospatial mapping to identify TB hotspots and vulnerable populations in a resource-constrained and geographically complex setting, with the objective of improving case detection, optimizing resource utilisation, and reducing TB transmission.

Programme Description

The intervention was implemented from April 2023 to September 2024 across five districts of Sikkim. A total of 3,944 notified TB patients (2020-2022) were extracted from the Ni-kshay portal. Using patient address data, geospatial mapping was conducted through online platforms including Google My Maps and Looker Studio to generate heat maps and identify TB hotspots. This mapping informed the identification of priority sites for Active Case Finding activities.

The intervention utilised existing human resources under the National TB Elimination Programme (NTEP) for conducting ACF as part of routine activities. Capacity building of key staff involved in ACF was undertaken through regular virtual training sessions to address implementation challenges and improve coverage.

Programme Outcome

Across five districts, 61 potential sites for Active Case Finding were identified through geospatial mapping. A total of 30,889 individuals were screened, resulting in the identification of 1,407 presumptive TB cases (4.6%), 19 cases (2%) were confirmed as TB positive and initiated on treatment. The intervention also emphasised strengthening the capacity of healthcare workers for effective screening and ensuring proper collection and transportation of diagnostic samples.

Financial Implications

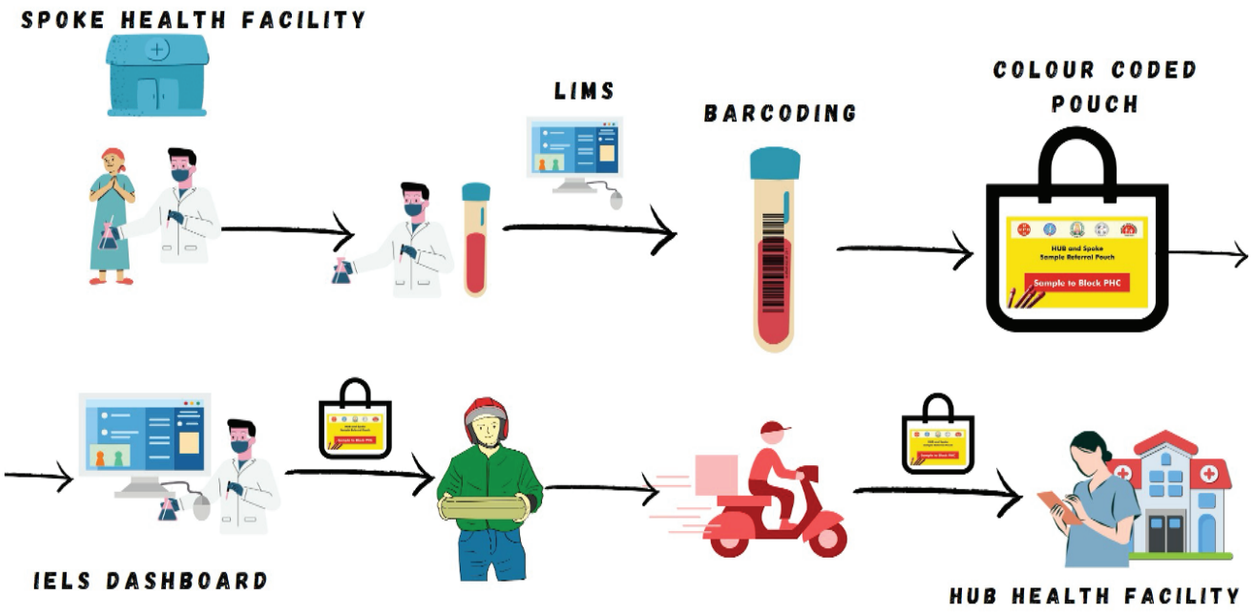
The intervention was implemented using existing funds under the NTEP, with an estimated cost of Rs. 10,000-12,000 per Active Case Finding activity.

