



Mother and Child Health Action Plan Punjab

*Translating Reproductive, Maternal, Newborn, Child and Adolescent Health
(RMNCH+A) Strategy into Action and Outcomes in Punjab*

2014 - 2017

Department of Health & Family Welfare, Punjab.

Government of Punjab

Mother and Child Health

Action Plan

(2014-2017)

**(Translating
Reproductive, Maternal, Newborn, Child and
Adolescent Health (RMNCH+A) Strategy
Into Action and Outcomes in Punjab)**

December 2013



D.O. No.
Dated :

PARKASH SINGH BADAL
Chief Minister, Punjab

MESSAGE

Health is the real driving force for a strong community. Providing good and affordable health services is indeed the real service to the humanity. As envisaged in our slogan of " Raj nahi Sewa" I reiterate my Government's commitment to provide preventive, promotive, and curative services of the highest standard to the people of Punjab.

The state of Punjab has consistently performed better than most other States in providing good health services to all the age groups and maternal and child health services in particular. The concept of Reproductive, Maternal, Newborn Child & Adolescent Initiative and its implementation will further bring a change in the provision of affordable health care to the adolescents, pregnant women, newborn and children.

I appreciate the initiative taken by the Department of Health and Family Welfare to transform the Reproductive, Maternal, Newborn Child & Adolescent Strategy into an Action Plan that would help bridge the gaps in providing good healthcare through different life stages. The Govt. of Punjab is committed to the successful implementation of this Action Plan.

(Parkash Singh Badal)

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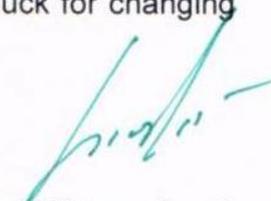
Health & Family Welfare and Social Security
& Dev. of Women & Children Minister,
Punjab.

Dated : 23-12-2013

Message

Health of the citizens determines the welfare and prosperity of the State. Punjabis are known for robust health and good humour. The Health indicators of Punjab are better than the national indicators and the State is ahead of majority of the States in the country. We are committed to improve the health of our pregnant women and lactating mothers as well as children and thus reduce the maternal and childhood mortality.

The State is going to ensure Universal Health Care through the various components of continuum of care i.e. reproductive, maternal, new born, child and adolescent health. RMNCH+A initiative will be a major step in achieving the good health and further lead to reduction of maternal and childhood mortality as per 12th plan targets. The Department of Health and Family Welfare will leave no stone unturned to implement this strategic plan in totality. I wish all the dedicated and hardworking officers and officials of Health and Family Welfare Department good luck for changing it into reality.


(Surjit Kumar Jyani)

PREFACE

Punjab leads the country on many parameters. According to various surveys and studies in recent years, Punjab has remained among frontrunners in the health domain also. However, the State govt. is committed to bringing further improvements and eventually, providing universal health care.

2. The interdependence of various components of continuum of care is well recognized. In other words, reproductive, maternal, newborn, child or adolescent health can be ensured only if all the life stages preceding a particular life stage are healthy. RMNCH+A initiative aim at providing equal focus to all the life stages across the continuum of care. This commitment to the global community can become a reality only if the whole concept of RMNCH+A can be translated into a robust and realistic action plan.

3. This thoughtfully and carefully prepared plan has taken into account the existing health dynamics in the state. In addition, the plan clearly lays down the governance measures like supportive supervision, Monitoring & Evaluation and program reviews that need to be in place for ensuring the quality of services.

4. I compliment and extend my grateful thanks to Dr Vinod Paul, Professor & Head, Department of Paediatrics, All India Institute of Medical Sciences, who spearheaded the preparation of this plan. The Task Group under the chairmanship of Dr. K. K. Talwar provided detailed advice and encouragement. I also thank the dedicated officers of the Health Department Punjab led by Dr. Karanjit Singh, who worked long and hard on this effort. The real challenge lies ahead to implement this strategic plan at all levels i.e. from state through district level up to the remotest village and beneficiary. I firmly believe that the Punjab Health Department will prove itself to be among the leaders and agents of change that India can be proud of.

(Vini Mahajan)
Principal Secretary to Govt. of Punjab
Department of Health & Medical Education

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ABBREVIATIONS

AFHCs	Adolescent Friendly Health Clinics
AFP	Acute Flaccid Paralysis
AHS	Annual Health Survey
AIIMS	All India Institute of Medical Sciences
ANC	Ante Natal Care
ANM	Auxiliary Nurse & Midwife
ARI	Acute Respiratory Tract Infection
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
BCC	Behaviour Change Communication
BPL	Below Poverty Line
BPNI	Breastfeeding Promotion Network of India
BSU	Blood Storage Unit
BSUs	Blood Storage Units
C-DAC	Centre for Development of Advanced Computing
CES	Coverage Evaluation Survey
CHC	Community Health Centre
CHD	Congenital Heart Disease
CMC&H	Christian Medical College and hospital
CMHO	Chief Medical & Health Officer
CMO	Chief Medical Officer
DHQ	District Head Quarters
DLHS	District Level Household Survey
DMC&H	Dayanand Medical College & Hospital
Dy Dir	Deputy Director
ECG	Electro Cardio Graphy
EDL	Essential Drug List
CEmOC	Comprehensive Emergency Obstetric Care
FBNC	Facility Based Newborn Care
F-IMNCI	Facility based Integrated Management of Neonatal and Childhood Illnesses
FIR	First Information Report
FOGSI	Federation of Obstetric and Gynaecological Societies of India

FRU	First Referral Unit
FW	Family Welfare
GGs Medical College	Guru Gobind Singh Medical College
GNM	General Nursing and Midwifery
GoI	Government of India
Hb	Haemoglobin
HBNC	Home Based Newborn Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPD	High Priority District
HR	Human Resources
IAP	Indian Academy of Paediatrics
ICDS	Integrated Child Development Services
ICT	Information and Communication Technology
ICTC	Integrated Counselling and Testing Centre
IDSP	Integrated Disease Surveillance Project
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IMA	Indian Medical Association
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IMS Act	Infant Milk Substitute Act
IPD	In Patient Department
IPHS	Indian Public Health Standards
IUCD	Intra-Uterine Contraceptive Device
IYCF	Infant and Young Child Feeding
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojna
LBW	Low Birth weight
LHV	Lady Health Visitor
LSAS Training	Life Saving Anaesthesia Skills Training
MBBS	Bachelor of Medicine and Bachelor of Surgery
MCH	Maternal and Child Health
MCP Card	Mother and Child Protection Card

MCTS	Mother and Child Tracking System
MDGs	Millennium Development Goals
MD-NRHM	Mission Director- NRHM
MHS	Menstrual Hygiene Scheme
MKKS	Mata Kaushalya Kalyan Scheme
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MNCH	Maternal Newborn and Child Health
MO	Medical Officer
MoU	Memorandum of Understanding
MPHW	Multi-Purpose Health Worker
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NABL	National Accreditation Board for Testing and Calibration of Laboratories
NACO	National AIDS Control Organisation
NBCC	New Born Care Corner
NBSU	New Born Stabilization Unit
NFHS	National Family Health Survey
NGO	Non-Government Organization
NLEP	National Leprosy Eradication Programme
NMR	Neonatal Mortality Rate
NPCB	National Programme for Control of Blindness
NRHM	National Rural Health Mission
NSSK	Navjaat Shishu Suraksha Karyakram
NUHM	National Urban Health Mission
OPD	Out Patient Department
ORS	Oral Rehydration Salts
PC&PNDT Act	Pre-Conception and Pre-Natal Diagnostic Techniques Act
PGIMER	Post Graduate Institute of Medical Education and Research
PHC	Primary Health Centre
PHSC	Punjab Health Systems Corporation
PRI	Panchayati Raj Institutions

PS	Principal Secretary
QA	Quality Assurance
RBSK	Rashtriya Bal Swasthya Karyakram
RHD	Rheumatic Heart Disease
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMO	Rural Medical Officer
RMSCL	Rajasthan Medical Services Corporation Limited
ROP	Record of Proceedings
RTI	Reproductive Tract Infections
SBA	Skilled Birth Attendant
SC	Sub Centre/ Scheduled Caste
SHCs	Subsidiary Health Centres
SMS	Short Message Service
SNCU	Sick Newborn Care Unit
SOP	Standard Operating Procedures
SPMU	State Program Management Support Unit
SRS	Sample Registration System
STI	Sexually Transmitted Infections
TFR	Total Fertility Rate
TNMSC	Tamil Nadu Medical Services Corporation Limited
TT	Tetanus Toxoid
U5MR	Under-Five Mortality Rate
USAID	United States Agency for International Development
VHND	Village Health & Nutrition Day
WCD	Women and Child Development
WIFS	Weekly Iron & Folic Acid Supplementation
WPV	Wild Polio Virus

CHAPTER 1: INTRODUCTION

The Mother and Child Health Action Plan (2014-17) aims to improve the health of women and children in Punjab, and in so doing, to improve the lives of all people in the State. The health of women and children is critically important to almost every area of human development and progress, and directly impacts our success in achieving the development aspirations of the country, in particular, the XII Plan targets, as well as the Millennium Development Goals (MDGs).

Experience from across the globe has demonstrated that the health of women and children is the fountainhead of public health. Equally important is the adolescent health which bridges the flow of health from childhood to adulthood. A healthy population is the foundation upon which the nation builds a successful economy and a welfare state. Prosperity and wellbeing is essential to political stability, creative society and social harmony.

The State of Punjab has been consistently performing better than the rest of the country in reproductive and child health. High per capita income, high literacy rate, community development enterprise together with healthcare programs have led to the attainment of impressive indicators of health in the State. As per the SRS data of 2012 (released in September 2013) Infant Mortality Rate (IMR) of Punjab is 28 per 1000 live births as against 42 at the national level. The State's total fertility rate (TFR) at 1.8 has already reached the replacement level. The Maternal Mortality Ratio (MMR) stands at 172 (per 100,000 live births) against the national average of 212.

Since 2005, the National Rural Health Mission has resulted in an unprecedented strengthening of the public health system with focus on health infrastructure, human resources, service delivery, program management, monitoring and communitization. Deployment of ASHAs across rural areas has changed the paradigm of the way services are delivered at doorstep of the people. The Government of Punjab has effectively harnessed the resources of NRHM and scaled up initiatives such as the Universal Immunization Programme, skilled care at birth, Emergency Obstetric Care, IMNCI (Integrated Management of Neonatal and Childhood Illnesses), NSSK (Navjat Shishu Suraksha Karyakram), FBNC (Facility Based Newborn Care), and referral transport services. Demand side financing initiatives such as the JSY (Janani Suraksha Yojna) and JSSK (Janani Shishu Suraksha Karyakaram) have helped in reducing out of pocket

expenses on healthcare of women and children. Indeed, the Government of Punjab has gone beyond the provisions of NRHM for maternal and child health by introducing the MKKS (Mata Kaushalya Kalyan Scheme) and the free treatment of all girls up to the age of five years in public facilities.

In January this year, the Government of India brought various healthcare initiatives and programs for women, adolescents and children into one strategic framework.¹ This strategy document on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) has emerged as the master driver of accelerated action under NRHM, in particular during the XII Plan period up to 2017.

The Mother and Child Health Action Plan (2014-2017) is a comprehensive effort by the Government of Punjab to translate the National RMNCH+A strategy into a State level action plan for the women, adolescents and children. This document is the outcome of discussions with the key stakeholders to identify gaps and solutions in coverage, quality of care, and health systems components. In addition, there were intense internal deliberations to articulate actionable tasks and timelines. This has indeed been a unique undertaking in program analysis, target setting and in envisioning a realistic work plan toward the avowed outcomes. The Action Plan is thus aspirational, yet deliverable.

Though the State of Punjab has better health indicators as compared to many other states of the country, this is not enough. The Government of Punjab is committed to raising the health status of the people of the State to the levels that prevail in the developed world in not so distant future. The Mother and Child Health Action Plan (2014-2017) is one cogent step in that direction.

¹ A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A): For Healthy Mother and Child. Ministry of Health and Family Welfare, Government of India. January 2013

CHAPTER 2: SITUATIONAL ANALYSIS

Women's health before and during pregnancy, place of delivery, quality of services for the mother and newborn during and after delivery have a far reaching impact on the survival, morbidity and mortality of a newborn/ child. Furthermore, adolescent health provides the crucial bridge for nurturing both maternal and child health, nutrition and wellbeing.

The Millennium Development Goals (MDGs) 4 and 5, aimed at maternal health and child survival, respectively, gave an impetus for action to all countries towards improving the health of women and children. As India moves beyond the MDGs, it is time to set sights well beyond survival – on quality lives and the realization of the full potential of human creativity and capital.

The State of Punjab has performed better in all the relevant health indicators (Table 2.1). Punjab's MMR stands at 172 (SRS 2007-09) having declined from 192 a few years earlier (SRS 2004-06), while the IMR at 28 (SRS 2012) has decreased from 38 in 2008 (SRS 2008). TFR at 1.8 (SRS 2011) is already at the replacement level.

Table 2.1 Key indicators of the country and the State of Punjab

Indicator	CURRENT	
	India	Punjab
MMR (SRS 07-09)	212	172
U5MR (SRS 2011)	55	38
IMR (SRS 2012)	42	28
NMR (SRS 2011)	31	24

MATERNAL HEALTH

Antenatal Care

Multiple factors have helped reduce infant and maternal morbidity and mortality in Punjab. High coverage of antenatal checkup of all pregnant women registered at health institutions to identify high risk pregnancies, motivation for institutional deliveries to minimize morbidity and mortality of mothers as well as newborns, and health education to mothers regarding child care are among the main reasons for the same. MCTS (Mother and Child Tracking System) to identify, register and follow up all pregnant women in health institutions for providing adequate services to the mother and child is helping in further reducing MMR and IMR. Interventions for improving health and nutrition of young women during pre-pregnancy (adolescent), pregnancy and childbirth will enhance the survival and optimal health of the woman and her newborn. More than 90% of pregnant women are registered with health institutions, out of which nearly 70% are registered within the first trimester and at least three antenatal checkups are done to identify high risk cases. The quality of antenatal checkup has improved with the ANMs conducting simple laboratory investigations like Haemoglobin and Urine Sugar and Albumin estimation at the sub-centre level. Skilled Birth Attendant (SBA) training to ANMs and Staff Nurses has helped ensure availability of skilled services.

Natal Care

Care of the mother and the newborn during delivery in a health institution significantly contributes in reducing the mortality of both mothers and babies by preventing delivery related complications. The ratio of institutional deliveries has increased significantly (82%) during the past few years due to various interventions. Still, a large number of deliveries occur at home. One hundred government health institutions, including 22 district hospitals, 41 sub-divisional hospitals and 37 Community Health Centres have been strengthened for round the clock services. The status of deliveries in the state over the last few years is as shown below (Table 2.2):

Table 2.2 Deliveries in the State of Punjab:

	2008-09	% age	2009-10	% age	2010-11	% age	2011-12	% age	2012-13	% age	2013-14 (up to July)	% age
Institutional	230436	59	249610	64	273238	69	320757	78	342798	83	100123	85%
Public	96542	25	101804	26	115865	30	157018	38	163646	40	50883	43%
Private	133894	34	147806	38	157373	39	163739	40	179152	43	49240	42%
Home	159335	41	138119	36	125510	31	92993	22	71047	17	17055	15%
Total Deliveries	389771		387729		398748		413750		413845		117178	

(Source: HMIS Data Punjab)

In order to motivate women to undertake institutional deliveries, the State is giving incentives for welfare of the mother and newborn:

Janani Suraksha Yojna (JSY)

Janani Suraksha Yojna is one of the flagship programmes under NRHM. All women belonging to Scheduled Castes (SC) and Below Poverty Line (BPL) are given incentives as follows (Panel 1):

Panel 1

Place of Delivery	Place of Residence	Incentive (in Rs.)
Institutional	Rural	700
	Urban	600
Domiciliary	Rural	500
	Urban	500

Mata Kaushalya Kalyan Scheme (State Scheme)

As a State initiative, the State of Punjab is giving a cash incentive of Rs. 1000/- to each pregnant woman for delivering in a Government Health Institution. During 2012-13, out of a total 413,845 deliveries, 163,490 (39.5%) took place in government institutions.

Janani Shishu Suraksha Karyakaram (JSSK)

All health services to pregnant women and newborn children (up to 1 year of age) are free at government institutions. This includes free drugs, diagnostics, diet, and referral services. The state aims to cover all 517,754 pregnancies (470,686 deliveries) under JSSK.

Referral Transport

The state government is committed to providing free referral transport to all pregnant women, delivery cases and newborn children. They are provided referral transport for travelling to and from a hospital and also for inter-facility transfer, if required. Apart from this, the Senior Medical Officers are provided a budget for arranging referral transport for cases where the official vehicle is not available due to some reason. At present 240 ambulances under the '**Dial 108**' **Emergency Response System** and 180 ambulances of government institutions are being utilized for this purpose. The emergency response system is being operated by ZIQITSA Healthcare under a MoU with the State Government. They also provide general emergency services to the community. The patients transported through the emergency response system during the past two years are as below (Table 2.3):

Table 2.3 Profile of referral transport activities

	Up to March 2012	April – March 2013	April-July 2013
Emergency calls	198162	369230	118369
Availed	153266	306591	97339
Un-availed	39895	62639	21030
Total	198162	369230	118369
Animal & snake bites	210	274	70
Burn & chemical accidents	1041	2251	755
Cardiac emergencies	4541	5543	1617
Farm accidents	2881	5669	1894
Pregnancy cases	49277	84891	28117
JSSK (Pregnancy Cases – Dropped Home) and Neonates Served	1036	80134	24458
Medical emergencies	29289	39306	12267
Others	41602	54558	18857
Road accidents	23144	34431	9732
Suicidal cases	245	384	131
Trauma cases		2879	1257
Total Patients Served	153266	310320	99155

OTHER INITIATIVES

Mobile Medical Units - Twenty four Mobile Medical Units, well equipped with diagnostic tools along with two doctors, have been operational in all districts since December 2008.

Mother and Child Tracking System (MCTS) - The system has been implemented in Punjab and data is being collected since December 2010 in the MCTS software system provided by the Govt. of India.

Free Medicines - The State has decided to provide all medicines under EDL (Essential Drug List) free of cost in all Government Hospitals.

Incentives - ASHAs are being given incentives for identifying severely anaemic pregnant females and providing iron supplements to these females for treatment of anaemia.

NEONATAL HEALTH

Neonatal deaths constitute 75% of total infant mortality. Main causes of neonatal deaths are pre-maturity, birth asphyxia, neonatal sepsis and respiratory disorders. Neonatal infections are the consequence of poor status of maternal health and nutrition, poor care at delivery, and inadequate essential newborn care during the postnatal period.