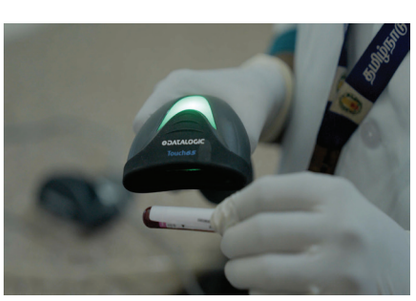
Scalability

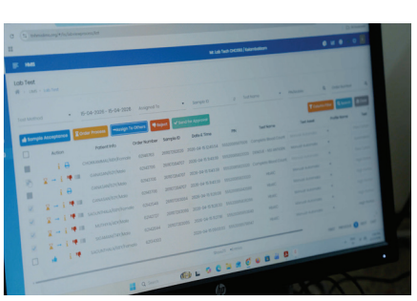
The geospatial mapping-based ACF model can be adapted to hilly and remote regions with limited healthcare access and high TB burden, where passive case detection is insufficient. Alignment with the NTEP enables use of existing infrastructure and human resources. Engagement with non-governmental and community-based organisations further supports outreach, resource mobilisation, and community trust. These elements provide a foundation for scaling the model to improve TB detection and treatment in high-risk populations.

TAMIL NADU

INTEGRATED ESSENTIAL LABORATORY SERVICES (IELS) - HUB AND SPOKE MODEL FOR SAMPLE TRANSPORTATION







Problem Statement

Limited access to timely and quality diagnostic services, particularly in rural and semi-urban areas of Tamil Nadu, remains a significant challenge. Peripheral facilities such as PHCs lack advanced diagnostic capacity, forcing patients to travel to higher-level centres and incur out-of-pocket expenditure. The absence of a structured sample transportation and referral system leads to delays, inefficiencies, and underutilisation of higher-level laboratories. Additionally, weak digital integration and quality assurance mechanisms hinder accountability and standardisation in service delivery. These gaps necessitate a coordinated and scalable approach to strengthen laboratory services across the public health system.

Programme Description

The IELS (Integrated Essential Laboratory Services) Hub and Spoke Model is an innovative laboratory strengthening initiative implemented by the Government of Tamil Nadu to transform public sector diagnostic services. The model establishes a structured laboratory network in which Primary Health Centres function as basic "Spoke" laboratories, while Block PHCs, Sub-District Hospitals, and District Headquarters Hospitals operate as both "Spoke" and intermediary "Hub" facilities. At the apex level, District Public Health Laboratories and Medical College Hospitals serve as primary "Hub" laboratories, ensuring advanced diagnostic capacity and technical oversight.

A key innovation of the model is its systematic sample transportation network, wherein organised facility clusters are supported by dedicated transporters using colour-coded pouches (Red, Green, Blue, Yellow, Orange) for efficient identification and routing. A web-based digital monitoring system enables real-time tracking of sample collection, transport, and delivery through facility-specific dashboards, enhancing accountability and turnaround time. The programme significantly reduces patient travel and lowers out-of-pocket expenditure for diagnostics—reportedly by up to 94%—thereby improving financial protection. Integration with a Laboratory Information Management System (LIMS) and participation in the External Quality Assessment Scheme (EQAS) ensure standardised quality assurance across all levels. The model provides comprehensive diagnostic coverage, including routine investigations, specialised tests, and histopathology/biopsy services.

The programme primarily benefits rural and semi-urban populations accessing public health facilities across Tamil Nadu, with a focus on underserved and remote communities, pregnant women, elderly individuals, and patients requiring regular monitoring for chronic diseases. The model covers tribal populations across the state and includes implementation in aspirational districts, where pilot testing began in the Thiruvallur district in September 2019. Following a successful demonstration, statewide implementation was launched on February 5, 2024, under the NHM, Government of Tamil Nadu, with support from the Directorate of Public Health and Preventive Medicine, Directorate of Medical Services, and Directorate of Medical Education.

Programme Outcome

The IELS Hub and Spoke Model has significantly enhanced operational efficiency with a manifold increase in diagnostic capacity and achieved 100% PHC coverage across Tamil Nadu. The initiative has generated an estimated cost saving of Rs.37 crores while reducing nearly 15 lakh patient journeys to higher facilities, thereby substantially decreasing the out-of-pocket expenditure for diagnostics.

Over 18 lakh samples have been processed, benefiting approximately 15 lakh patients, particularly rural and semi-urban populations, including underserved communities, pregnant women, elderly individuals, and patients requiring regular monitoring for chronic diseases. The programme has improved access to specialised tests such as histopathology and strengthened early disease detection and management in rural areas.