The underlying causes of pre-term birth and LBW are related strongly, although not exclusively, to social, economic and cultural factors such as low maternal age and literacy, under nutrition, inadequate antenatal care, and too frequent pregnancies. Maternal health, birth spacing and age of marriage have a direct bearing on neonatal deaths and still births.

INFANT AND YOUNG CHILD HEALTH

Punjab has made great progress in infant and newborn care. The infant mortality rate of the State is far below the national average. The State has planned to track each and every child till the first year of age with a view to ensure child survival and hence, further reduce the IMR as per the target for 2015.

The burden of infectious diseases in children is an important determinant of morbidity and mortality among young children. The major contributors to child mortality being pneumonia, diarrhea and malnutrition, the incidence and severity of both pneumonia and diarrhea show a socioeconomic gradient due to exposure to risk factors related to the environment, such as lack of clean water, sanitation, indoor air pollution and overcrowding,

and to impaired immune response caused by inappropriate feeding practices, lack of exclusive breastfeeding, artificial feeding and under nutrition.

It is important to keep in mind the three key indicators of optimal Infant & Young Child Feeding Practices, i.e. **initiation of breastfeeding within one hour of birth, exclusive breastfeeding for the first six months and timely and appropriate complementary feeding after six months along with continued breastfeeding**. Current rate of these practices remains low and is a challenge to increase in the coming five year plan.

Malnutrition is still widely prevalent in preschool children and is a direct or indirect underlying factor in about 60% of the deaths in under-five children. Wasting, stunting and micro-nutrient deficiencies have important consequences on children's susceptibility to infectious diseases and cause development delay which, if continued, is irreversible. Lack of food is not the only cause for deficiency. It can also be due to inappropriate infant feeding and care, poor access to health care, and exposure to insanitary and unhygienic conditions.

From conception to the third year of life, disruption of brain development, caused by illness, poor nutrition or high stress levels can have an important effect on the child's ability to reach its physical, sensory, motor, cognitive, language and socio-emotional potential. HIV infections in children pose a serious challenge. The incidence of HIV transmission from mother to child is not very alarming (0.12%) (*NACO Report, December 2012*). Even though the incidence of HIV infection has declined in Punjab, there is a need to strengthen advocacy for prevention of parent to child HIV transmission.

SCHOOL CHILDREN

Health problems of school children are different from the previous groups. These include refractory errors, dental and dermatological problems, nutritional deficiencies etc.

In female students, the drop-out rate and early marriages are important issues. Though midday meal is being provided to all school going children, malnutrition is still widely prevalent. Prevalence of anaemia in school going children is also quite high.

There are 19,973 Government and Government Aided Schools having 27, 79,645 students. All these students are examined twice a year by the Medical Officers/ RMOs. Treatment of all ailments is free of cost at all government health institutions in the state.

De-worming of all school children is done twice a year by administering Tab. Albendazole on the second Friday of May and November which is celebrated as De-worming Day.

Children suffering from heart diseases like RHD/ CHD, Cancer and Thalassaemia are treated free of cost at super-specialty hospitals (PGIMER, Chandigarh, DMC & H, Ludhiana, CMC & H, Ludhiana, Mohan Dai Oswal Cancer Hospital, Ludhiana, Fortis Hospital, Ajitgarh, Silver Oaks Hospital, Ajitgarh and IVY Hospital, Ajitgarh).

ADOLESCENT HEALTH

Adolescent Health especially in the context of females is an important issue that needs to be addressed separately. Problems of young girls like, menstrual hygiene, regular use of Iron and Folic Acid tablets, and sex education, need to be addressed. Teenagers in Punjab are falling prey to drugs and unsafe sexual practices are making them prone to HIV infection and early pregnancy.

Menstrual Hygiene Scheme has been initiated in five SABLA districts. Adolescent girls are given sanitary napkins through social marketing with the involvement of AHSAs.

Weekly Iron and Folic Acid Supplementation Scheme (WIFS), a community based intervention to address nutritional (iron deficiency) anaemia has been initiated for adolescents in both rural and urban areas.

Access to reproductive and sexual health information services, including access to contraceptives and safe abortion services, delivered in an adolescent-friendly environment are critical to reducing incidences of STIs, unplanned and unwanted pregnancies and unsafe abortions.

Under Adolescent Health Programme, special Adolescent Friendly Health Clinics (AFHCs) have been operationalised at District Hospitals (21), Sub Divisional Hospitals (36), Primary Health Centres (9) & Community Health Centres (23) all over the state. These clinics provide preventive, promotive, curative and referral services. Counselling & Guidance is also provided at these clinics for adolescent health problems. These clinics have 1 day/ week with dedicated & adequately trained staff under ARSH Programme for the above mentioned services where ICTC counselors provide counseling services. District Ajitgarh

was taken as a Pilot project for strengthening of AFHC and the following activities have been taken for strengthening:

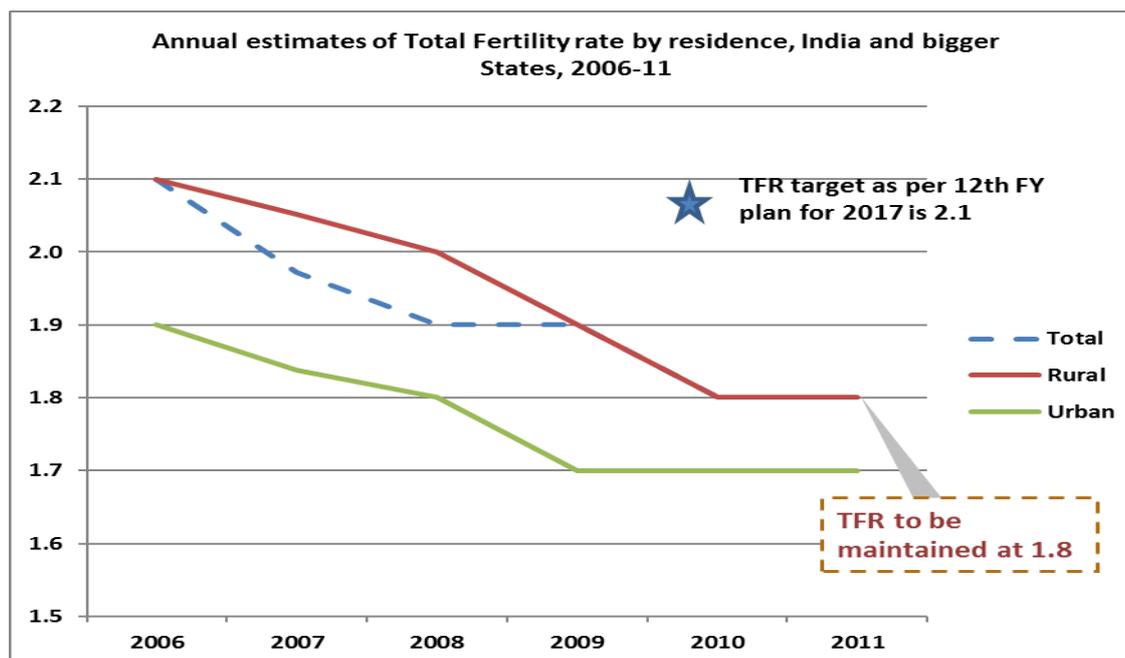
- Display Board, showing time, day & location put up in all schools
- Specialist services are provided
- Suggestion box put up in all higher secondary schools
- Pamphlets & Posters
- E-mail ID for answering queries of adolescents
- Exit interview regarding the services/ drawbacks/ improvement

Suicidal tendencies and automobile accidents amongst teenagers are another cause of concern. They also need to be addressed in this transition period.

FAMILY PLANNING

Although the state has been able to achieve a TFR of 1.8 (Fig 2.1), the Family Planning Programme needs continuous efforts to ensure child birth after 20 years of age and adequate spacing in pregnancies. This would improve infant and child survival, in addition to reducing maternal morbidity and mortality.

Fig. 2.1



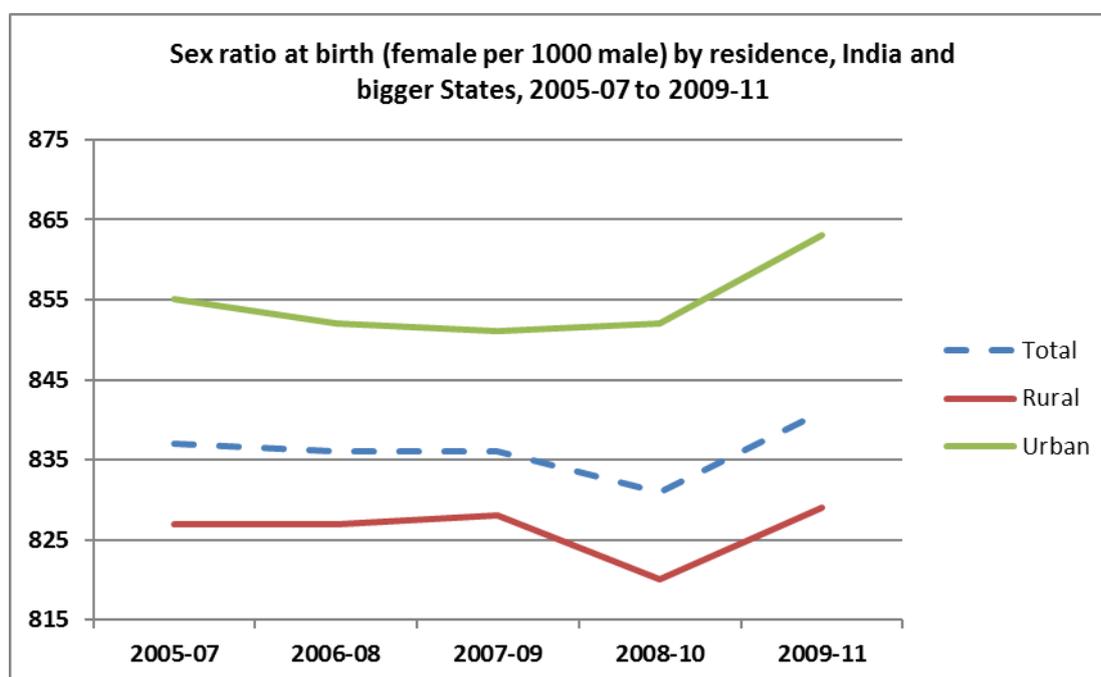
The overall status of Family Planning in the state has been satisfactory due to high literacy. As per NFHS III and DLHS III, the adoption of family planning practices is as below:

Family Planning Method	NFHS III (%)	DLHS III (%)
Any method	63.0	69.3
Any modern method	56.0	62.9
Female sterilisation	31.0	32.6
Male sterilisation	1.0	0.6
Oral pill	3.0	4.1
IUCD	6.0	6.2
Condom	16.0	19.4
Any traditional method	7.0	6.3
Use of spacing method for more than 6 months	--	23.7

IMPLEMENTATION OF PC & PNDT ACT

The state of Punjab has been suffering from low child sex ratio. The good news, however, is that there has been an improvement in the child sex ratio in the state as per the 2011 Census (Fig 2.2) which indicates an increase from 798 in 2001 to 846 in 2011. The state is committed to increasing the child sex ratio to 890 by 2014-15. Regular inspections of 1,365 ultrasound centres are conducted and actions taken as per the provisions of the Act. Till 2012-13, 124 court cases/ FIRs have been launched against violators, out of which 26 violators have been convicted.

Fig. 2.2



At the same time the state has started the process of awarding village panchayats which achieve the child sex ratio of 1000 or more during a year. Since 2008, 383 panchayats have been awarded Rs. 1.5 lacs each. During 2013, the award amount has been increased to Rs. 2.0 lacs.

SEXUALLY TRANSMITTED INFECTIONS AND REPRODUCTIVE TRACT INFECTIONS (STI/ RTI)

The diagnosis, treatment and monitoring of STI/ RTI and HIV/ AIDS is being done by Punjab State AIDS Control Society, with inputs from NACO. There are 28 centres in the state carrying out these activities at the district and sub-divisional hospitals. The Medical Colleges are involved in the activity as Sentinel Surveillance Centres. The STI/ RTI Services are to be expanded further to adolescents and pregnant mothers. The IEC/ BCC for STI/ RTI would be included in the educational materials for adolescents under RBSK. The screening and treatment of pregnant women by ANMs through syndromic approach would be taken up. The ANMs would be given refresher training on diagnosis and treatment of STI/ RTIs. The performance of ANMs would be monitored at monthly meetings at the block level. All these activities would be combined with regular and assured supplies of drug kits for STI/ RTI treatment.

IEC/ BCC

IEC (Information, Education, and Communication) and BCC (Behaviour Change Communication) play an important role in improving maternal and child healthcare. The state has been spreading the awareness for maternal and child health care through various media including print, audiovisual and interpersonal communication. There is need for further improvement in the efforts to reach the community, spread awareness and create an environment for behavior change through advocacy, communication and social mobilization, regarding various health programmes and initiatives being undertaken by the state for the reduction in maternal and child morbidity and mortality.

URBAN HEALTH

The State is in the process of developing the urban health strategy under the National Urban Health Mission that would incorporate the urban RMNCH+A Action Plan.

HEALTH SYSTEM IN PUNJAB

Healthcare System in Punjab works at three levels - Primary, Secondary and Tertiary.

a. **Primary Health Care** – Primary Health Care System is mainly responsible for preventive and promotive healthcare services and consists of:

- *Subcentres* – There are 2951 sub-centres in the State, manned by 4604 MPHWS (F).
- *Primary Health Centres (PHC)* – Operational at a population of approximately 30,000, there are 437 Primary Health Centres. Medical Officers are posted at the Primary Health Centres. While most of the PHCs offer only OPD services, some have been identified as delivery points and provide 24*7 services. The PHCs are also vaccine storage points.

b. **Secondary Health Care**

- *Community Health Centres/ Block Primary Health Centres* – The State has 141 Community Health Centres/ Block PHCs which act as FRUs for the purpose of Maternal and Child Healthcare. The services of Obstetricians, Paediatricians, Anaesthetists and Surgeons are available at these institutions.
- *Sub-Divisional Hospitals and District Hospitals* – There are 22 district hospitals and 41 sub-divisional hospitals in the state. These hospitals work 24*7 and provide all emergency services apart from 24*7 delivery services.

c. **Tertiary Health Care**

- *Medical Colleges* – The state has 10 Medical Colleges (3 in Government Sector at Patiala, Amritsar and Faridkot and 7 in Private Sector (2 at Ludhiana, 1 at Amritsar, 1 at Bathinda, 1 in district Patiala, 1 in Jalandhar and 1 in Pathankot). These Medical Colleges are providing tertiary level healthcare services.
- *Other Hospitals* – Apart from Medical Colleges, large corporate hospitals like Fortis, Ivy, MAX and Apollo, are also providing tertiary care.
- *Nursing Homes and Clinics* – The cities and towns have large number of private nursing homes and clinics operated by single or multiple doctors, which are providing healthcare, especially MCH services to the community.

d. **Subsidiary Health Centres (SHCs)**

- Once a part of Department of Health & Family Welfare, the Subsidiary Health Centres operational in rural areas were transferred to the Department of Rural

Development. There are 1186 SHCs, manned by Medical Officers apart from other staff, but their participation in the National Health Programmes is very little.

Annex

MMU Report

	2010-11	2011-12	2012-13	2013-14 (up to June 2013)
Villages Covered	9938	8964	10440	2616
Patients Examined	477006	391632	392318	94522
X-Ray	9998	6250	10568	1826
ECG	6911	4885	6333	1163
Lab Tests	123751	101982	131434	28210

Mobile medical units have played a crucial role in providing services in many difficult and hard to reach areas, but their output decreased in the financial year 2011-12 as compared to 2010-11. To know the underlying factors and suggested solutions for this decline, a study is proposed in collaboration with the School of Public Health, PGIMER, Chandigarh.

ASHA Incentives

S. No.	Activity Name	Incentive Amount (per case/session)	Cases 2012-13	Cases 2013-14
Maternal and Child Health				
1	To register every pregnant woman within three months	Rs. 100/-	254160	90297
2	To ensure minimum 3 Ante Natal Checkups (ANC), 2 Tetanus Toxoid (TT) immunization and Institutional delivery	Rs. 100/-	137295	40392
3	If Pregnant Woman is covered under Janani Suraksha Yojna, then for ensuring Institutional delivery	Rs. 200/-	83868	44830
4	To ensure 100 Iron Folic Acid (IFA) Tablets to pregnant women	Rs. 50/-	175616	59861
5	If ASHA worker stays at night in the hospital with the pregnant woman for the delivery	Rs. 50/-	70392	23030
6	For ensuring treatment/ cure of anemic women (any woman who has been found to be having HB less than 7 gm at the time of	Rs. 250/-	4154	1684

	ANC is to make it reach 9 gm at the time of delivery			
7	To Conduct Home Visit for the care of the New Born and Post Partum Mother -> Six Visits in the Case of Institutional Delivery (Days 3rd, 7th,14th, 21st, 28 th & 42nd) - >Seven visits in the case of Home Deliveries (Days 1st, 3rd, 7th, 14th, 21st, 28 th & 42 nd)	Rs. 250/-	170075	56337
8	For bringing the children for immunization and for attending the session	Rs. 150/-	152910	46281
9	For ensuring that Low Birth Weight infants (> 2.5 kg) to gain 2 kg weight in first three months	Rs. 200/-	2424	1403
10	Reporting death of mother within 24 hrs. of delivery	Rs.100/-	570	86
11	Reporting death of infant within 24 hrs. (Since Birth up to 1 year)	Rs. 100/-	4910	1276
12	For child birth registration & issue of birth certificate	Rs. 30/-	100602	31535
13	Timely referral of dehydrated patients	Rs. 50/-	1938	972
14	Support screening camp at school under School Health Programme	Rs. 50/-	4652	4376
	Family Planning			
15	For motivating and ensuring male sterilization - Vasectomy	Rs. 200/-	475	113
16	For motivating and ensuring female sterilization - Tubectomy	Rs. 150/-	5483	2516

CHAPTER 3: STRATEGIC APPROACH TO RMNCH+A

Goal

The overarching goal of the Maternal and Child Health Action Plan of the Punjab State is to ensure survival, healthy growth and development of mothers, children and adolescents, and achieve the 12th Five Year Plan targets.

Vision

- This Action Plan promotes a systemic and holistic vision for health of women, neonates, children and adolescents.
- Using the principles laid out in the national RMNCH+A strategy (2013); the purpose is to move from fragmented programmes and projects to scaling up health interventions for a comprehensive health care across the life stages along the continuum of care.
- The Action Plan would aim at creating an enabling environment to improve quality of care and address the underlying causes of morbidity and mortality amongst mothers, newborns, children and adolescents.
- The Action Plan will be a pathway to ensure that health, nutrition and development interventions are equitably implemented across all levels in the State with the active participation of all stakeholders and partners.

Outcome Targets

Following are the targets envisaged for coverage of interventions across the continuum of RMNCH+A (Table 3.1).

Table 3.1 Current status of key indicators and targets

Indicators	Current Status		Targets for Punjab		
	India	Punjab	2013-14	2014-15	12th Plan 2017
Maternal Health					
MMR	212 (SRS 07-09)	172 (SRS 07-09)	105	95	78
Child Health					
U5MR	55 (SRS 2011)	38 (SRS 2011)	30	26	20
IMR	42 (SRS 2012)	28 (SRS 2012)	23	20	16
NMR	31 (SRS 2011)	24 (SRS 2011)	19	17	13
Family Planning					
TFR	2.4 (SRS 2011)	1.8 (SRS 2011)	To maintain replacement level		

In order to attain MMR, IMR and NMR targets, significant acceleration in action will have to be achieved because the current level of progress is not sufficient. Figures (3.1 to 3.3).

Fig. 3.1. Maternal Mortality Ratio of Punjab with projection

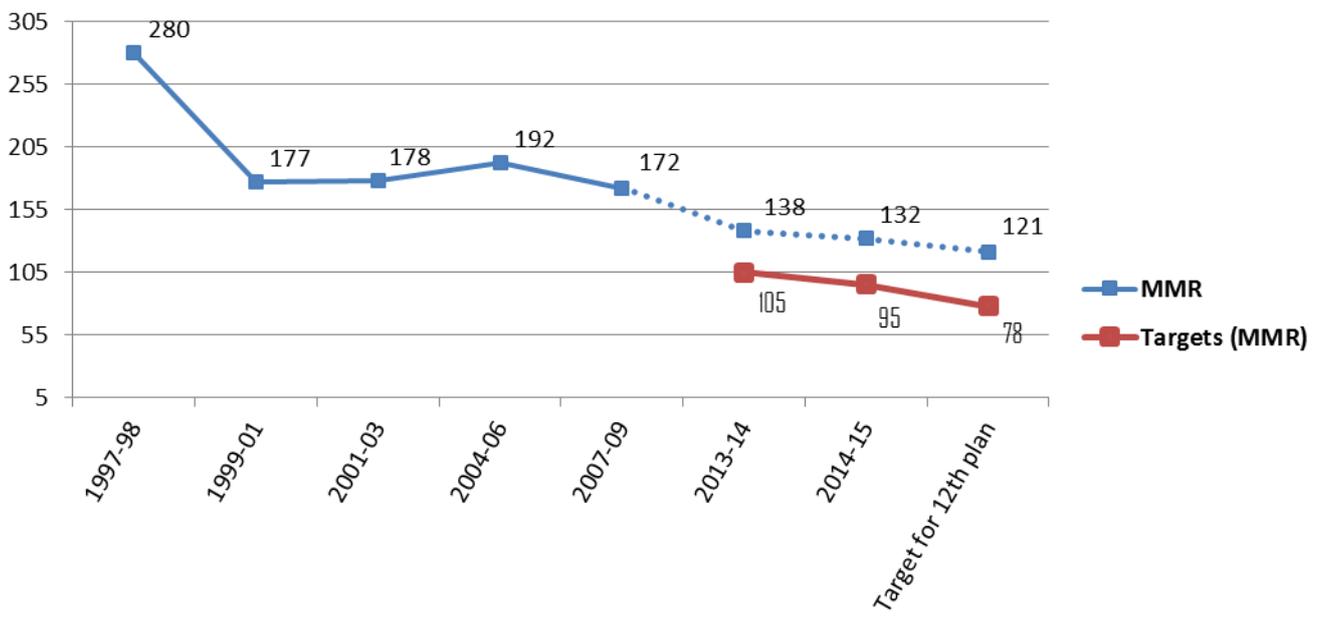
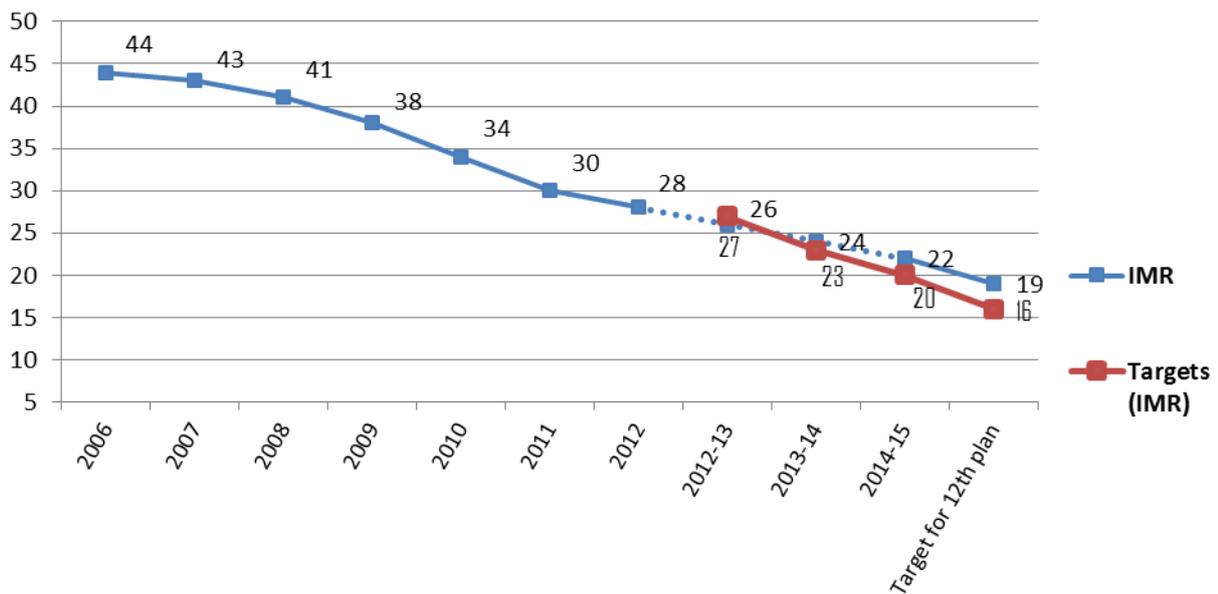
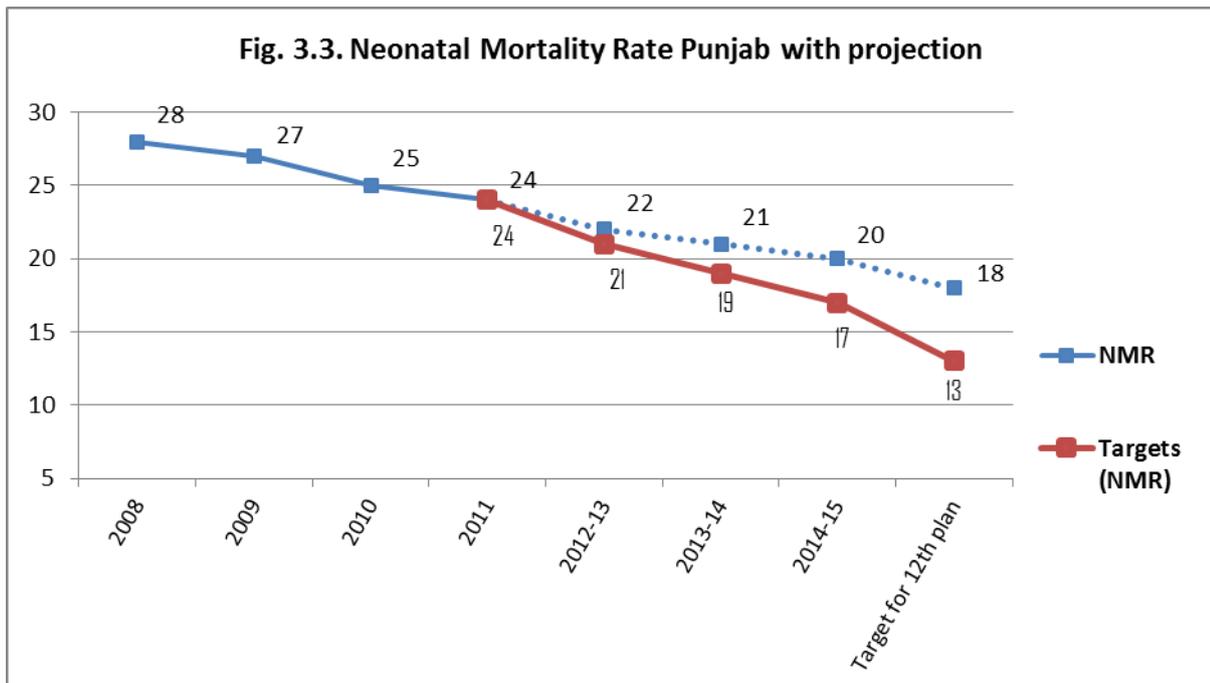


Fig. 3.2. Infant Mortality Rate Punjab with projections





Coverage targets

The Action Plan aims to achieve quality coverage of the following cardinal interventions for women, newborns, children and adolescents (Table 3.2). Only when the interventions reach most of the target beneficiaries that the impact is affected. Endeavour is that every woman, newborn, child and adolescent should receive care.

Table 3.2 Targets for coverage of key interventions

Indicators	Present status	Target for 2015	Target for 2017
Women who received 4+ANCs (%)-CES 2009	48.1	60	>80
ANCs registered during first trimester (%) -CES 2009	65.5	80	90
Deliveries taking place in public facilities (%) - CES 2009	21.8	55	70
Early initiation of breast feeding (<1hour) (%) - CES 2009	16.4	50	75
Exclusive breast feeding till 6 months of age (%) - CES 2009	43.3	65	90
Complementary feeding semi-solids (6-9 months) (%) - CES 2009	52.9	65	95
Full immunization (%) - CES 2009	83.6	90	>95
Use of ORS for treatment of childhood diarrhoea (0-2 years) - CES 2009	51.8	60	70
Proportion seeking treatment for acute respiratory tract infection at Govt. health facility/ Provider (%) - CES 2009	16.5	45	60
Post-partum IUCD insertions (%) – HMIS Reports	-	20	35
Use of any method of family planning by individuals (%) - DLHS-3	69.3	80	95

Guiding Principles

This plan strives to:

- **Implement and scale up evidence-based, cost-effective interventions** through effective service delivery strategies across the continuum of care at a high level.
 - **Strengthen Health Systems** to ensure affordable, equitable access of good quality healthcare services to all pregnant women/ mothers, newborns and children, with particular attention to the poorest and most discriminated-against population groups.
 - **Promote multi-sectoral approaches** to address the determinants of MNCH including Adolescent Health.
 - **Ensure equity and reduce disparities** in access to quality health care with a special focus on urban poor, SCs and backwards, minorities and other underserved sections of society.
-

CHAPTER 4: INTERVENTIONS ACROSS LIFE STAGES

The continuum of care approach has three dimensions with profound implications for the way in which policies, programmes and interventions are organized and executed.

- The healthcare must be provided ***throughout the life-cycle***, including the preconception period, pregnancy, childbirth, postnatal period, infancy, childhood and adolescence, since the benefits of some intervention packages straddle across different phases in the course of life.
- The healthcare must be provided through ***a process that preserves functional continuity*** across different levels of health-care delivery including home/ community, first-level health centre and referral hospital.
- It also implies ***interventions in health promotion, disease prevention and control, treatment, rehabilitation and reintegration*** into society (comprehensive health care).

The goal of addressing these continua of care is to guarantee the availability of and access to evidence-based interventions that will make it possible to improve the health of mothers, newborns, and children.

MATERNAL HEALTH

ANTENATAL CARE

Early registration of all pregnant women –

Registration of pregnant women early in the first trimester is of utmost importance for early detection of high risk cases and optimum care, and hence to reduce the incidence of pregnancy associated complications. This would be achieved by:

- Sensitization of ANMs and ASHAs to mobilize communities.
- Ensuring haemoglobin estimation and urine examination for sugar and albumin.
- Referral of high risk pregnancies to appropriate level and their follow up and monitoring through MCTS.
- Ensuring intake of at least 100 tablets of IFA by all pregnant women.
- Completion of at least 4 Ante-natal checkups for all pregnant women.
- Completion of data in MCTS and regular follow up on that basis.

- Tracking of all pregnant women irrespective of their place of ANC (public or private sector).
- Ensuring one to one skilled counseling on infant feeding to all pregnant and lactating women through skilled counselors.
- Massive IEC/ BCC Campaign for awareness generation in the community regarding services and facilities being provided by the Health Department for care of the mother and newborn and to encourage institutional deliveries.
- Raising awareness regarding Janani Suraksha Yojna and Mata Kaushalya Kalyan Scheme.
- Ensuring timely transportation of pregnant women for delivery to the nearest healthcare institution.
- Regular monitoring of the programme at the block, district and State level.

Strategic Output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
ANTENATAL CARE						
	Rapid assessment of gaps in supplies to ANMs for ANC (BP instruments, Hb estimation system, education material, IFA etc.)	Completed in April System to streamline supplies instituted by March				
	Ensure supplies to all ANMs	July onwards	Supplies ensured Six monthly reviews			Fix responsibility Develop ICT based system to monitor supplies
	Strengthened supportive supervision and monitoring of ANMs to ensure quality and ANC service delivery in all aspects	Develop a check list on how to provide supportive supervision – with roles specified for each level of supervisor from PHC MO to Directorate by April Implement stronger supervision and monitoring system	Implement strong supervision and monitoring system			
	Orientation of ANMs to ensure quality and ANC service delivery in all aspects including counseling	Plan a 3 hour orientation program on ANC quality by end of January; Conduct orientation sessions at monthly meetings for all ANMs by May				

	<p>Planning and execution of wide/ effective IEC campaign to generate awareness on benefits of ANC, birth preparedness and institutional deliveries VHND, Mamta divas, BCC campaigns – with focus on early registration, four contacts and birth preparedness</p>	<p>Plan IEC/BCC campaign to improve awareness regarding ANC, EmOC, JSY, JSSK</p> <p>Implement IEC/BCC campaign</p> <p>Ensure that all villages/ urban areas are covered by August</p> <p>Implement IEC/BCC campaign</p> <p>Ensure that all villages/ urban areas are covered at least once</p>	<p>Implement IEC/ BCC campaign</p> <p>Ensure that all villages/ urban areas are covered at least once</p>			<p>Align this campaign with IEC/BCC strategy</p> <p>Senior officers to attend VHND meetings to improve quality</p>
	<p>Surveys to assess</p> <p>1. Quality of care,</p> <p>2. Awareness and reach of the services</p>		<p>In January 2015</p> <p>Use this information to plug gaps</p>	<p>In January 2016</p> <p>Use this information to plug gaps</p>	<p>In January 2017</p> <p>Use this information to plug gaps</p>	

BIRTH CARE

Skilled care at birth is the right of every pregnant woman and her baby. Promoting institutional deliveries through motivation, incentives and community engagement would go a long way in reducing the maternal and infant mortality. The proportion of institutional deliveries has been constantly increasing over the years with greater increase in the deliveries occurring at the government institutions. Dedicated MCH Centres for care of the mothers and newborns are being undertaken.

Following measures are planned to improve natal services:

Identification and strengthening of delivery points: Fully operational PHCs, CHCs, Sub-divisional and District Hospitals are the key to provide good intra-natal and postnatal care. Developing CHCs and PHCs for **CEmOC** (Comprehensive Emergency Obstetric Care - 7 doctors undergoing training) and **BEmOC** (Basic Emergency Obstetric Care – 31 doctors trained) services, respectively, is an important intervention aimed at increasing institutional deliveries. Training of adequate numbers of doctors and staff nurses to give skilled birth attendance services at these centres has been in progress. The rational deployment of trained manpower along with regular monitoring and on – the – job training would help in improving the skilled care at and after birth for the mothers and the babies.

Incentives for Institutional Deliveries: In order to attract pregnant women to deliver in the hospitals especially the Government Hospitals, the State intends to further propagate the incentives being given to the women. **JSY (Janani Suraksha Yojna)** scheme initiated by the Government of India and implemented by the State Government has helped increase the proportion of institutional deliveries. Linking of JSY with AADHAR, and payment through Direct Benefit Transfer to the account of the beneficiaries, would further improve the institutional deliveries. **MKKS (Mata Kaushalya Kalyan Scheme)** on the other hand will further help increase deliveries in the government institutions.

JSSK (Janani Shishu Suraksha Karyakram): The availability of free drugs and consumables, diagnostics and referral transport has already been ensured at all levels for pregnant women and neonates. As mentioned earlier, rate contracts have been finalized for the drugs and consumables at the State level. Ensuring free referral transport for all pregnant women during pregnancy, for childbirth, drop back after the delivery as well as

for the transportation of sick newborn from home to hospital and back will further increase the confidence of the community on the public health care system. The efforts will be made to further strengthen the system by ensuring availability of Referral Transport Vehicles (Ambulances) exclusively for the sick neonates.

Intensified monitoring and supportive supervision: In order to ensure quality of care a monitoring system will be established. Critical components of obstetric care will be monitored on regular basis by a team consisting of supervisors from district level. A nodal officer at district will be responsible for data compilation and drawing key findings for feedback sharing and necessary action for improvement. The officials deployed for monitoring will also provide supportive supervision for onsite correction.

Deployment of skilled doctors and nurses: Rational deployment of trained human resources is a big challenge. The State will prepare a comprehensive list of all the human resources available with their training status. This list will be made readily available to all planning units i.e. from block to State. This will help in mapping the trained human resources and their redeployment according to their training status. Shortage of human resources will be managed by hiring contractual as well as full time staff. The State will take this issue on a priority basis.

Assessment of the quality of services including client satisfaction: Tools will be developed to assess the quality of services which will also include the feedback from the beneficiaries. This exercise will be done biennially. The findings will be used during review meetings and for planning activities for the coming years.

Ensure enabling environment for stay of beneficiaries for at least 48 hours: The challenge to ensure the stay of beneficiary mothers and babies for at least 48 hours after the delivery will be addressed by counselling of women during antenatal checkups and post-delivery. To provide an enabling environment, beneficiaries will be provided free of cost referral transport, food, medicines, investigations and drop back facility under Janani Shishu Suraksha Karyakaram (JSSK). Utmost attention will be paid to ensure quality services.

Strengthen capacity of staff for counselling for adoption of postpartum family planning method and on exclusive breast feeding, immunization: As both mother and baby enter a new life stage, postpartum counselling of mothers is a very important area. Multiple counselling sessions at the health facility will pave the way for a better home care

for mothers and newborns. The staff responsible for deliveries and post natal care will be given biannual refresher trainings focused on counselling of mothers. It is proposed to be mandatory at the time of discharge for mothers to be able to recall the knowledge they gained from counselling.