Financial Implication

The budget allocated for the programme included Rs. 80 Cr for lab equipment over a period of 6 years, Rs. 120 Cr per annum for reagents & consumables, Rs. 4.5 Cr per annum for sample transport and

Rs. 1.03 Cr per annum for EQAS. The programme has demonstrated substantial cost-effectiveness, achieving total savings of Rs. 36.94 crores through centralised and optimised diagnostic services. Major savings were observed in Complete Blood Count (Rs.5.34 crores), Thyroid Function Tests (Rs.7.18 crores), Liver Function Tests (Rs.4.06 crores), HbA1c (Rs.2.57 crores), and Lipid Profile tests (Rs.2.54 crores), along with Rs.13.67 crores saved from other investigations including renal function tests, dengue, CB-NAAT, peripheral smear, and biopsies. These savings reflect reduced per-test costs and enhanced efficiency in public sector laboratory services.

Scalability

The model scaled from a 7-month pilot in Thiruvallur (2019) to expansion in two districts (2023) and full implementation across all 38 districts of Tamil Nadu (2024). Its standardised hub-and-spoke framework and digital monitoring system support easy replication in other states with similar health systems.

TAMIL NADU

DIFFERENTIATED TB CARE - TNKET (TAMIL NADU KASANOI ERAPPILA THITTAM)

Problem Statement

Tuberculosis (TB) continues to remain a significant public health challenge, with India contributing nearly 26% of the global burden; although incidence has declined by 21% from 2015 to 2024, outpacing global trends, TB mortality remains high. A substantial proportion of deaths occur early in the course of treatment, primarily due to delayed identification of severely ill patients and lack of systematic risk-based prioritisation at diagnosis.

Despite improvements in notification and treatment outcomes, this gap limits timely clinical decision-making and targeted care. This underscores the need for a real-time mechanism to identify high-risk patients, enable prioritised interventions, and optimise resource allocation to reduce TB-related mortality.

Programme Description

Tamil Nadu has implemented a differentiated TB care model under the Tamil Nadu, Kasanoi Erappila Thittam (TN-KET), becoming the first state in India to operationalise a TB death prediction model integrated within its state-wide TB care platform, TB SeWA (Severe TB Web Application). The initiative focuses on early identification and prioritised management of high-risk TB patients to reduce mortality.

Under this model, drug-sensitive TB patients (≥15 years) notified from public health facilities are triaged at the time of diagnosis by National TB Elimination Programme staff. Patients identified as triage-positive-based on severe undernutrition, respiratory insufficiency, or poor performance status-are prioritised for comprehensive assessment and inpatient care, given that 70-80% of TB deaths occur at early stages.

TB SeWA enables frontline health workers to input key patient details at diagnosis and automatically classify patients based on severity. The embedded TB death prediction model uses five clinical indicators-low body mass index (BMI), pedal oedema, high respiratory rate, low oxygen saturation, and inability to stand without support-to stratify patients into risk categories. Triage-positive patients have an estimated death risk of 10-50%, while triage-negative patients have a lower risk of 1-4%, with these predictions displayed within the patient's digital record to support clinical decision-making.

The model has been developed using data from over 56,000 adult TB patients (July 2022-June 2023) and validated for accuracy, enabling real-time, data-driven risk assessment. Unlike conventional reporting systems with inherent delays, TB SeWA provides instant feedback, facilitating timely interventions such as hospital admission, therapeutic nutrition, and close monitoring. The initiative also supports programmatic decision-making by enabling prioritisation of resources, strengthening treatment planning for high-risk patients, and informing district-level planning for triaging, inpatient care, and nutritional support.

Programme Outcome

Implementation of the differentiated TB care model has resulted in a reduction of early TB deaths by approximately 20% within two quarters of implementation. Additionally, two-thirds of districts reported a 20-30% reduction in TB deaths during 2024. These improvements are attributed to early triaging, targeted inpatient care, and provision of therapeutic nutrition to high-risk patients.