Ensure referral transport system that reaches the patient within 30 minutes of receiving a call and a health facility within the following 30 minutes: The referral transport will be restructured in such a way that every geographical location can be reached within 30 minutes after receiving a call. For this an extensive exercise will be carried out to map all the villages and nearby transportation facility. Clear guidelines will be issued in accordance to JSSK to ensure both referral transport and drop-back facility.

Service guarantees and elimination of out-of-pocket expenses - JSSK (Janani Shishu Suraksha Karyakram): The availability of free drugs and consumables, diagnostics and referral transport has already been ensured at all levels for the pregnant women and neonates. As mentioned earlier, rate contracts have been finalized for the drugs and consumables at the State level for the essential drugs and consumables. Ensuring free referral transport for all pregnant women during pregnancy, for childbirth, drop back after the delivery and for the transportation of sick newborn from home to hospital and back will further increase the confidence of the community on the public health care system.

Operationalisation of FRUs as per the guidelines: All the FRUs in the State are expected to be made functional as per the guidelines in a phased manner. All the birth attendants and doctors will be trained in BEmOC and/ or CEmOC as per the guidelines. Blood Storage Units will be made functional in all FRUs. The staff posted in FRUs for blood storage units will be trained for necessary skills. All the necessary equipment will be checked for functionality and their maintenance will be ensured through annual maintenance contracts.

Establishment of Maternal and Child Health (MCH) Wings: It is important to provide a feeling of safety and privacy to mothers who have delivered at a health facility. At the health facilities where there is a high delivery load, the State government plans to establish maternal and child health wings.

Strategic Output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
SKILLED OBSTETRIC CARE/ REFERRAL TRANSPORT						
	Intensified monitoring and supportive supervision	Take an in- depth review of monitoring and supervision system by February Launch new, intense system by April	Implement strengthened monitoring and supervision	Take another in- depth review of monitoring and supervision system by February Launch more intense system by April	Implement strengthened monitoring and supervision	Identify specific roles and responsibilities of supervisors – from PHC MO to DFW and MD NRHM and up to the PS; improve mobility and communication/ reporting
	Deployment of skilled doctors and nurses	Ensure >80% level of deployment of skilled doctors and nurses	Ensure 90% level of deployment of skilled doctors and nurses	Ensure >90% level of deployment of skilled doctors and nurses	Ensure >90% level of deployment of skilled doctors and nurses	Link with activities under training and HR deployment
	Assessment of the quality of services including client satisfaction	April - May Plug gaps based on assessment		April - May Plug gaps based on assessment		
	Ensure enabling environment for stay of beneficiaries for at least 48 hours	Introduce counseling of families at all delivery points by counselors to be deployed at district and SDHs Track stay of				Link with provisions of JSY and JSSK; link with ASHA's home based newborn care action

		beneficiaries				
	Strengthen capacity of staff for counselling for adoption of postpartum family planning method and on exclusive breast feeding, immunisation	At least one refresher session every 6 months on these key aspects				Medical College Hospitals should also be included in the breastfeeding initiatives
	Ensure referral transport system that reaches the patient within 30 minutes of receiving a call and a health facility within the following 30 minutes. Also system to drop back home under JSSK	<p>Assess gaps in transport system in every district (PGI study)</p> <p>Devise dash board indicators that would be monitored at District and State level</p> <p>Develop integrated system with the medical colleges by March</p> <p>Streamline the transport system.</p> <p>Create an online</p>	Ensure high performance; to be the best State in referral transport	<p>Conditions for referral of high risk cases from different levels of health institutions should be specified so that unnecessary referrals are avoided and, in case of referral, the patient is referred to the appropriate institution. (Triaged transport)</p> <p>Link referrals to the Medical Colleges for emergencies in a structured way</p>		

		system for monitoring the performance by May			
		Introduce a system of audit			
	Service guarantees and elimination of out-of-pocket expenses: Janani Shishu Suraksha Karyakram (JSSK)	Streamline payments under JSY/ JSSK. Set up grievance redressal system by March	Ensure streamlined system for JSY and JSSK		
EMERGENCY OBSTETRIC CARE (BEmOC and CEmOC)					
	Operationalisation of FRUs as per the guidelines including placement of all HR a. BEmOC b. CEmOC	a. 40 total b. 29 total	a. 20 new b. 12 new	a. 20 new b. 12 new	Ensure full complement of specialists; ensure adherence to protocols
	Blood storage units (BSUs)	24 already operational 29 BSUs to be made functional till April 2014	BSUs fully operational as per norms	BSUs fully operational as per norms	
	Establishment of MCH Wings at all high load facilities	6 to be operational by June 2014	17 facilities to be completed by end 2015		
	Trainings				To be reflected in training matrix also
	LSAS Training Medical Officers	93 (74 Certified) 48 to be trained			
	CEmOC Training Medical Officers	7 existing 32 additional			

	BEmOC Training Medical Officers	31 existing 80 additional				
	SBA Training Staff Nurses LHV/ ANM	360 staff nurses and LHV/ ANM each	Training of new ANMs/ nurses	Refresher trainings		Training of new ANMs/ nurses

NEONATAL HEALTH

The period immediately after delivery is the most crucial period for a newborn as it is responsible for nearly 25% of the total infant deaths. It is extremely important to ensure appropriate care to the newborn during this period irrespective of the place of delivery.

Recent trends have shown an increase in institutional deliveries with a shift from domiciliary to institutional deliveries and from private to public institutions. Home Based Newborn Care (HBNC) through ASHAs with support from ANMs is extremely important for reducing morbidity and mortality among newborns.

Home Based Newborn Care (HBNC)

For effective implementation of Home Based Newborn Care the State of Punjab intends to take following steps:

Completion of training of ASHAs for HBNC: Mop up trainings will be carried out to achieve 100% coverage of HBNC training for ASHAs.

Orientation of Programme Managers on Home Based Newborn Care: In order to effectively implement HBNC, it is imperative for providers and officials to have adequate knowledge and required skills. To ensure proper understanding about HBNC, all the district program managers and CMOs will be oriented in a State level workshop. The workshop will focus on developing understanding on HBNC guidelines, roll-out strategy, supportive supervision, data management and review of the program. The health providers i.e. ASHAs will be trained as per the norms. ANMs and other supervisory cadre will be oriented at block level hospitals (CHC/ FRU). To ensure quality of the trainings, State and districts will form and mobilize monitoring teams. The existing development partners working in the State will be encouraged to participate in the monitoring process along with the government.

Supplies of kits: All the trained ASHAs will be provided the kits for implementing the HBNC programme.

Framework for supportive supervision and monitoring, with well-defined roles and responsibilities of various supervisors at different levels – block, district and State:

For an effective supportive supervision it is necessary that supervisors have clarity about their roles and responsibilities. On the other hand the program managers must have the details of supervisory cadre and the domains they will be supervising. For this, a detailed

framework will be prepared for block, district and State level depicting the officials with their designation at each level and the areas they will supervise and at what frequency. During monthly reviews the achievements and areas for improvement will be discussed.

Operationalize HMIS for HBNC: The HMIS is operational in the State but it is not being used by some facilities for data updating. The State will identify the gaps and apply appropriate solutions for operationalizing HMIS in all units. The data from HMIS and monitoring system will be used for bottleneck identification and taking targeted corrective actions.

Orientation of community stakeholders, specifically PRI, WCD etc: The Health Department will facilitate orientation of officials from PRI, WCD and Education Departments to draw cooperation in implementation of health schemes. It will be ensured that the key messages reach up to the frontline functionaries of these departments to maximize the output.

Achieve high HBNC coverage: The State will improve HBNC coverage as per the decided targets in a phased manner.

Evaluation and mid-course correction of the program: As the HBNC is currently being implemented in the State, an evaluation of the program will be done. The information will be used to draw the measures needed to improve the current situation.

Guidelines on permitting ANMs to administer injection Gentamicin in newborns to treat sepsis in selected situations

The Government of India have recently developed guidelines on allowing ANMs to treat neonatal sepsis with injection Gentamicin and oral Amoxicillin where referral is not possible or is refused. These guidelines will be scaled up in high focus districts backed by close surveillance.

Strategic Output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
HOME BASED NEWBORN CARE (HBNC)						
	Workshop of District Program Managers and CMOs on HBNC	January 2014; Quarterly review	Quarterly reviews			
	Training of all target ASHAs	Complete trainings by March Orientation for effective HBNC – at least one orientation for each ASHA	Refresher orientation – at least one session for each ASHA			
	Training of supervisory cadre/ASHA facilitators	Start in February and complete by May				
	Orientation of all ANMs	Start in February and complete by May				
	Ensure supply of kits	Develop SOP for uninterrupted kit supplies and procurement thereof by end of January and complete by June	Ensure regular supply of each component of the kit			
	Create framework for supportive supervision, with well-defined roles and responsibilities of various supervisors at different levels – block, district and State	Ready by end of February; Implement effective supervision system	Implement effective supervision system			
	Develop and operationalize a monitoring framework	Ready by March Operationalize by June	Implement			
	Operationalize HMIS for HBNC	Ready by February; Operationalize by June	Implement			
	Orientation of community stakeholders, specifically PRI, WCD etc.	Orientation of all PRI members and AWWs by September		Re-orientation of all PRI members and		

				AWWs by September		
	Meeting on convergence with WCD	Ready by January; Quarterly meetings with WCD				
	Achieve high HBNC coverage	25% of birth cohort in first quarter, 60% in second quarter and 75% in the remaining period of 2014	90% coverage of the birth cohort	90% coverage of the birth cohort	90% coverage of the birth cohort	
	District, sub-district and block level orientation meetings on HBNC	Completed by July				
	Evaluation and mid-course correction	Second half of 2014				
	Implement guidelines on ANMs administering sepsis treatment with Inj. Gentamicin and Oral Amoxicillin	Train ANMs in High Focus Districts in implementing the guidelines to provide ambulatory treatment of neonatal sepsis where referral is refused or not possible	Implementation			

Facility Based Newborn Care (FBNC)

For reduction in neonatal mortality (NMR), especially early NMR, facility based new born care is to be strengthened. Care of the newborn including appropriate newborn resuscitation, thermal management, prevention and treatment of neonatal sepsis, jaundice and extra care of low birth weight babies at SNCU and NBSU is to be ensured. Establishment of NBSU (*New Born Stabilization Units*), NBCC (*New Born Care Corners*) and SNCU (*Special Neonatal Care Units*) at relevant levels in the health institutions envisaged as per the NRHM norms.

The State is going to operationalise *20 SNCUs, 78 NBSUs and NBCC at every delivery point soon*. Availability and appointment of dedicated pediatricians/ trained Medical Officers and trained Staff Nurses (Human Resources) to handle sick newborns and children is still a matter of concern. Training of doctors and staff nurses in neonatal care would be ensured. The details of these trainings are given in the HR Development section.

The planned actions on perinatal and neonatal health will complement existing policies.

- i) Operationalize FBNC units:** Measures will be taken to complete the establishment of SNCUs, NBSUs and NBCCs as per the stipulated norms and time. Ensuring availability of doctors and staff nurses trained in neonatal resuscitation and care of the newborn would be an important intervention for improving child survival. Management protocols for these units will be prepared and made available.
- ii) Training of staff:** A pool of trainers will be prepared for training of newly recruited staff at these units. Measures will be taken for quality assurance of these trainings.
- iii) Establish linkages with mentoring institutions:** As these FBNC units deal with sick newborns, it is important to establish a support and mentoring system for the staff to perform optimally. There is a need to establish linkages with Medical Colleges and other institutes of excellence so that the staff posted at these units can get guidance on managing difficult cases and also refresh their knowledge and skills. The mentorship mechanism will be developed in a way so that the faculties from these institutions can visit these units on a periodic basis and assess the performance of the unit and provide necessary handholding of the staff. Besides, the visiting experts will also share their inputs

with the health officials at district and State for necessary corrective actions. The mechanism will be evolved so that the mentoring institution can also provide support through telephone and internet.

- iv) Establish ICT system for SNCU data management and reporting:** The State will replicate the Madhya Pradesh to implement SNCU data system.
- v) Establishment of follow-up program of SNCU graduates:** To ensure continuum of care, a system will be developed through which all SNCU graduates may be tracked and their wellbeing can be assessed. They will be called for regular checks. For this every time a newborn will be discharged, the concerned ASHA/ ANM will be contacted and will be shared the current clinical status. The data operator at SNCU will track the wellbeing of newborn through telephone to ASHA on a periodic basis as well as call the babies for follow up. In addition, home visits by ASHAs will be ensured and monitored.
- vi) Formulation of quality assurance system:** Regular evaluations system will be established. For this, checklists for the use of supervising staff will be developed. The findings from these assessments will be used to identify the gaps for improvement. District and State nodal officers will keep a track on measures taken to improve the situation within the given timeline. Mentoring institutions will play an important role in the process. A comprehensive review of these units will take place on a quarterly basis.
- vii)** As a large population of Punjab receives health care from private sector, it would be important to establish reporting and surveillance mechanisms for collecting maternal and infant mortality statistics separately for private and public institutions. Comparatively higher figures in a particular set-up can help identify the underlying problems and devise appropriate solutions.
- viii) External evaluation:** To draw a clear picture of the FBNC units, the State will invite external evaluators from institutes of excellence. This will help in standardization of functioning of the units and will give an unbiased view about the functioning. The nurses trained for specific activities like SNCUs should not be shifted from there as that would adversely affect the working of the SNCUs. They should also be given some incentive for working in the intensive areas.

Strategic Output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
FACILITY BASED NEWBORN CARE (FBNC)						
	Fully staffed and operationalized SNCUs as per norms	Two existing to be strengthened Additional 8 SNCUs (Total 10)	Additional 10 SNCUs (Total 20)			
	Fully staffed and operationalized NBSUs as per norms	Total 78 to be operationalized by May				
	Fully staffed and operationalized NBCCs as per norms	172 already underway Additional 236 to be developed (Total 408 by May)				
	Training of staff	As per training matrix				
	Establish linkages with mentoring institutions	With Government Medical College, Patiala, and other colleges For 10 SNCUs Use telemedicine to link	For all 20 SNCUs	Sustain strong mentoring		Link with Amritsar, DMC, CMC & Faridkot Medical Colleges
	Establish online system for SNCU data management and reporting as in MP	Establish system by May and operationalize fully thereafter		Implement fully		System established also in Haryana
	Establishment of ICT based follow-up program of SNCU graduates	Establish system by March and operationalize fully thereafter		Implement fully		

	Establish a system to monitor newborn care in the private sector	System established by July	Reports generated	Reports generated	Reports generated	
	Formulation of quality assurance system	Develop QA system by August; Start implementation October	Implement	Review, refine. Implement	Implement	
	Review of progress of FBNC	Quarterly review				
	External evaluation	Evaluation in April-August; Introduce improvements		Evaluation in April-August; Introduce improvements		

ROUTINE IMMUNIZATION

Routine Immunization plays an important role in reducing infant morbidity and child mortality. Immunization coverage in the State is good at 83% (CES 2009) but further focus is required to ensure achievement of fully immunized status of children *particularly among the unreached children.*

Immunization of the children born in the health institutions would be ensured before they are discharged from the hospital. The co-ordination mechanisms between labour room/ postpartum ward staff and immunization clinics/ PP Units would be strengthened. The cold chain in the State is appreciated at the national level which needs to be sustained in order to maintain the quality of immunization.

The State is Polio free since 2009 and the status would be maintained through continuous efforts and AFP surveillance. Measures to avert cross border transmission of Polio Virus will be sustained.

The State foresees following initiatives to further strengthen immunization in the State:

- i) Map the migratory population:** In order to sustain the immunization efforts the State aims to reach the unreached. Migratory populations pose a great challenge to maintain the immunization coverage. Furthermore, these populations may introduce vaccine preventable diseases in Punjab from other endemic States. The migratory populations will be mapped and updated on regular basis. The plan will be made to link these pockets with a health facility and health provider so that vaccination can be ensured.
- ii) Hold health camps and campaigns:** To raise awareness about immunization and other health services health camps and campaigns will be organized in the targeted populations. These events will be organized at all levels viz. community, hospitals and schools etc.
- iii) Supportive supervision:** The supportive supervision as a part of integrated approach for maternal and child health services will be put in place.
- iv) Study on limitations and solutions to improve coverage in the unreached population:** The State wishes to conduct a study to explore the unreached populations and collect evidences to devise measures to improve the immunization coverage. The Gap analysis exercise will also add to the knowledge about achievements and gaps.

v) Pentavalent vaccine introduction: The State plans to introduce pentavalent vaccine by the start of next financial year. For this the State will put in place the mechanisms to assess the demand of vaccine and to ensure uninterrupted flow of supplies.

Strategic output	Activity	Time line				Remarks
		2014	2015	2016	2017	
Immunization						
Routine	Map the migratory population		Remap		Remap	
	Hold health camps and campaigns	Implement				
	Study on limitations and solutions to improve coverage in the unreached population	By April				
	Findings from GAP analysis to be taken into account	Introduce improvements	Implement			
	IEC/ BCC to be sustained in VHNDs	Regular campaigns				Link with IEC/ BCC strategy
	Pentavalent vaccine introduction to be requested to the GoI	Develop surveillance system; Introduce	Scale up			
Polio	Sustained efforts	Sustained effort and AFP surveillance				
	Cut transmission of WPV will be sustained	Ensure measures to avert cross border transmission				

INFANT AND YOUNG CHILD FEEDING

Exclusive breastfeeding initiated immediately after birth and continuing up to 6 months of age provides all the nutritional requirements and bonding needs of the infant. The practice of exclusive breastfeeding prevents up to 13% of all deaths in under-five children. *Early initiation of breastfeeding in all newborns* would be mandatory for all institutional deliveries.

All district and sub-divisional hospitals would be made baby friendly through breast feeding hospital initiatives by the end of next financial year.

The implementation of Ministry of Health & Family Welfare's Guidelines for Infant and Young Child Feeding Practices (2013), to ensure optimum feeding for all children including those in difficult circumstances such as children infected or affected by HIV/AIDS and low birth weight (LBW) is one of the major strategies for reducing the incidence of infections and malnutrition. The guidelines on infant and young child feeding need to be ensured at all levels i.e. family, community and health institutions. It would be linked with implementing the IMS Act in its letter and spirit. A State level sensitization workshop followed by district level advocacy meetings would be conducted within next one year with the help of BPNI.

Vitamin A supplementation along with routine immunization is an important strategy. Adequate supply of Vitamin A has been ensured to all health institutions through Rate Contract by the Punjab Health Systems Corporation.

Malnutrition in the infants would be taken care of with the help of skill trained ASHA and Anganwadi Workers *by monitoring through growth charts printed in the MCP card*. ANMs would also be sensitised in educating the mothers about breastfeeding and monitoring of developmental milestones in children.