Financial Implication

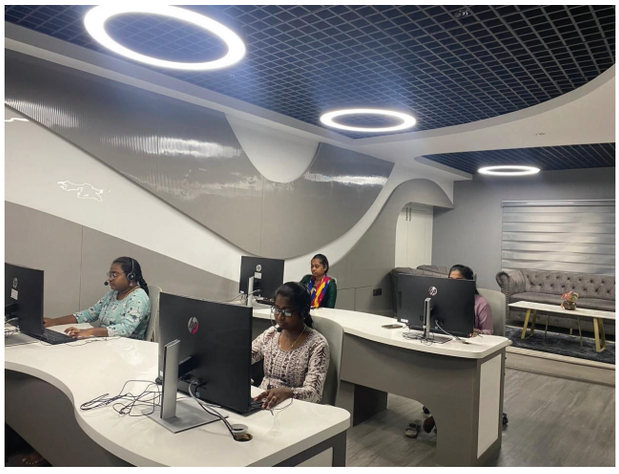
No separate funding has been allocated for this initiative, as it is integrated within the existing programme framework.

Scalability

The model is currently implemented statewide in Tamil Nadu and demonstrates potential for replication in other states. Integration with national platforms such as Nikshay could enable wider adoption.

TAMIL NADU

WAR ROOM FOR SAFE MOTHERHOOD - AN INNOVATION TO REDUCE PREVENTABLE DEATHS



Problem Statement

Tamil Nadu has consistently reported one of the lowest Maternal Mortality Ratios (MMR) in the country, supported by strong health infrastructure, high institutional deliveries, and established maternal death surveillance systems. However, preventable maternal deaths continue to persist due to last-mile delays, fragmented data systems, and coordination gaps. There is a need for a comprehensive approach integrating real-time monitoring, data integration across departments, rapid emergency response mechanisms, and targeted interventions to effectively identify and manage high-risk pregnancies and reduce preventable maternal mortality.

Programme description

The Government of Tamil Nadu established a State War Room for Safe Motherhood as a centralised command and control centre based on the recommendation of the State Task Force Committee on MMR reduction to enable real-time monitoring, coordination, and data-driven decision-making for reduction of preventable maternal deaths. The War Room is supported by a multidisciplinary team to ensure continuous monitoring and rapid response.

The War Room is supported by a multidisciplinary team to ensure continuous monitoring and rapid response.

- Comprehensive Pre-Birth Planning Mechanism (PBPM): Birth preparedness and complication readiness are strengthened through systematic planning, particularly for high-risk pregnancies. High-risk mothers are mapped to appropriate facilities including CEmONC centres and Level II & III private institutions to ensure timely care and avoid referral delays. Private facilities are categorised as Level I (basic care), Level II (emergency obstetric care including LSCS), and Level III (multi-disciplinary care). Birth plans are linked with 108 ambulance services, and 2,623 Birth Planning Help Desks have been established for tracking mothers nearing EDD.
- Monitoring and validation of data captured in PICME portal: Key parameters are mandated for entry and regularly monitored to track antenatal care and delivery outcomes across public and private facilities, enabling improved follow-up and continuity of care.
- Follow up of High-risk mothers: The War Room, in coordination with the 102 State Call Centre, tracks antenatal mothers from registration to delivery and postnatal stages using PICME 3.0. Based on telephonic assessment, cases are categorised as routine follow-up, continuous follow-up, or requiring immediate attention. Red-flagged cases trigger immediate field-level response, with escalation mechanisms in place. District call centres conduct scheduled follow-ups at defined intervals, including prior to EDD, ensuring early identification of complications and continuity of care.

Programme Outcome

The initiative has strengthened management of high-risk pregnancies through systematic identification and flagging of high-risk mothers using data from digital platforms, enabling prioritised follow-up and triage.

Implementation of the Comprehensive Pre-Birth Planning Mechanism (PBPM) has resulted in a substantial reduction in inappropriate birth planning, with cases decreasing from 2469 (Nov 2024) to 306 (Jan 2025) and further to 161 (July 2025), indicating improved alignment of high-risk mothers to appropriate facilities. Monitoring and validation through the PICME portal has led to marked improvement in antenatal visit entry and delivery outcome reporting across both government and private facilities, supporting better tracking and follow-up of beneficiaries.

The structured call centre-based follow-up mechanism has ensured comprehensive tracking of high-risk antenatal mothers. Between October 2024 and June 2025, a total of 172,724 mothers received appropriate birth planning and check-up support, while 202 cases required continuous follow-up and 200 cases required immediate attention. All identified high-risk antenatal mothers were contacted and provided counselling, with red-flagged cases followed up and closed through

field-level action. District-level call centre data (Jan-June 2025) further indicates extensive outreach, with 166,981 calls made 35 days prior to EDD (163,644 answered), 167,560 calls at 21 days (164,080 answered), and 161,443 calls at 10 days (158,731 answered). Additionally, 136,144 newly identified high-risk mothers and 184,269 postnatal mothers were tracked, strengthening continuity of care.

The system has improved referral planning, ensured facility readiness, and facilitated timely transport of mothers to appropriate health facilities (FRUs/CEmONCs), thereby reducing delays in accessing care during obstetric emergencies. Real-time data monitoring and coordinated response mechanisms have also enhanced tracking and management of postnatal mothers, particularly high-risk cases.

Financial Implication

The estimated cost for establishing the State War Room is approximately Rs.50 lakh, including infrastructure, IT systems, communication setup, and recurring staffing costs.

Scalability

The War Room model serves as a centralised, data-driven platform for real-time monitoring and coordinated action, with potential for replication at district, state, and national levels. Scaling this model can support standardisation of maternal health interventions, strengthen accountability, and enhance early identification and management of high-risk cases, contributing to sustained reduction in maternal mortality and improving new-born health outcomes.

TELANGANA

URBAN ACTION PLAN (UAP) FOR THE PREVENTION AND CONTROL OF DENGUE CASES IN URBAN AREAS





Problem Statement

Dengue cases have been steadily increasing in urban areas, particularly within the municipal limits of Adilabad district headquarters. The rapid spread of dengue in these regions is attributed to multiple factors such as high population density and the availability of numerous mosquito breeding sites. To address this, the Urban Action Plan (UAP) has been developed with an aim to implement targeted and coordinated efforts to prevent and control dengue effectively across the urban landscape.

Programme Description

The 49 municipal wards in Adilabad area have been divided into 06 operational teams. Each team includes staff from the Medical & Health, Municipal, and MEPMA departments. Coordinated field activities are scheduled for three days a week – Tuesday, Thursday, and Friday. On these days, the three departments will jointly conduct field visits and execute assigned tasks between 07:00 AM to 11:00 AM. The Health dept. undertakes daily fever surveillance by ASHAs in at least 25 houses/day, outbreak response by medical teams, regular anti-larval measures, and public

awareness campaigns promoting dengue prevention, mosquito control, personal protection, and improved waste management practices. Municipal dept. teams support surveys, ensure waste management, remove stagnant water, maintain sanitation, conduct fogging and larvicide spray, eliminate breeding sites, perform inspections, and educate communities on mosquito control and prevention. MEPMA department mobilises SHGs for dengue awareness, conducts outreach and education drives, promotes community ownership, encourages behaviour change through door-to-door engagement, and supports access to healthcare for suspected dengue cases.

Programme Outcome

Through the strategic implementation of this Urban Action Plan, dengue prevention and control measures have been significantly strengthened in Adilabad's municipal areas. The coordinated efforts of all three departments have contributed to early detection, community participation, and effective management of dengue cases.

Financial Implication

No additional cost implications.

Scalability

The model is scalable and replicable.

TRIPURA

MUKHYAMANTRI SUSTHO SHAISHOB SUSTHO KAISHORE ABHIYAAN (MSSSKA)




Problem statement

The programme was conceived in response to persistent challenges such as micronutrient deficiencies, preventable infectious diseases, poor nutritional status, and gaps in service delivery among the young population. Prior to MSSSKA, several child and adolescent health interventions were implemented through separate vertical programmes, often resulting in fragmented planning, duplication of efforts, and missed opportunities for comprehensive coverage. MSSSKA addresses these systemic gaps by converging key interventions—including deworming, Vitamin A supplementation, Iron and Folic Acid (IFA) distribution, nutritional assessment, hygiene promotion, and diarrhoea management—under a single mission-mode platform.

Programme description

The Mukhyamantri Sustho Shaishab Sustho Kaishore Abhiyan (MSSSKA) has progressively expanded and diversified its health intervention components from version 1.0 to 7.0. This phased evolution reflects the Government of Tripura's commitment to strengthening child and adolescent health through an integrated, mission-mode approach. The first phase laid the foundation with four essential child health interventions: (1) Intensified Diarrhoea Control Fortnight (IDCF), (2) Iron and Folic Acid (IFA) supplementation, (3) Vitamin A Supplementation (VAS), and (4) National Deworming Day (NDD). MSSSKA 2.0 introduced POSHAN Abhiyan (Growth Monitoring) as the fifth component, promoting improved nutrition tracking and awareness. In the third phase, Tetanus and Diphtheria (TD10 and TD16) vaccination and SAANS (Social Awareness and Actions to Neutralise Pneumonia Successfully) were added.