Well Baby Clinics integrated with IYCF Counselling Centres or Skilled Lactation Counsellors to be operationalised at all healthcare institutions in the State.

ADDRESSING DIARRHEA AND PNEUMONIA

The major causes of death in under-five children in Punjab are Acute Respiratory Infection (ARI) particularly pneumonia, diarrhea and malnutrition. All these deaths are preventable through simple measures such as use of ORS/ Zinc and antibiotics. Most of these cases can be managed at the community level. However, severe cases need prompt referral and optimum treatment at the facility level. The treatment of these diseases would lead to rapid reduction in childhood mortality. A major and rapid reduction in childhood mortality is possible in the State by addressing these diseases as the guidelines and systems are already in place.

To address diarrhea and pneumonia, following measures are planned to be taken:

- i) **Ensure supplies:** As per the estimated incidence of diarrhea and pneumonia, State will procure the essential drugs which include ORS kits, Zinc tablets and antibiotics etc. It will be ensured that supplies reach the health provider in time to minimize stock-outs. Utmost care would be taken about the quality of medicines.
- ii) **Circulation of zinc guidelines:** Zinc guidelines will be disseminated up to the level of ANMs and ASHAs. This will help minimize the wastage and proper utilization of supplies.
- iii) **Orientation and sensitization of health functionaries:** Trainings and refresher orientation of health workers will be done to develop adequate understanding about management of diarrhea and pneumonia. Special focus would be given to training on usage of Zinc in diarrhea.
- iv) **Campaigns for pneumonia and diarrhea:** Special drives will be conducted for diarrhea and pneumonia. These campaigns will focus on generating awareness in community about prevention and appropriate treatment. Usage of ORS and zinc in treatment of diarrhea will be promoted. The campaigns will be undertaken in community as well as in institutions like schools, health facilities and Anganwadi centres etc. focused BCC and IEC packages will be developed for maximizing the impact. Before the onset of diarrheal season ORS demonstration session will be done in every village during VHND.

- v) **Sensitization of the doctors (IAP, IMA and other professional bodies) for Zinc treatment in diarrhea:** To increase usage of zinc by medical practitioners working in private sector, orientation sessions will be organized. The opportunity of periodic meetings of these professional bodies will be utilized for the purpose. Health department will keep a track of these meetings and prepare focused resource material for these meetings.
- vi) **Enhance visibility of the program at political level:** Political leaders would be involved in campaign against diarrhea and pneumonia to ensure commitment at all levels.
- vii) **Enhancing free availability of ORS from non-government sites like places of worship, grocery shops, ration shops and primary schools:** A special needs assessment exercise will be done to identify the non-government sites for free distribution of ORS. This will help the community to have easy accessibility of ORS and will ensure timely treatment.
- viii) **Supportive supervision and enhance focus in monitoring:** During field visits by health supervisors and officials, management of diarrhea and pneumonia will be at the focus of supportive supervision and monitoring procedures. During block and district level reviews the findings will be discussed for future action.
- ix) **Pre-service training of nurses and doctors about usage of Zinc:** Professional training institutions like Nursing Schools and Medical Colleges will include in their curriculum the details about usage of zinc in treatment of diarrhoea. A notification for the same will be issued and compliance will be monitored.
- x) **Provision of antibiotics:** Cotrimoxazole and// or Amoxycillin for treatment of non-severe pneumonia at home and supervised treatment of severe pneumonia at a health facility.
- xi) **Addressing the problem of water and air pollution through IEC/ BCC.**
- xii) **Child safety:** Safe use of insecticides and pesticides, preventing child abuse specially the girl child.
- xiii) **Collaborate with development partners and other agencies:** This will be done to promote the home treatment for ARI, use of Oral Rehydration Therapy, Hand washing and Zinc to reduce mortality and promote health of the children.

Strategic output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
DIARRHOEA AND PNEUMONIA						
	Supportive supervision and enhance focus in monitoring	Plan stronger supportive supervision	Implement			
	Ensure ORS kits with ASHAs	Uninterrupted supply of ORS with ASHAs				
	Campaign for diarrhea	May-June each year				
	Campaign for Pneumonia including community campaigns	October-December each year				
	Public awareness through BCC/ IEC	Reflected in BCC/ IEC strategy				
	Enhance visibility of the program at political level	Engage/ involve top political leadership				
	Sensitization of HWs at all levels – ASHAs, AWWs, ANMs	Refresher orientation in monthly meetings May/ June for diarrhoea and September/ October each year for Pneumonia				
	Optimizing and streamlining of supplies					
	Ensure ORS demonstration before diarrheal season in every village during VHND (April - July)	Each village to have a demonstration in diarrhoea season each year Every household to be given 2 packets of ORS by March/ April each year				
	Strengthen facilities for treatment of severe diarrhoea and pneumonia	Review gaps, if any, in treatment (drugs, oxygen, antibiotics, supportive treatment)				

		Implement effective care				
	Enhancing free availability of ORS from non-government sites like places of worship, grocery shops, ration shops and primary schools	Make plan by March. Implement	Implement	Evaluate implement	Implement	
Zinc for treatment of diarrhea	Ensure supplies	Ensure uninterrupted supply at SCs and all facilities Check supplies				
	Circulation of Zn guidelines	Circulated widely by March				
	Sensitization of the doctors (IAP, IMA and other professional bodies etc.) for Zinc treatment in diarrhoea					Involve IMA, IAP, etc.
	Orientation of all doctors, ANMs and nurses	By the end of 2014				
	Pre-service training of nurses and doctors must have Zinc included by active participation of Medical Colleges	Introduce in the curricula				
	Special efforts to ensure girl patients access care	Raise awareness of the problem in the Government and among other stakeholders				Monitor admission rates of girls in SNCUs, Medical Colleges etc.

FAMILY PLANNING

Contraceptive Services and Comprehensive Abortion Care

With increased institutional deliveries postpartum contraceptive advice to the newly delivered mothers is important to promote spacing between children. This provides a very good opportunity to promote postpartum IUCD. Adequate capacity building of the doctors and staff nurses apart from dedicated counselors for contraceptive advice at the delivery points is required. At the same time contraceptive services would also be promoted through community-based door step distribution by ASHAs and AWWs. The counselling of post natal women for sterilization would also be taken up through counsellors and available manpower.

It is well known that unsafe abortions account for 8% of maternal deaths in India. Besides this, women who survive unsafe abortion are likely to suffer long term health complications. Safe and comprehensive abortion care is an essential component of overall pregnancy care. Consistent efforts would be made to expand and sustain safe abortion services in peripheral health care facilities in rural areas. The strategy for providing safe abortion services are provision of Manual Vacuum Aspiration (MVA) facilities and medical methods of abortion in 24*7 PHCs. Comprehensive MTP Services already available in the district and sub-divisional hospitals would be strengthened further by training of doctors (gynaecologists).

In order to enhance awareness about family planning and safe abortion services the State will develop good IEC material and conduct campaigns both at community and facility level. A rapid assessment will be done to identify bottlenecks in supplies both in facilities and at field level i.e. ANMs and ASHAs. Measures will be taken to devise appropriate solutions for ensuring regular supplies. The deployment of human resources for birth spacing, sterilization and abortion services will be according to their training status. To ensure counselling of families for birth spacing methods especially interval IUCD, the hospital staff will be provided appropriate orientation.

Strategic Output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
FAMILY PLANNING AND SAFE ABORTIONS						
General	IEC/ BCC	Implement stronger BCC/ IEC campaign Mount intensified campaigns on World Population Day etc.				Align with BCC/ IEC strategy
	Rapid assessment of bottlenecks in supplies of contraceptives to facilities and to ANMs and ASHAs	Completed in February Improvements implemented		Repeat assessment		
	Supplies of contraceptives to ASHAs and ANMs	Ensure uninterrupted supplies at all levels, in particular, ANMs and AWWs				
Sterilization	Skilled manpower	Ensuring availability of skilled manpower for male and female sterilization procedures at all designated facilities				
Abortion care	Manual Vacuum Aspiration(MVA)	Provision of Manual Vacuum Aspiration (MVA) at all 24*7 PHCs, CHCs and DHs				
	Comprehensive Abortion Services	Provision of Comprehensive Abortion Services at all district hospitals				
	Ensuring trained manpower	Assess gaps in trained manpower by May Accomplish training of all the target providers				
Promotion of spacing methods: Interval IUCD	Ensure training of manpower	Assess gaps in trained manpower Accomplish training of all the target providers				
	Promote individual counselling in hospitals soon after birth	Develop job aids by June	Implement			

Implementation of PC & PNDT Act

In spite of the fact that there has been an improvement in the child sex ratio in the State, there is further scope in improving it and the State is committed to reverse the trend in female foeticide. Instructions have been issued to all appropriate authorities to enforce the PC & PNDT Act in letter and spirit and take strict action against defaulters. Further, in order to give impetus to reduction of sex discrimination the State had made the entire treatment of girl children free up to the age of 5 years. This would help further reduce the gap in child sex ratio in the State.

Improving care seeking for the girl neonates and children

The care seeking for the girl neonates and children is often delayed or denied. This results in higher probability of complications and mortality among girl infants and children compared to boys. The State has recently made provision for free treatment of girls up to 5 years of age by effectively extending the reach of JSSK beyond 5 years through its own resources. Active campaigns will be undertaken to raise awareness of the public on this issue of great importance.

Focus on development, mental health and substance abuse

The most important groups of disorders that should be taken cognizance of in the planning and implementation of the RMNCH+A are as follows:

- Mental retardation and other neurodevelopmental disorders
- Emotional disorders, adjustment disorders and conduct disorders
- Substance use disorders

These disorders are not mutually exclusive and comorbidities are high. However, at a meta-level, this scheme is useful. This is because these groups of disorders appear in the same chronology as given above, the diagnoses are usually obvious and can be easily differentiated from the other groups and the preventive, treatment and rehabilitative modalities are similar within each group.

The RBSK offers a useful platform to address these challenges.

SCHOOL GOING/ OUT OF SCHOOL CHILDREN AND ADOLESCENTS

School Health Programme provides for health care of the school going children. The School Health Programme would be strengthened and utilized to screen children for various diseases, deficiency disorders and disability, including visual disorders, congenital cardiac diseases and most importantly anaemia. Early intervention for childhood disorders under Rashtriya Bal Swasthya Karyakram (RBSK) will be strengthened through addition of more manpower and capacity building of the existing human resources. The opportunity would also be used for counselling of children towards lifestyle diseases.

The most important population group in the community, the adolescents are usually at a loss to have advice on their problems. They usually learn from their peers who are also as ignorant. It is, therefore, important to give appropriate attention to this age group. The situation is much worse for the adolescent girls who are passing through an important phase of their lives but are unable to get any advice due to social setup in the State.

Adolescent health services established at district and sub-divisional hospitals and CHCs are working towards improving adolescent health in the community. There is an urgent need to provide adequate manpower at the State and District levels for the better functioning of School Health and Adolescent Health services. Dedicated counsellors are required at health facilities to cater to the needs of adolescents. Menstrual Hygiene Scheme for adolescent girls would aim at providing them advice and facilitate provision of sanitary napkins through social marketing.

Adolescents constitute 25% of the population in the State. The major issues associated with the adolescents are inadequate knowledge and reluctance to seek help lead to myths and misconceptions. With this limited knowledge about their body they find themselves vulnerable to HIV, STI, Drug Abuse, Sex Abuse etc. Girls particularly are more vulnerable due to socio cultural barriers. Given the above scenario, the Government of India has recognized the need to impact the health seeking behavior of adolescents through Adolescent Reproductive and Sexual Health (ARSH) Strategy. For the proper implementation of ARSH the Government of Punjab will deploy dedicated counsellors for ARSH & outreach sessions in schools and VHND. Furthermore, dedicated Medical Officers for ARSH will be positioned in ARSH clinics. It is very important to improve involvement of adolescents for which social media, SMS, FM radio will be used. Suitable material will be developed for these platforms.

Weekly Iron Folic Acid Supplementation (WIFS) is an important initiative to address iron and folic acid deficiency amongst school going children and adolescents. To bolster the support to districts the State will hire a State level WIFS/ Menstrual hygiene consultant. To give WIFS a fresh impetus re-sensitization and supportive supervision of frontline workers will be done. Male volunteers will be hired at each sub-centre level to ensure services to out of school/ school drop-out boys. Cooperation and coordination with media will be increased to spread the message about benefits of WIFS and allay fears about the side effects.

Menstrual Health Scheme has played an important role in highlighting issues related to health and hygiene of adolescent girls. To improve the reach of services, an assessment will be done for need of additional AWW in urban slums. Resources will be strengthened as per the findings. Further, to support the program, recruitment of program consultant and statistical assistant at State & district level will be done, respectively. For proper implementation of the scheme inter-sectoral coordination especially with education department will be established. To involve a volunteer/ social worker/ mid-day meal worker for MHS, a policy dialogue will be started with education department. The State will develop guidelines for distribution of sanitary napkins in rural areas, urban slums by ASHAs and AWWs respectively. In order to reach out to more girls, WIFS days in schools will be utilized.

The Department of Health would work closely with the Department of Education in this area and would use EDUSAT for its activities.

Punjab is a sports-loving State. Since sports injuries are common, education for their prevention would be disseminated. Seminars on health and fitness of sportsmen will be held in schools.

Initiatives for better lifestyles (prevention of obesity in children in urban and rural areas. education regarding TV viewing, time spent in sports and enhanced physical activity including sun exposure) will be undertaken.

Monitoring of school health programme including the Mid-Day Meal Programme will be done for quality of services.

Strategic Output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
ADOLESCENT HEALTH						
Weekly Iron Folic Acid Scheme (WIFS)	Re-sensitization and supportive supervision at the grass-root level	April 2014				WIFS should be linked with the school health programme as well as with Mid-Day Meal Programme
	Increase cooperation & coordination with press/media to highlight benefits and allay fears about side effects of WIFS	Meeting with press/media 4 monthly				
	Recruitment of WIFS/MH & consultant	By April 2014				
	Male Volunteers for out of school boys	Recruitment	Recruitment completed			
Menstrual Hygiene Scheme (MHS)	Assessment and mapping of the need for additional AWWs in urban slums	By December 2015				Align with NUHM
	Recruitment of Programme Consultant & Statistical Assistant at State & District level	Start	Completed by May 2015			
	Improved coordination with Education Department	Quarterly meetings with education department at directorate level and at principle secretary level every 6 months				
	Involve a volunteer/ social worker/ mid-day meal worker for MHS	Prepare a concept note Discuss with Education Department in first quarterly meeting of 2014	Implement			
	Distribution of sanitary napkins through ASHA in rural areas	<ul style="list-style-type: none"> Policy decision in January 2014 Guidelines in April 2014 Implementation May 2014 onwards 		Implement		
	Distribution of sanitary napkins through AWW in urban areas and slums	<ul style="list-style-type: none"> Joint policy decision by Feb 2014 Guidelines by May 2014 Implementation from August 2014 onward 		Implement		

	Distribution of sanitary napkins in schools on WIFS day to reach out to more girls	Prepare a concept note by February Discuss with Education Department in first quarterly meeting of 2014	Implement	
Promote healthy habits	Use EDUSAT to promote ADH	Prepare MoU with Education Deptt; Implement	Implement	
	Promote life-long habits for healthy lifestyles	Develop program activities Develop resource materials Plan activities Develop MoU with Education Department	Implement	Prevention of obesity, drug abuse to be important focus
Gender sensitivity counseling	Counseling adolescents on gender imbalance and sensitivity	Develop approach paper; plan activities	Implement	
Preparing adolescents for parenthood	Preparing adolescents to be good parents; preparing girl adolescents for motherhood (breastfeeding, mother craft, child development etc.)	Develop approach paper; plan activities	Implement	
	Prevent sports injuries in school	Prepare educational material for dissemination by July	Seminars on health and fitness of sports men Disseminate education materials	
Link with MDM Programme	Monitor quality of Mid-Day Meal Programme (food quality)	Develop agreed SOP for monitoring quality of MDM Programme with Education Department	Implement	
Access to Adolescent Reproductive and Sexual Health (ARSH)	Dedicated counsellors for ARSH & outreach sessions in schools and VHND	<ul style="list-style-type: none"> • Concept note and guidelines April 2014 • Approvals in June 2014 Implementation from August onward 	Implement	
	Dedicated Medical Officer for ARSH			
	Involve youth by social media, SMS, FM radio on ARSH			
	Establish helpline for ARSH			

NATIONAL IRON+ INITIATIVE

Anaemia is an important public health problem all over the country. The State has taken Iron + Initiative under the NRHM very seriously. As per the strategy, iron and folic acid supplementation is being provided to children from 6 months to 19 years as per the Government of India guidelines as below:

- a. **6 months to 5 years** – IFA Syrup containing 20 mg elemental iron and 100 mcg Folic Acid – Biweekly.
- b. **5 – 10 years** – IFA tablet containing 45 mg elemental iron and 400 mcg Folic Acid – Weekly
- c. **10 – 19 years** – IFA Tablet containing 100 mg elemental iron and 50 mcg Folic Acid – Weekly
- d. **Women of Reproductive Age group** – Tablet containing 100 mg elemental iron and 50 mcg Folic Acid – Weekly
- e. **Pregnant & Lactating Women** – Tablet containing 100 mg elemental iron and 500 mcg Folic Acid daily for 100 days during pregnancy + same dose for 100 days in postpartum period.

SEXUALLY TRANSMITTED DISEASES AND REPRODUCTIVE TRACT INFECTIONS (STI AND RTI)

STIs and RTIs constitute an important public health problem in India. These diseases are responsible for several adverse pregnancy outcomes including abortion, stillbirth, preterm delivery, low birth weight, postpartum sepsis and congenital infection. These infections also have important bearing upon the health of the adolescents who are prone to them due to inadequate knowledge and awareness. The control of STI/ RTIs during pregnancy is a priority and would be linked to the pregnancy care. All delivery points and other health institutions would be strengthened to provide RTI/ STI services. RTI/ STI will be included in the education material of ARSH. With the support of NACO, RTI/ STI services will be improved. An assessment to identify gaps in supplies and diagnostic services will be done and appropriate solutions for the identified problems will be devised to ensure quality services. Resources for IEC/ BCC will be developed to generate awareness about prevention and treatment. ANMs will be oriented during monthly meetings about RTI/ STI, so that they can effectively counsel the target groups in their catchment areas about appropriate preventive measures and health seeking.