MSSSKA 4.0 marked a significant scale-up with the inclusion of awareness initiatives on teenage marriage and exclusive breastfeeding, along with Acute Flaccid Paralysis (AFP) surveillance and Measles and Rubella surveillance. Under MSSSKA 5.0, the campaign further expanded to incorporate Home-Based Newborn Care (HBNC), Home-Based Care for Young Children (HBYC), and Gram Sabha and special sessions focusing on teenage marriage and exclusive breastfeeding. MSSSKA 6.0 and 7.0 retained the 12-programme structure introduced in version 5.0, demonstrating sustained commitment to comprehensive coverage through both preventive and promotive health interventions.

The campaign operates as a coordinated, multi-sectoral initiative involving the Departments of Health, Education, Social Welfare, and Social Education. The Health Department leads medical interventions, including deworming and micronutrient supplementation; the Education Department facilitates access to school and college students; and the Social Welfare and Social Education Department ensures outreach to children in Anganwadi centres, marginalised communities, and out-of-school populations.

Programme Outcome

Implemented in mission mode from 2021 to 2024, the MSSSKA campaign has had a transformative impact on child and adolescent health in Tripura. The initiative began with an impressive coverage of 99.40% under MSSSKA 1.0. Although there was a slight decline in MSSSKA 2.0 (93.56%), likely due to initial implementation challenges, coverage steadily improved in subsequent phases. By MSSSKA 5.0 and 6.0, achievement levels exceeded 98%, reflecting strengthened coordination and enhanced operational efficiency. MSSSKA 7.0 recorded a peak coverage of 100%, successfully reached 11,36,083 children and adolescents aged 0-19 years, achieving 100% of the targeted population of 11,36,083, surpassing set targets and demonstrating exceptional outreach and programme performance. Considering the key learnings and experiences garnered from previous MSSSKA rounds, the state government has resolved to continue the MSSSKA - 8.0 campaign during October - November 2025.

Financial Implication

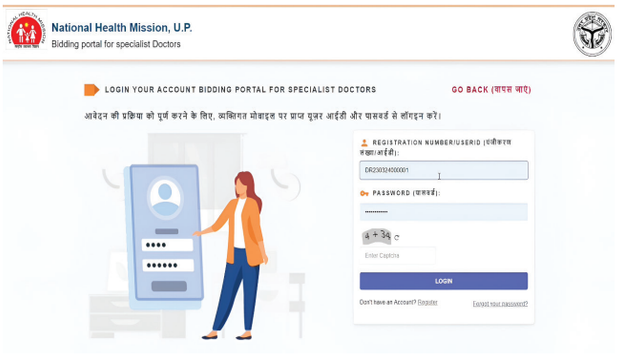
No additional implication, existing NHM funds are utilised for activities.

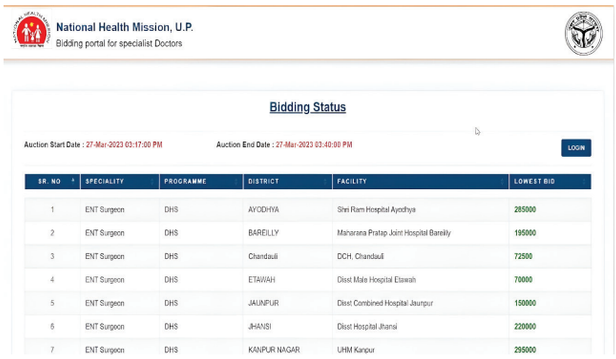
Scalability

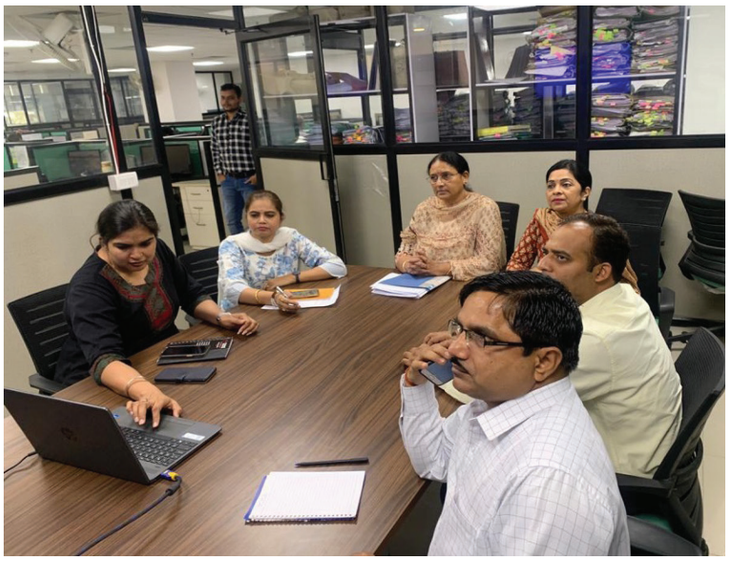
The model is scalable and replicable.

UTTAR PRADESH

YOU QUOTE, WE PAY: THE REVERSE BIDDING APPROACH







Problem Statement

Uttar Pradesh, with a population of 237 million, has long faced a shortage of specialist doctors across public health facilities. This shortage has adversely impacted health outcomes, particularly in maternal and child health and non-communicable diseases. One of the key challenges has been the difficulty in attracting and retaining specialists in underserved areas, both geographically and across specialities. The existing salary range of Rs.1.20 lakh to Rs.1.75 lakh per month under the National Health Mission (NHM) generated limited interest among specialists, resulting in inadequate availability, estimated at only 1.5 specialists per lakh population. These gaps in human resources have affected the functionality of health facilities and highlighted the need for an innovative, efficient, and transparent recruitment mechanism to ensure adequate specialist availability across districts.

Programme Description

To address the shortage of specialists, the Government of Uttar Pradesh introduced an innovative Reverse Bidding Model for recruitment under the National Health Mission. Under this model, specialist doctors are invited to participate in a bidding process where they submit their preferred monthly remuneration within a defined range of Rs 70,000 to Rs. 5,00,000. The system follows a reverse auction mechanism, where specialists can view the current lowest bid and adjust their quotes within a specified time window.

The process includes registration, submission of facility preferences, eligibility screening, document verification, and participation in the reverse auction. The system identifies the lowest (L1) bidders for each facility and assigns positions based on preferences. In cases where multiple facilities are involved, allocation is done systematically, and offers cascade to the next lowest bidders if required. Selected specialists are engaged on a contractual basis and deployed at specific health facilities to ensure service delivery. The model aims to optimise recruitment while ensuring that all government health facilities are adequately staffed and functional.

Programme Outcome

The implementation of the reverse bidding model has resulted in the recruitment of 565 specialists under the National Health Mission in Uttar Pradesh. The model has improved the recruitment process by minimizing favouritism and standardizing selection through a competitive mechanism. It has also reduced negotiation time and streamlined hiring procedures.

By allowing specialists to quote their preferred remuneration, the model has generated greater interest and participation, contributing to improved availability of specialists across facilities. This, in turn, supports better service delivery and strengthens the functioning of health systems.

Financial Implication

The reverse bidding model optimises government expenditure by ensuring competitive salary quotes through a market-driven mechanism. By allowing specialists to bid within a defined range, the system enables cost-effective recruitment while maintaining service quality.

Scalability

The reverse bidding model demonstrates strong potential for scalability across districts and other states. Its structured, transparent, and technology-driven approach allows easy replication within existing health system frameworks. The model can be adapted to address specialist shortages in various contexts, including underserved and remote areas. Its ability to streamline recruitment, optimise costs, and improve specialist availability makes it a scalable solution for strengthening the health workforce.

UTTAR PRADESH

IMPLEMENTATION OF DIAGNOSTIC NETWORK OPTIMISATION FOR TB ELIMINATION IN UTTAR PRADESH

Problem Statement

Tuberculosis (TB) continues to be a major public health challenge in India, with Uttar Pradesh contributing a significant proportion of the national TB burden. Despite sustained efforts under the National Tuberculosis Elimination Programme (NTEP), several systemic and operational challenges persist, including delays in diagnosis, which often leads to setbacks in receiving time-appropriate treatment.