Strategic Output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
RTI/STI						
	Incorporate RTI/ STI in education material of ARSH	Develop materials by April Implement	Implement			
	Strengthen RTI/ STI activities with the NACO	Quarterly Joint Review Meetings at State and district level				
	Diagnostic services	Identify gaps Plug gaps Ensure uninterrupted services	Ensure uninterrupted services			
	Assessment of gaps in supplies	By March				
	Ensure supplies	Ensure supplies of drugs for treatment of RTIs/ STIs				
	IEC/ BCC activities	Carry out IEC/BCC campaign along with HIV and other messages				
	Strengthening the involvement of ANMs	Refresher trainings of ANMs through monthly meetings				
	Treatment kits	Ensure optimum supplies				
	Monitoring	Review of the status of the program; Plan intensified focus and supervision	Implement intense supervision and monitoring			

URBAN HEALTH

Recruitment of 308 Medical Officers, 308 Staff Nurses, 784 ANMs, 154 Pharmacists and 154 Laboratory Technicians on regular or on contract basis is envisaged under the National Urban Health Mission to strengthen the health services in the urban areas.

A study is required to understand in depth the reality, role/ strengths of various service providers/ agencies and pathways to improve RMNCH+A healthcare using the NUHM framework. In addition State level consultation would be held and action plan developed under an expert group to develop an action plan.

As a part of community participation and risk pooling effort there is a plan to enroll 8,769 Mahila Arogya Samitis at the rate of one per 400 slum population.

NEW INITIATIVES

On a mission to improve continuously, the State of Punjab is open to adopt proven, cost effective and high impact technologies. To reinforce the commitment the State has taken initiative to include three major interventions in the State Action Plan viz.

- i) **Preconception Folic Acid Prophylaxis to prevent neural tube defects**
- ii) **Elimination of Rh linked disease through counseling, screening and timely intervention, and**
- iii) **Thalassemia screening of adolescents.**

To rollout the new initiatives the State will hold detailed consultations and field tests to design guidelines for implementation, and supportive supervision and establish reporting and feedback mechanism.

Another important initiative will be detecting and managing developmental delays and behavioural problems of children within the RBSK, and to prevent substance abuse among the adolescents for which a plan will be developed after consultations.

Strategic Output	Actions	Time frame			
		2014	2015	2016	2017
NEW INITIATIVES					
Focus on child development and mental/ behavioural health	Action plan for child development, mental-behavioural health and substance abuse prevention	Hold consultation Develop plans embedded in RBSK, mental health and substance abuse prevention programs			
Prevention of Neural defects in newborns by preconception folic acid prophylaxis	Designing guidelines for providing preconception folic acid to women planning to conceive	By July 2014			
	Planning of orientation for health providers (AWW, ASHA and ANMs)				
	Estimation of additional supplies and ensuring the availability				
	Planning and roll out of preconception folic acid strategy				
	Plan and establish supportive supervision				
Elimination of Rh linked disease	Develop guidelines for counselling of adolescent boys and girls and screening of expecting couples				
Screening of adolescents for Thalassemia	Consultation to draft a policy	Consultation			
	Planning, advocacy and implementation		Planning, advocacy and implementation		

CHAPTER 5: HEALTH SYSTEMS STRENGTHENING

The improvement in health care services requires strengthening of the health system. The building blocks of health system are: policy and stewardship; health financing; physical infrastructure; skilled, motivated and enabled human resources; service delivery; monitoring and supervision, and health information and management system.

5. 1 HEALTH INFRASTRUCTURE FOR RMNCH+A

NRHM has given a major impetus to health infrastructure in the State. The State is strengthening its facilities with the aim of ensuring IPHS norms at all levels.

In order to provide good maternal and child health services in the State, 100 government health institutions will be strengthened to IPHS standards for round-the-clock services. These include 22 district hospitals, 41 sub-divisional hospitals and 37 Community Health Centres (CHCs). These institutions would, in future, be supplemented with the strengthening of more peripheral institutions which would take the load off these institutions. Improvement in the infrastructure in Medical Colleges is also being taken up on priority.

Creation of Sick Newborn Care Units (SNCUs), Newborn Stabilization Units (NBSUs) and Newborn Care Corners (NBCCs) at all delivery/ childbirth points, is high on the agenda of the State. The process for establishment of SNCUs, NBSUs and NBCCs was initiated in 2010-11. Till date 5 SNCUs – three at Medical Colleges and 2 at district hospitals (Patiala and Bathinda) have been operationalised. Work is already in progress at 8 district hospitals for the creation of SNCUs. NBSUs and NBCCs are being strengthened at the district and sub-divisional hospitals, CHCs and 24*7 PHCs.

Consequent upon the 4-point reduction in the IMR, the State has received an **incentive grant** of Rs. 106.71 crores from Thirteenth Finance Commission, Govt. of India, for the year 2011-12. This grant is being utilized for improving the Child Health Services in the State under the guidance of a High Level Committee constituted under the Chairmanship of Chief Secretary. The detailed proposal for the utilization of this grant is as below:

S No.	Activity	Estimated Cost (Rs. in crores)
1	Up gradation of Medical Colleges	
	Govt. Medical College, Amritsar	2.5
	Govt. Medical college, Patiala	15
	GGS Medical College, Faridkot	15
2	Strengthening of District and Sub-District Hospitals	
	1. Establish/ Strengthen SNCUs at District Hospitals	3.25
	a. CH Mansa	
	b. CH Sangrur	
	c. CH Barnala (Equipments)	
	d. CH Bathinda (Equipments)	
	e. CH Muktsar	
	f. CH Fazilka	
	g. CH Faridkot (Equipments)	
	h. CH Ferozepur	
	i. CH Jalandhar (Equipments)	
	j. CH Kapurthala	
	k. CH Tarn Taran (Equipments)	
	l. CH Amritsar (Equipments)	
	m. CH Gurdaspur	
	n. CH Pathankot	
	o. CH Mohali (Equipments)	
	p. CH Roop Nagar	
	q. CH SBS Nagar (Equipments)	
	r. CH Ludhiana (Equipments)	
	s. CH Fatehgarh Sahib	
	2. Creation of Mother and Child Hospitals	69
	a. Ajnala (Amritsar)	
	b. Manawala (Amritsar)	
	c. Kotkapura (Faridkot)	
	d. Batala (Gurdaspur)	

e. Sultanpur (Kapurthala)	
f. Kapurthala	
g. Ludhiana	
h. Mohali	
i. Mansa	
j. Rajpura (Patiala)	
k. Roop Nagar	
l. Mandi Gobindgarh (Fatehgarh Sahib)	
m. At five Urban Health Care Units in Amritsar	
3 Strengthening of State MCH Cell	2
TOTAL	106.75 Cr

The Government has already started the expansion of the physical infrastructure and the faculty of the Medical Colleges. But there is a need for a comprehensive improvement in maternal and child health services at all the government Medical Colleges. It was decided that a specific action plan be developed accordingly in consultation with Medical Colleges by March 2014 and implemented as a part of the present initiative. Such a plan should also take into account the report of the Task Force on improvements in medical education already prepared.

The aim of strengthening the infrastructure is to ensure that 100 public health facilities achieve IPHS standards by 2016 by creating the necessary infrastructure, equipment and manpower in order to ensure high quality care of mothers, neonates, children and adolescents. Efforts for quality improvement in all facilities will continue simultaneously. The focus, in particular would be on ensuring skilled birth attendance, essential newborn care, care of the small/ sick neonates, care of sick children and adolescent friendly services. Furthermore linkages between facilities, and facilities and community, would be strengthened.

Existing linkage of all the district hospitals with Medical Colleges and then with Institutes like PGIMER though tele-technology will be used for child health activities not only for curative aspects but also for preventive aspects especially for IEC activities. There is a

need to use the National Knowledge Network SWAN for making linkages between different health facilities.

Blood Banks and Blood Storage Units

Availability of blood transfusion facilities at FRUs and district hospitals is extremely important. Forty blood banks and 28 Blood Storage Units (BSUs) are already functional in the State and 29 BSUs are being operationalised soon by the PHSC (Punjab Health Systems Corporation). By the end of next financial year, the State plans to have BSUs at all the FRUs.

5.2 HUMAN RESOURCES

Infrastructure strengthening is of little use if it is not supplemented by deployment of appropriately trained human resources.

The Government will take effective steps to ensure deployment, retention and high motivation of the health workforce.

- The Government also will take all round actions to ensure high level of motivation and quality of performance by doctors, nurses and other health professionals through enabling policies and service conditions.
- The Government will review transfer procedures to ensure that there is confidence among the doctors and other health professionals.
- The Government will take innovative steps to fill vacancies deploy specialists, program managers and doctors, and to get the best out of their performance, including:
 - Monetary and non-monetary incentives to work in underserved areas.
 - Redeployment of retired doctors on contract.
 - Performance-based compensation for better outcomes (such as survival of LBW neonates in SNCUs, high coverage of ORS etc.).
 - Regularization of contract doctors without change in posting.
 - Strategic placement of the specialists to make facilities operational rather than spreading them thin without effect.

The State would create a role model system of ICT driven distance education and telemedicine system linked to the telemedicine hub of PGIMER, Chandigarh.

Female Medical Officers would be deployed at all 24*7 PHCs in order to provide adequate and appropriate ante-natal, natal and post natal care to the mothers and newborns.

Readjustments in the deployment of manpower, their adequate training, orientation and motivation would be some of the pre-requisites for improving the health status of these groups.

Rational posting of the trained manpower will be ensured to improve the functioning of the health institutions.

Recruitment of manpower for urban areas specifically urban slums under the Urban Health mission would help reduce the gaps in health care services in the urban areas. Following trainings targeted at maternal and child health care are being carried out in the State:

1. F-IMNCI (Facility Based Integrated Management of Neonatal and Childhood Illnesses) Training

Care of the child in the health care institutions where the services of specialist paediatricians are not available is a challenge. Training of M.B., B.S. Medical Officers in F-IMNCI is an important intervention for improving the care of the newborn child in the 24*7 PHCs and FRUs. Till date 377 Medical Officers have been trained in F-IMNCI. The plan is to train another 640 Medical Officers in the next two years. The availability of trained staff nurses to complement the trained doctors is a prerequisite for improving maternal and child health care services. F-IMNCI Training of staff nurses deployed at the centres where F-IMNCI trained doctors are working is important. Four hundred F-IMNCI trained staff nurses would be supplemented with another 640 during the next two years.

2. IMNCI (Integrated Management of Neonatal and Childhood Illnesses) Training

IMNCI is the key to providing primary care to sick children. IMNCI Training of LHV's, ICDS Supervisors, ANMs and AWWs. The training being conducted at the district hospitals would help in reducing the child hood mortality due to common illnesses. Till 2012-13, 877 LHV's/ ICDS Supervisors and 1889 ANMs have been trained in IMNCI. There is plan to train further 480 LHV's/ ICDS Supervisors and 1440 ANMs during the next two years.

3. NSSK (Navjat Shishu Suraksha Karyakram) Training

NSSK Training of Medical Officers, Staff Nurses and ANMs focuses on resuscitation and essential care of the newborn child. Until last year 1332 Medical officers and 1981 staff nurses were trained in NSSK. The State has resolved to train another 640 Medical Officers, 1280 Staff Nurses and 1280 ANMs in NSSK during 2013-14 and 2014-15.

4. SNCU Training

Training of Medical Officers and Staff Nurses in care of sick neonates admitted to SNCUs in the State is another important component in newborn care. As mentioned earlier SNCUs are being established at the district hospitals to provide specialized care to the sick neonates. Medical Officers (Paediatricians or General Duty Physicians) and Staff Nurses

posted in the SNCUs would be trained appropriately. Apart from the onsite workshops, the training would be conducted in the PGIMER, Chandigarh and 88 Medical Officers and 88 Staff Nurses would be trained during the current financial year. In addition, other Medical Colleges of the State (including the Private Medical Colleges such as the DMC, Ludhiana and CMC Ludhiana) would be engaged for this training.

5. Training in Infant and Young Child Feeding Practices

All Obstetricians, Paediatricians and other staff attending to deliveries need to be skilled in infant and young child feeding counseling. An integrated course on Breastfeeding, Complementary Feeding & Infant Feeding, HIV Counselling and Growth Monitoring that provides core training material for all levels including Master Trainers, Mid- Level Trainers, Facility based service providers and frontline workers will be imparted to the target professionals. The training would be planned and conducted in collaboration with the Breastfeeding Promotion Network of India (BPNI).

6. Life Saving Anaesthesia Skills Training (LSAS)

As an important Maternal Health intervention, M.B., B.S. Medical Officers are being trained in Life Saving Anaesthesia Skills whereby they are being trained in giving Spinal Anaesthesia in LSCS cases at the FRU level. Ninety three Medical Officers (74 certified as per GoI Protocol) have been trained in Life Saving Anaesthesia Skills to fulfill the deficiency of Anaesthetists in the State. Another 48 Medical officers would be trained during current financial year.

7. Emergency Obstetric Care Training

Training of Medical Officers in conducting normal deliveries and Caesarean Sections is another important Maternal Health Intervention. The M.B., B.S. Medical Officers deployed at PHC are being trained in conducting Normal Deliveries (Basic Emergency Obstetric Care – BEmOC) while those at the CHC/ FRU are being trained in conducting Caesarean Sections (Comprehensive Emergency Obstetric Care – CEmOC). Thirty one doctors have been trained in BEmOC during 2012-13 and 7 in CEmOC during the current year and there is plan to train another 80 Medical Officers in BEmOC and 24 in CEmOC during 2013-14.

8. **Skilled Birth Attendance Training**

Care of the mother during pregnancy, identification of high risk pregnancies and intra-natal and post-natal care of the mother and the child requires trained manpower at the peripheral level. Skilled Birth Attendance Training being conducted at the district hospitals aims at capacity building of ANMs and Staff Nurses towards this end. As such 1345 staff nurses & 1411 LHVs and ANMs have been trained in SBA till 2012-13 and another 360 staff nurses and 360 LHV/ ANMs are being trained during 2013-14.

9. **Task shifting for Pediatric Care**

In order to bridge the shortage of pediatricians in the interim, it is proposed to train a suitable number of M.B., B.S. Medical Officers in providing child healthcare for a period of 6 months at PGIMER, Chandigarh and other designated teaching institutions. A competency based curriculum would be prepared by mid-2014, and program launched thereafter.

10. **Other Trainings**

Apart from maternal and child health trainings listed above other trainings aimed at other population groups and programme components i.e. Adolescent Health, School Health, WIFS, ASHA etc. are also planned to be conducted in the State. The details of these trainings are given in the matrix below (Panel).

Panel: Capacity Building of Human Resources in Health

S. No.	Name of Training	Present Level	Target 2013 – 14	Target 2014 – 15
HBNC				
1.	Training of ASHAs in Module 6 & 7	Round I & II completed	Round III 100%	
2.	Home Visit after delivery by ASHA/ ANM	50%	80%	10%
3.	Care of the Sick Children by ANM/ ASHA		60%	80%
Child Health				
1.	NSSK Training			
	Medical Officers	1332	320	320
	Staff Nurses	1981	640	640
	ANMs		640	640
2.	IMNCI			
	LHV/ ICDS Supervisors	877	480	
	ANMs	1889	720	720
3.	F-IMNCI			
	Medical officers	377	320	320
	Staff Nurses	400	320	320
4.	SNCU			
	Medical Officers		88	
	Staff Nurses		88	
5.	Training of MBBS MOs in child health (6months)		Develop curriculum, identify sites by mid-2013 Train 50 doctors by end 2015	
Maternal Health				
1.	LSAS Training			
	Medical Officers	93 (74 certified)	48	
2.	CEmOC Training			
	Medical Officers		32	
3.	BEmOC Training			
	Medical Officers	31	80	
4.	SBA Training			
	Staff Nurses	1345	360	
	LHV/ ANM	1411	360	
School Health				
1.	Medical Officers		584	
2.	Paramedics		255	
ARSH Training				
1.	Medical Officers	353	300	
	LHV/ ANM/ Counsellors	764 + 26	1200	

Creation of Public Health Cadre

The State has already taken the initiative of setting up of Public Health Cadre in the Department of Health & Family Welfare which will help in appropriate utilization of services of Public Health Specialists in Programme Management and Clinical Specialists in providing good clinical care to the patients.

Strengthening of Training Institutions

The State Institute of Health and Family Welfare, Aritgarh and Health & Family Welfare Training Centre, Amritsar are two important in-service training centres in the State. They have been provided with State of the art equipments for conducting trainings but need further strengthening in terms of human resources. Deployment of more technical staff at these institutions is of utmost importance for them to function to their full their potential. Apart from these, 6 ANM Training Centres and 9 GNM Training Schools also need strengthening in terms of infrastructure and human resources.

Capacity building of Medical Colleges

Medical Colleges are an important link in the delivery of health care to the community. Apart from giving tertiary care facilities they help in pre-service and in-service training of doctors and other staff. In order to involve the faculty of Medical Colleges in various National Health Programmes and take their assistance in the training of health care functionaries they need to be re-oriented towards changing scenario in the country. The faculty from the Departments of Paediatrics, Obstetrics and Gynaecology and Community Medicine would be trained as trainers at the apex institutes like AIIMS, New Delhi and PGIMER, Chandigarh.

Involving Rural Medical Officers

The workforce of Rural Medical Officers has a significant potential to contribute to RMNCH+A programs. As Stated earlier in Chapter 3, a total of 1186 subsidiary health centres were transferred to the Department of Rural Development from the Health Department. Involvement of these Rural medical Officers in the NRHM, specifically RMNCH+A, is highly desirable. This can be achieved by creating a convergence mechanism with the Rural Development Department, or preferably by bringing these

institutions back into the fold of Department of Health & Family Welfare. Since this is an interdepartmental issue, a committee may be constituted to take appropriate decision on the subject. Mainstreaming this cadre into the RMNCH+A/ NRHM activities would be a force multiplier and could prove decisive in the quest for attaining the XII Plan goals.

5.3 SUPPLY CHAIN MANAGEMENT

Maintaining adequate supplies of medicines and consumables at various levels in the health care system is a great challenge. Till recently, the procurement was done by multiple agencies for their individual requirements leading to no co-ordination in the procurement and distribution process. The process has been streamlined based upon the recommendations by a Committee of Directors of Health Services. The Punjab Health Systems Corporation has been authorised to finalise the contract rates of various items (drugs and consumables) required in health institutions.

Contract rates have been finalized for 225 essential drugs, 40 surgical/ consumable items and 19 types of suture materials. To maintain quality of medicines, they are tested at two stages – The suppliers are required to get each batch tested from a NABL accredited laboratory before dispatch, and are tested again by a Government Analyst on delivery.

The supply chain management through computerized system is being established at all levels to ensure the availability of drugs at all levels esp. Delivery Points. The system for online inventory management is being developed on the lines of TNMSC and RMSCL. Regional warehouses have been planned to be established in the State. The State has signed a MoU with C-DAC, Noida for the development of web based inventory management.

5.4 QUALITY OF CARE

The provision of quality services requires an efficient organization of work and a high level of motivation and commitment besides the addition of equipment and human resources. Maintaining the quality of services esp. Maternal and Child Health Services is one of the major commitments of the State. The quality assurance committees already established at various levels i.e. State, District, Block and Facility need to be reactivated and strengthened. The forum of these committees would be utilized to improve the quality of health services at all levels. USAID as the nodal development partner would be engaged in this effort.

NB: Action Matrix on this chapter follows after Chapter 12

CHAPTER 6: PROGRAMME MANAGEMENT

SUPERVISION, MONITORING AND EVALUATION

Achievement of targets mentioned in this Action Plan would not be possible without efficient managerial systems.

6.1 SUPPORTIVE SUPERVISION

The health manpower at the peripheral level is performing a great job but their efforts need to be continuously supported by the technical expertise of the senior and experienced professionals. Supportive supervision has been identified both nationally and internationally as a tool for optimal functioning of a health system. It helps ensuring the supervisory cadre to remain in regular contact with the health providers with a motive to identify gaps in service delivery and suggesting corrective measures during supportive supervision. Supportive supervision is an established method that prevents attrition of knowledge and skills of workers after trainings. It provides opportunity to derive local solutions to the problems within the frame of set guidelines. The State will prepare an extensive supportive supervision plan with the involvement of supervisors at all levels – State to district to block and local level supervisors. The formats devised by the Government of India for this purpose would be utilized for supervision and improvement in the health care activities at the grass root level. The plan would specifically include roles and responsibilities of supervisors, frequency of activities, sub plan to manage the information for action and essential resources including transportation, checklists, manuals etc. Equal emphasis would be given to all the life stages.

The State will strengthen the monitoring and supervision system to assure the quality of service delivery. Field visits of supervisory cadre will be made mandatory and will be used for orientation of ANMs and onsite correction of wrong practices. This system will bring about a better exposure of facility level staff to the field and help them plan in a better way.

A group will review the supportive supervision procedures and prepare a revamped plan for supportive supervision with specified roles and responsibilities and accountability for

each supervisor/ official. Emphasis would be on field visits. Deputy Commissioners will be held accountable for the overall performance of the RMNCH+A activities and timelines.

ICT and mobile phones will be used extensively for this purpose.

Mobility of the State and district level program managers must be facilitated with vehicles or outsourced transportation without which effective supervision is not possible.

6.2 HEALTH MANAGEMENT INFORMATION SYSTEM

The success of any public health programme depends upon maintaining records and monitoring and evaluation. The present scenario of record keeping is not very encouraging. Records are poorly maintained and the staff is ill trained to analyse the reports. The medical and paramedical staff needs to be reoriented for proper record keeping and data analysis.

The use of Health Management Information System (HMIS) for relevant, accurate, comprehensive and timely data for improving operational planning, monitoring and evidence-based policy formulation is very important. Presently, the data is being collected through three different agencies:

- i. HMIS – The data on primary healthcare is being generated through HMIS and collated at the State through NRHM.
- ii. Punjab Health Systems Corporation – The Corporation has its own HMIS and it collects data pertaining mainly to secondary healthcare services.
- iii. Directorate of Health & Family Welfare – Data related to various health programmes also flows manually from the field to the individual State programme divisions.

As a result of the multiplicity of the HMIS systems, there is a mismatching in the data at the State level and the reliability of data suffers. Often the concerned persons do not share data with stakeholders of other streams.

- The State has undertaken a major initiative to channelize the data in such a manner that the duplication of data is prevented and all data from the field flows into single HMIS system which can be accessed by all concerned. The process would be ready for piloting by December 2013 and full scale launch by March 2014.
- The quality of data generated through HMIS would be improved and it would be used for improving quality of health services in the State. The data would be reviewed at all levels – block, district and State for appropriate actions.
- The system for streamlining of data collection and analysis is not likely to be effective in the absence of adequate hardware and human resources. Updating of the computers, software and data generation systems would be given priority. The gaps in human resources would be plugged in order to ensure availability of accurate data at all levels of analysis.

- The State will continue to track all indicators required under the RMNCH+A strategy.

Survey based Score Card and HMIS based Dashboard

An integrated monitoring and reviewing system has been proposed to measure the progress against RMNCH+A interventions at National, State and District level through “score card”. The score card refers to two distinct but related management tools: (1) HMIS based dashboard monitoring system and (2) Survey based child survival score card. The dashboard seeks to improve accountability in the public health system and catalyze States into using the HMIS data for improved decision-making; a comparative assessment of State and district performance in terms of service delivery is proposed on a quarterly/yearly basis. Unlike the HMIS-based dashboard, the survey-based score card is developed to capture both public and private sector data and provides a basis for assessment of performance at national and State levels in terms of both outcomes and service delivery; this would be updated as and when new survey results are available. Detailed methodology and list of both indicators are provided in Annexure for further reference.

Annual Health Survey

The Government will explore initiating Annual Health Surveys in the State.

NB: Action Matrix on this chapter follows after Chapter 12.

CHAPTER 7: COMMUNITY PARTICIPATION

The community-based monitoring of health services is the key strategy to ensure that services reach those for whom they are meant. Community monitoring is also seen as an important aspect of promoting community led action in the field of health. The community participation needs to be improved through advocacy and capacity building in order to create a conducive environment for utilization of available health services and enhancing quality of services locally.

Training of ASHAs, development of Self Help Groups at local level, involvement of PRIs in planning and implementation of National Health Programmes specifically for the maternal and child health care would be taken up in the coming days. Capacity building of Village Health Sanitation and Nutrition Committees, Rogi Kalyan Samitis and appropriate utilization of Village Health and Nutrition Days (VHNDs) as a platform for assured and predictable package of outreach services would be the major activities for improving maternal and child health.

These activities would ensure:

1. Registration of all (100%) pregnancies during first trimester, appropriate ANC and infant and young child feeding counseling.
2. Testing and treatment for anaemia in pregnant women.
3. Post natal care to mothers including contraceptive advice.
4. Facilitate access to contraceptive devices.
5. Growth monitoring and achievement of 100% full immunisation.
6. Follow up care for malnourished children.
7. Care of the children suffering from diarrhoea with ORS and Zinc and ensure availability of ORS and Zinc at the grass root level.
8. Referral support to ASHA and AWW in community level care, for sick children.
9. Sessions and services for adolescent girls as well as boys.

This would provide platform to the PRIs for participating in improving health of their communities.

CHAPTER 8: BEHAVIOUR CHANGE COMMUNICATION

The improvement in maternal and child health is largely dependent upon the behavior of the community. Change in the health care practices of a community can be achieved by communication with them through various media. Interpersonal communication through local level health functionaries like ASHA, ANM, AWW; extensive use of print and electronic media and involvement of local influencers would be used to reach the community for adoption of good maternal and child health care practices.

A new BCC Strategy is being developed for the State with a view to better reach to the community in order to have maximum impact of the maternal and child health action plan.

The Mass Media Division of the Directorate of Health and Family Welfare needs to be revamped through induction of more professional human resources having greater insight into the present day communication strategies.

The Behaviour Change Communication Strategy would also include all behaviours related to RMNCH+A. In order to give appropriate messages for youth electronic social media like facebook, twitter, sms etc. would be used extensively.

NB: Action Matrix on this chapter follows after Chapter 12.

CHAPTER 9: PRIORITY ACTION FOR HIGH FOCUS DISTRICTS

As per the Government of India classification 6 districts (Gurdaspur, Pathankot, Mansa, Sangrur, Sri Muktsar Sahib and Barnala) in the State have been identified as high focus. These districts need additional inputs for almost all programmatic components. Deployment of additional human resources including Doctors (both specialist and non-specialists), Staff Nurses, ANMs, etc. is urgently required. Most of the health staff prefers to serve at places that have easy accessibility and where the facilities are available to maintain an appropriate lifestyle. This general preference is behind the lesser motivation to work in underserved and difficult areas. In order to provide a stimulus to the workforce and attract them to such areas it is essential to provide better incentives for personnel posted at such locations. It is important to map such hard areas and do a need assessment to know the adequate incentives that would attract the staff to these places.

The important steps being undertaken in these districts include:

1. Recruitment of more doctors specifically for these districts and giving them additional incentives.
2. Deployment of an additional ANM at all subcentres.
3. Priority in the creation of SNCUs and NBSUs.
4. Creation of specialist MCH Centres on priority basis.
5. Cater to the needs of urban poor and slum dwellers through additional resources being generated under Urban Health Mission.

The plan for these districts would be prepared by March 2014.

RMNCH+A strategy is to be implemented across the country with further intensification of efforts in each of the identified High Priority Districts (HPDs) of the States through committed technical support by the Development Partners. In each HPD the States will allocate 30% higher resource envelope per capita (within the overall State Resource Envelope under NRHM). This has to be mandatorily specified and earmarked as a part of the ROP and diversion of this envelope to other districts would not be permitted. Relaxation of norms allowed in tribal areas under NRHM will further be extended to HPDs.

As the HPD districts are lagging behind in terms of RMNCH+A indicators and possibly most other development indicators, they need special focus and support in terms of planning and implementation. It is considered that maximum gains in reduction of fertility and mortality can be made by reaching out to underserved and vulnerable populations in these districts.

1. District Assessment

The first step in the HPD should be to conduct a detailed assessment of the district in terms of equity and access to health services and key social determinants of health (including nutrition, water and sanitation, connectivity, electricity and motorable roads). The remoteness of the block/ village and accessibility to basic health services, including maternal and child health services should be assessed. District Level Checklist should be used for systematic mapping of underserved districts and vulnerable social groups.

2. Assessment of local health system

Mapping of the health infrastructure (SC, PHC, CHC, DH), manpower (Medical Officers, specialists, staff nurses, ANMs, ASHAs), training facilities (ANM/ GNM training schools, district training centres), and assessing the functionality of health facilities (IPD, OPD, minor & major surgeries, delivery points, FRUs conducting C section, 24x 7 PHCs, newborn care facilities) should be undertaken as the first step.

3. Differential Health Systems Planning for HPD

(i) Financial allocations: The State will allocate 30% higher resource envelope per capita for each HPD (within the overall State Resource Envelope under NRHM). This should be specified and earmarked as a part of the ROP and diversion of this envelope to other districts would not be permitted.

(ii) Relaxation of norms

Relaxation of norms may be extended to all high priority districts.

- **ASHA recruitment:** The general norm is 'one ASHA per 1000 population'. In HPD, the norm could be relaxed e.g. to one ASHA per habitation, in remote, inaccessible areas/ blocks.

- **Health Infrastructure as per IPHS norms:** Population norms for establishment of sub-centre could be relaxed when needed based on ‘time to care’ norm.
 - **Up gradation of Sub centers:** As Sub centre is envisaged as the first health post and will possibly be the only health infrastructure within close access, follow up on construction/ renovation, equipment and manpower is important. It is being proposed that a full-fledged village health team be located at the SC to address the basic health needs for the local population.
 - **Medical Mobile Units:** Till the time SC or PHC are established, underserved, areas may be reached through MMUs and HPDs may be allowed to have more MMUs than other districts.
- (iii) **Performance based incentives:** Special incentives to medical and para-medical staff for performing duties in difficult areas (e.g. identified health facilities; facilities remote from DHQ) may be incorporated with appropriate financial and non-financial incentives schemes for attracting qualified human resource to work in HPD with time-bound targets and performance benchmarks for addressing the key issues and optimum utilization of funds to ensure effective implementation of NRHM.
- (iv) Special strategies, incentives, packages, schemes for HPDs

4. Accrediting private health institutions

In order to increase the access to delivery care institutions, functioning private institutions that meet the criteria set out by GOI, can be accredited to provide delivery services, abortion care and newborn care. The State and district authorities should draw up a list of criteria/ protocols for such accreditation; which could be inspected by team from State Medical Colleges. These institutions could be reimbursed for the health facilities provided to local population on pre-agreed rates.

5. Improving demand for services

Community outreach: Social mobilisation is an important strategy to increase demand for health services. In addition, creating awareness on health issues in general and on social determinants of health and information about available health services will be important aspects for frontline workers and social mobilisers. The local population may not recognise

the need for health services or there may be lack of trust in service providers or even the allopathic system of medicine. Due emphasis should be given to platforms like VHND which bring both information and services to the villages.

Involving NGOs for community mobilisation, service delivery: to make the information and services more accessible to the underserved or especially vulnerable populations.

6. Multisectoral Planning

Health of the population cannot be improved in isolation; other services like transport, telephone/ mobile connectivity, water, sanitation, girls' education and nutrition services are required in the area. In addition, convergence with other departments will promote better resource utilization.

7. Monitoring:

Close monitoring of the progress and outputs should be undertaken, based on the routine from HMIS and various other evaluation studies. Facility based tracking should be the focus in districts where facility based reporting has already been initiated. District Score cards, filled in every quarter, can be another tool that can provide a snapshot of progress made in the district and also to compare changes over time. Regularity of monthly review meetings are to be ensured by CMHO/ District Collector.

District score card or HMIS based dashboard monitoring system is a mechanism to improve accountability in the public health system and catalyze States into using the HMIS data for improved decision-making; a comparative assessment of district performance in terms of service delivery "dashboard" indicators on a quarterly/ year to quarter basis. Survey based score card will be prepared to monitor the changes at outcome and impact level as and when updated data available for the districts in the State.

NB: Action Matrix on this chapter follows after Chapter 12.

CHAPTER 10: CONVERGENCE AND PARTNERSHIPS

The achievement of outcome outlined in this document are difficult to achieve if, the Department of Health and Family Welfare works in isolation. Involvement of other stakeholders in this effort is absolutely essential. Involvement of PRIs, Department of Medical Education, Department of Women and Child Development, Department of Education, Water and Sanitation Department, Department of Urban Development and Department of Rural Development is the key. In addition, involvement NGOs and Public Private Partnerships are required to augment the momentum for achieving the goals.

- It is proposed to ensure **intradepartmental convergence** through joint reviews with Department of Medical Education at quarterly intervals. There is an urgent need for a seamless convergence of the PHSC.
- The inter-sectoral convergence would be achieved through a proposed **Apex Committee on Health and Development** under the chairmanship of Chief Secretary, with Principal Secretary Health as the Member Secretary. This Apex Committee that would meet quarterly shall be the convergence point of interdepartmental endeavor on health and nutrition. Its membership would comprise secretaries of the Departments of Education, Panchayati Raj, Women and Child Development, Water and Sanitation, Rural Development, Urban Development, Planning etc. The Committee may also have independent development experts. This mechanism shall play a decisive role to address the social determinants of health in addition to enhancing convergence across development sectors for attaining high level of health and nutrition in the State.
- **Private Sector and not-for-profit NGOs** would be involved for service delivery at secondary as well as tertiary care for the mothers, neonates as well as the children. This would require a policy framework to be developed by March 2014.
- The Government expects a greater role of the **professional bodies** (National Neonatology Forum, Indian Academy of Pediatrics, FOGSI and others) to partner RMNCH+A action. In particular, their assistance is required for:

- Capacity development, training and continuing education of specialists, doctors, nurses and others
- Quality of care in facilities
- Technical guidelines
- Developing framework for public – private partnerships in service delivery
- Needs assessment and rapid surveys
- Tele-medicine
- Voluntary service delivery to underserved populations/ pockets/ settlements

NB: Action Matrix on this chapter follows after Chapter 12.

CHAPTER 11: OPERATIONS RESEARCH

For a health program to succeed and to pave way for even more ambitious and visionary program new knowledge and insights are a must.

The State will invest in operations research for which a budget would be earmarked. A mechanism, say a Research Committee, will be created. The focus would be operations and implementation research to enrich the program delivery and to enhance equity.

Not only studies will be commissioned, but also academics/ institutions would be encouraged to seek funds for studies.

Steps will also be taken to build capacity for such research with help from PGIMER, AIIMS, PHFI and ICMR.

NB: Action Matrix on this chapter follows after Chapter 12.

CHAPTER 12: TECHNICAL STEWARDSHIP FOR MCH ACTION PLAN

The success of the MCH Action plan is critically dependent upon technical stewardship at all levels – State, district and block. This would require not only short term strengthening of the MCH Cell, but also reorganization/ revamping of the Directorate for long term impact and sustained gains with the aim of having health services in the State that match those in developed countries in near future. The suggestions that follow in this chapter may be seriously examined by the Government.

- **Strengthen linkages between the Department of Health and FW and the State Program Management Unit (SPMU)**

The purpose of the SPMU is to be a catalyst to ensure that each intervention under NRHM/ RMNCH+A reaches every women, neonate, child and adolescent. That would materialize only through a close working relationship between the SPMU and the technical divisions. One way to do so is by making SPMU report to the MD-NRHM through the Director, Health and Family Welfare. This would add a strategic impetus to the Directorate resulting in more effective technical stewardship.

- **Strengthen technical and supervisory capacity of the Directorate of Health and Family Welfare**

To translate this Action Plan into implementation, outcome and impact require considerable technical and managerial strengthening of the Directorate. Improved survival and health outcomes for women, neonates, children and adolescents of the State necessitates a competently – manned, well-knit and well supported team at the State level. There are simply too few technical people at present to drive an ambitious RMNCH+A program in the State. *The organogram in the Annex is suggested for consideration of the Government to develop a critical capacity to ensure sustained progress over the medium/ long term.*

The ecosystem at the Directorate should be challenging, conducive and satisfying for bright persons to move from the districts to the headquarters. Currently, it is more exciting to be in the field. *The technical staff at the State directorate should be provided optimum office equipment, support staff and mobility support for effective stewardship and monitoring.*

In the immediate, there is an urgent need to strengthen the MCH Cell at the State headquarters. *Induction of at least 2 Public Health Specialists (Maternal Health and Child Health) to assist the Programme Officer (MCH) would help in achieving better co-ordination the State level. Apart from this there is need for at least 4 consultants and 6 computer assistant – cum – data managers.*

- **Strengthen technical and supervisory capacity at the District level**

The districts are the nerve centre of RMNCH+A action, and there are simply innumerable tasks to be done. There is a need to discuss the needs for strengthening the technical capacity district level through a consultation. Provisionally, there is need for at least 1 public health specialist, 1-2 consultants (depending upon the size of district) and 2 computer assistant – cum – data managers at each district headquarter.

- **Strengthen synergy between the Departments of Medical Education and Department of Health & Family Welfare**

Transformation of healthcare in the State is also dependent on strategic and functional linkages between the Medical Colleges, the Directorate of Health & Family Welfare and the State NRHM. Medical College hospitals are a part of the continuum of care that is grounded in community where ASHAs and ANMs toil. Medical Colleges need to emerge as role model institutions in quality of care. Medical Colleges should be developed as centers of excellence for tertiary care as well as centres for providing trained human resource for healthcare delivery. Strengthening of State Medical Colleges in terms of infrastructure as well as human resources needs to be taken up on priority. The State has already started the process with huge budgetary allocations for the Medical Colleges and recruitment of faculty. This process should be taken forward by systematically planning their up-gradation. It is suggested that a committee be constituted to propose a rapid action

to strengthen their facilities and capacity for education, mentoring and research in the area of RMNCH+A.