Programme Description

To enhance TB case detection, the state aligned with national priorities and implemented a transition in diagnostic strategy from smear microscopy to Nucleic Acid Amplification Test (NAAT). Under this, a Diagnostic Network Optimisation (DNO) exercise was initiated in January 2024, where comprehensive geo-location mapping and capacity assessment of all molecular devices/ sites were carried out. Using this exercise, the accessibility of NAAT testing was ensured in all the districts. Sample transportation from AAM SHCs & PHCs to nearest TB Detection Centers was also streamlined by the State.

From 2025, all NAAT machines were made to run in two shifts during TBMBA (100 day campaign), by rational use of existing lab technicians available. NAAT Testing against capacity was also tracked on a monthly basis, with close monitoring and supply of lab kits, consumable kits and cartridges to ensure no stock-outs.

Programme Outcome

This re-enforced the use of 185 UNO NAAT Machines for testing, resulting in the number of NAAT machines increasing from 725 in 2023 to 910 in 2024, as well as overall block coverage enhancing from 65% to 73%. Moreover, NAAT Utilization against capacity enhanced from 46% into 88%. Further, presumptive testing by NAAT had gone up to 63% as compared to 15% in 2023. Annualised Presumptive Tuberculosis Examination Rate (PTER) had increased from 1,928 in 2023 to 2,578 in 2025.

Financial Implication

Existing NHM funding was utilised for program activities, while additional support was provided through CSR.

Scalability

The intervention leverages existing system resources and is therefore suitable for scaling up.

UTTAR PRADESH

KISHOR SWASTHYA MANCH: EMPOWERING ADOLESCENTS FOR A HEALTHY FUTURE

Problem Statement:

India has a large adolescent population (10–19 years), accounting for nearly one-fifth of the total population, with Uttar Pradesh having the highest share. Adolescence is a critical developmental phase marked by rapid physical, cognitive, and psychosocial changes. Despite lower prevalence of infectious diseases, adolescents face significant challenges, including unhealthy dietary habits, sedentary lifestyles, mental health issues, substance abuse, and environmental risks. Additionally, gaps were identified in awareness and service uptake related to key health interventions such as Weekly Iron and Folic Acid Supplementation (WIFS), especially in districts with poor coverage.

Programme Description

The Kishor Swasthya Manch (KSM) initiative, implemented under the National Health Mission in Uttar Pradesh including all components of RKSK, is designed as a platform to address adolescent health, nutrition, and development needs. The KSM event is held annually in two selected intercolleges (schools with 9th -12th grades) in each block of all 75 districts. The programme evolved from earlier pilot initiatives such as Anaemia Free Adolescent (AFA) events conducted in selected districts and schools and mentor activity pilot to address the issue of anaemia amongst adolescents by Nutrition International. Building on these learnings, KSM serves as a convergence platform where adolescents are mobilised and engaged through interactive sessions. The primary objectives of KSM are to sensitise adolescents on health and nutrition topics, address their health concerns, provide point-of-care treatment and counselling and promote interdepartmental convergence for adolescent health.

To achieve these objectives, the following key strategies have been adopted: Micro level planning is done at the district and block level to ensure the effective rollout of KSM activities in schools. KSM activities are organised in collaboration with the departments of Health, Education, Women & Child Development and Panchayati Raj Institution. Coordination among these departments, and with political leaders, local administration, non-governmental organisations, community-based organisations and influencers, is crucial for the programme's successful implementation To understand the reach of KSM, inter-departmental coordination, and effectiveness of programme, reporting is ensured from all the districts. Online reporting ensures accurate data collection and evaluation of the events

Programme Outcome

The initiative has contributed to improved awareness among adolescents regarding health, nutrition, and healthy lifestyle practices. It has strengthened community-level engagement and created a platform for adolescents to discuss their concerns .

The programme has been organised in 822 blocks and 75 urban areas, reaching a total of 1790 inter-colleges annually. From 2019 onwards, the KSM activities have engaged approximately 30 lakh adolescents, providing awareness on various health and nutrition topics. Additionally, over 7 lakh adolescents have been tested for haemoglobin levels through this initiative. KSM has sensitised over 45000 teachers and 6000 school principals on issues related to adolescent health.

Financial Implications

No additional cost incurred.

Scalability

The model is scalable.

National Health Systems Resource Centre