It is also recommended that both the departments should be under the same administrative head for greater synergy and effectiveness.

NB: Action Matrix on this chapter follows in the next section.

ACTION MATRICES

- **Health System Strengthening**
- **Programme Management**
- **BCC**
- **Community Participation**
- **High Priority District Planning**
- **Convergence and Partnerships**
- **Operations research**
- **Technical Stewardship**

Strategic Output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
HEALTH SYSTEMS STRENGTHENING						
	Achieving IPHS Standards at 100 public health facilities by 2016	Rapid assessment of gaps in IPHS standards by January				This will be the flagship program under this initiative that would benefit all other facets of health care in addition to RMNCH+A
	District Hospitals	Achieve IPHS standards at 22 District Hospitals	Maintain IPHS standards			
	Sub-district Hospitals	Achieve IPHS standards at 15 Sub- District Hospitals	Achieve IPHS standards at 15 additional Sub-District Hospitals (Total 30)	Achieve IPHS standards at 11 additional Sub- District Hospitals (Total 41)	Maintain IPHS standards	
	Community Health Centres (Geographically appropriate)	Achieve IPHS standards at 10 CHCs	Achieve IPHS standards at 14 additional CHCs (Total 24)	Achieve IPHS standards at 13 additional CHCs (Total 37)	Maintain IPHS standards	
	Up-gradation of Medical Colleges for RMNCH+A: Infrastructure, HR; includes in service training of faculty/	Develop action plan by March 2014	Completed			

	nurses, and establishment of sub specialties					
	Telemedicine and ICT driven Distance Education System	Develop plans by March 2014; MoU with PGIMER by July 2014; Implementation thereafter	Implementation			
	Establish and operationalize blood banks at all district hospitals and blood storage units at all FRUs (40 blood banks and 28 BSUs already functional).	Operationalized				
	Establish and operationalise Mother and Child Hospitals (15 have been proposed)	Established				
	Strengthening of 24*7 PHCs	Completed by September				
	Strengthening of State MCH Cell	Completed by March				
	More efficient supply chain management guidelines	Launch a new ICT driven supply chain system				
	Development of quality assurance guidelines	By July				
	Operationalize quality assurance committees	By December				
	Review the achievements of QA committees for corrective action	By November				
	Quality certification: Develop an accreditation system for evaluating the health facilities as per their respective levels of care	By October	Implement starting January			

	Streamline RKS system	Review performance of RKSs by April by in depth study Streamline working of RKSs	Streamline working of RKSs			
Human Resources						
	Deployment and retention of motivated health work force	Announce new liberal provisions to dramatically improving deployment and retention of doctors and nurses <ul style="list-style-type: none"> ▪ Monetary and non-monetary incentives to work in underserved areas. ▪ Redeployment of retired doctors on contract. ▪ Performance-based compensation for better outcomes (such as survival of LBW neonates in SNCUs, high coverage of ORS etc.). ▪ Regularization of contract doctors without change in posting. ▪ Strategic placement of the specialists to make facilities operational ▪ Other measures 				
	Strengthening of Training Institutions at Ajitgarh and Amritsar	Develop plans by April Start strengthening by June	Implement plan completed by March			

	Rational transfer policy for doctors, nurses and other staff of the department	Discussions to streamline transfer policy Revise policy by April Declare a revised transfer policy with long term vision to ensure a strong health system				
	Involving RMOs in NRHM/ RMNCH+A programs	Constituting a committee to examine the issue; report by March Implementation from April				
	Creation of Public Health Cadre	Created by mid-year				

Strategic Output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
Program Management						
	Supportive Supervision	Review supportive supervision system through consultations. Develop a revamped Supervisory system that lists roles and responsibilities of all concerned. Launch revamped system from April 2014		Review supportive supervision Launch further improvements		Supportive Supervision was recognized as one of the weakest areas
	Health Management Information System	Data entry into HMIS system to be made mandatory and functional				
		New, ICT based revamped data flow system accessible to all concerned				
		Revamping the hardware for HMIS				
		Meting HR needs to ensure functional HMIS				
		Guidance note about utilization of information from HMIS for planning and action by February 2014				

		Dash Board indicators on RMNCH+A available and system operationalized by March 2014				
	Death reviews	Preparation and dissemination of maternal and infant death review guidelines (emphasis on corrective instead of punitive approach)				
		Training and supportive supervision of human resources to conduct death reviews				
		Guidance note about utilization of information from death reviews for planning, prioritization and action by March				
	Annual Health Survey	Explore initiation of AHS in Punjab				
	Gender-based monitoring	Create a template for incorporating gender into monitoring indicators on care-seeking, mortality and coverage indicators by April Implement				
	Accountability	Define roles and responsibilities for all concerned including Deputy Commissioners				
		Map the accountable persons as per their names and designation against each thematic area/program domain/activity				

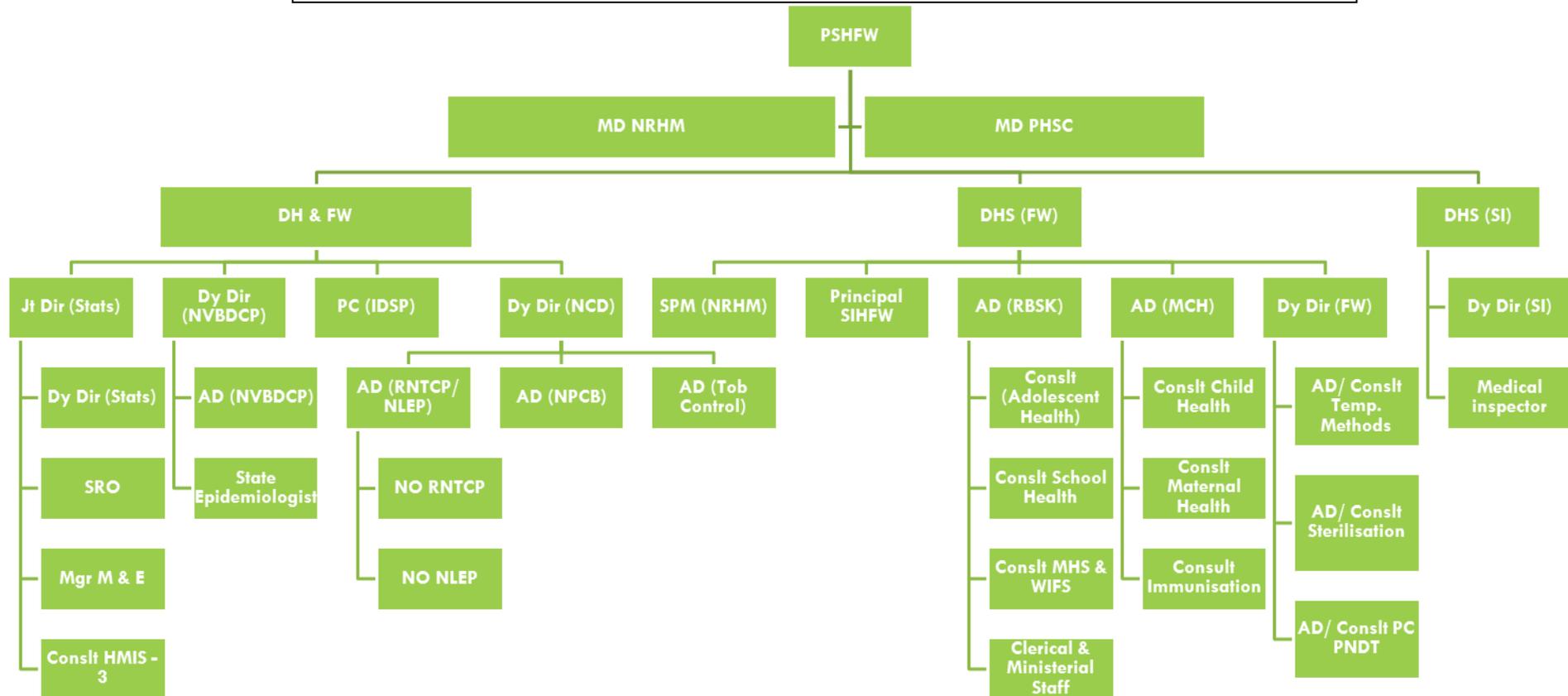
Strategic Output	Actions	Time frame				Remarks
		2014	2015	2016	2017	
BCC / IEC						
	BCC Strategy	Finalization of a comprehensive BCC strategy by January	Implementation	Review progress	Implementation	
Community Participation						
	VHNDs	Evaluate performance of VHNDs by May Revamp activities of VHNDs and provide stronger oversight thereof	Implementation	Review progress	Implementation	
	Involve women's groups, Rotary, Lions' Club, Red Cross, charitable institutions, NGOs in RMNCH + A program	Hold Consultations. Develop a Plan. Implement by May	Implementation	Review progress	Implementation	
High Focus District Plans						
	High Focus District Strategy	District Assessment by USAID Strategy in place by March 2014 Implementation from April 2014	Implementation	Review progress		

Convergence and Partnerships				
	Intradepartmental Convergence	Quarterly meetings		
	Intersectoral Convergence	Constitution of Apex Committee on Health and Development by February	Quarterly meetings/ reviews	
	Private Sector/ NGOs	Create a policy framework for PPP; Implement	Implementation	
	Professional bodies (NNF, IAP, and FOGSI etc.)	Action Plan by May 2014; Implementation thereafter	Implementation	
Operations research				
	Promote implementation/ operations research	Announce a plan to support such research Create a budget Create mechanism to manage/ support research	Also, seek requests for research by individual scientists Commission studies Build capacity for research in collaboration with PGIMER, PHFI, AIIMS and ICMR	

Strategic Output	Actions	Time frame				Remark
		2014	2015	2016	2017	
Stewardship/ Administration						
	Strengthen linkages between the Department and the State Program Management Unit (SPMU)	Constitute a high level committee to examine this issue Report of the Committee by April 2014 Policy decisions by June 2014				
	Immediate strengthening of technical capacity at all levels for effective implementation of RMNCH+A programs with appointment of consultants and data entry persons	Immediate strengthening of technical capacity at State and District levels by February				
	Strengthen technical and supervisory capacity of the Directorate of Health and Family Welfare	Examine issues about office/ mobility/ support systems by February Implement required steps from April				
	Strengthen technical and supervisory capacity at the District level	Hold consultations with district program managers Strengthen implementation capacity				
	Strengthen synergy between the Departments of Medical Education and Department of Health/ FW	Develop action plan for strengthening the role of Medical Colleges for RMNCH+A activities Create a Medical College network to mentor RMNCH+A action				

ANNEX

A suggested reorganized organogram to strengthen the technical capacity and program coordination at the State level for consideration



Annexure:

HMIS based Dashboard monitoring system

The need for relevant, accurate and timely data to facilitate improved operational planning and monitoring and evidence based policy formulation is well recognized. In 2008, MoHFW, GoI initiated a web based Health Management Information System (HMIS). At present, all 35 States and UTs (656 districts) upload health related data on a range of outputs and service delivery indicators; by March 2013, facility level data would also be available.

Methodology

1 Objective:

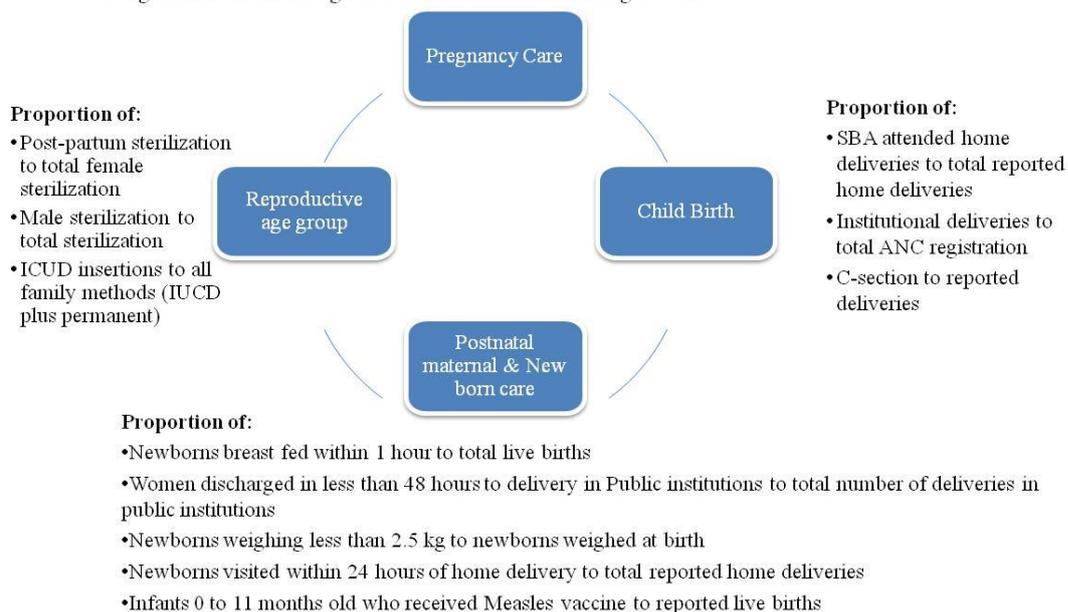
- Review the progress and performance of services/ interventions at State level

1.1 Selection of Indicators:

A total of 16 indicators have been selected based on life cycle approach i.e. Reproductive and pre-pregnancy, Pregnancy, Child birth, Post natal care (Mother and Child), representing its various phases. Selection of the indicators is based on likelihood of accurate data and its amenability to improved decision making. Indicators are listed below for reference.

Proportion of:

- 1st Trimester registration to total ANC registration
- Pregnant women received 3 ANC to total ANC registration
- Pregnant women given 100 IFA to total ANC registration
- Cases of pregnant women with Obstetric Complications and attended to reported deliveries
- Pregnant women receiving TT2 or Booster to total ANC registration



2 Way of preparation:

The methodology described below can be used for preparing All India/ State or State/ District score card.

2.1. Let X_{Bi}B represent the value of the i-th indicator in the d-th district of a State (i =1,2,3.....16: d=1,2,3....., n) (n being the number of districts in a State). For each of the indicators, a normalized index value is worked out. If an indicator X_{Bi}B is positively associated with development, like safe deliveries, then

$$\text{Index Value } X_{id} = \frac{(X_{id} - \text{Min}(X_{id}))}{(\text{Max}(X_{id}) - \text{Min}(X_{id}))}$$

Where Min (X_{Bi}B) and Max (X_{Bi}B) are, respectively, the minimum and maximum of (X_{Bi}1B, X_{Bi}2,B X_{Bi},nB) that particular indicator across districts.

If, however, X_{Bi} B is negatively associated with development, as, for example, ‘women discharged in less than 48 hours to delivery in Public institutions to total number of deliveries in public institutions’ or ‘newborns weighing less than 2.5 kg to newborns

weighed at birth', etc. which should decline as the district develops, then the index value for X_{id} can be derived as:

$$\text{Index Value } X_{id} = \frac{\text{Max}(X_{id}) - X_{id}}{(\text{Max}(X_{id}) - \text{Min}(X_{id}))}$$

The index values of each of the 16 indicators for a district are then combined by using simple average to arrive at composite index value for each district as follows:

$$\text{Composite Index for } d^{\text{th}} \text{ (d=1,2,\dots,n) District} = \frac{\sum_{i=1}^{16} IX_{id}}{16}$$

The composite indices for each of the four phases (Pregnancy care, Child Birth, Postnatal maternal & new born care, Reproductive age group) are also obtained by simple average of the index values of individual indicator falling in respective phases.

2.2. The composite index may be taken as an index of overall progress of that district on the above mentioned parameters. Based on the quartile values of index for each of the four Phases / overall Index, the States / districts have been categorized into four categories, i.e., very low performing, low performing, promising and good performing.

Survey based Score Card

The survey-based score card is developed to capture both public and private sector data and provides a basis for assessment of performance at national, State and district levels in terms of both outcomes and service delivery.

Methodology

1. Objective:

- To monitor the utilization of services and measure the outcomes at national, State and district level periodically, once in every 1 or 2 years.
- To measure the performance against MDG at National level and States

1.1 Selection of Indicators:

A total of 19 survey based outcome and coverage indicators related to health, nutrition and sanitation were used for the score card.

Indicators for survey based score card	
Mortality	Neonatal mortality rate - SRS 2010
	Infant mortality rate - SRS 2011
	Under-five mortality rate - SRS 2010
	Maternal mortality ratio (per 100,000 live births) - SRS 2007-09
Fertility	Total Fertility Rate - SRS 2010
	Births to women during age 15-19 out of total births - DLHS 3
Nutrition	Children with birth weight less than 2.5 Kg – AHS
	Children under 3 years who are underweight - NFHS3 2005-06
Gender	Child sex ratio 0-6 - Census 2011
Cross-cutting	Full Immunization (Children (12-23 months) receiving 1 dose BCG, 3 doses of DPT/ OPV each and 1 measles vaccine - CES-2009
	Household having access to toilet facility DLHS 3
	Couple using spacing method for more than 6 months DLHS3
Diarrhoea	ORT or Increased Fluids for Diarrhea (Among children <2 year of age who had diarrhea in preceding 2 weeks) - CES 2009
Pneumonia	Care Seeking for ARI in any health Facility (Among children <2 year of age who had ARI in preceding 2 weeks) - CES 2009
Service Delivery	Woman who received 4+ ANC - CES 2009
	Skilled Birth Attendance (Delivery by Doctor, ANM/Nurse/LHV) - CES 2009
	Mothers who received postnatal care from a doctor/nurse/LHV/ANM/other health personnel within 2 days of delivery for their last birth (%) - NFHS3 2005-06
	Early Initiation of Breast Feeding (<1hr) - CES 2009
	Exclusive Breast feeding for 6 months (among 6-9 months children) - CES-2009

Source of data: Latest available data will be taken into consideration from Sample Registration System (SRS), Coverage Evaluation Survey (CES), District Level Household and Facility Survey (DLHS), National Family Health Survey (NFHS), Census and Annual Health Survey.

Ways of preparation

- All India average for each indicator will be taken as reference point in case of India vs. States. States will be colour coded based on:
 - Mortality Indicators, Nutrition, Fertility: Green - Less than 20% of the National average, Yellow - 20% below and above National average, Red - More than 20% of the National average
 - Remaining Indicators: Green - More than 20% of the National average, Yellow - 20% below and above National average, Red - Less than 20% of the National average

Similarly, State average will be taken as reference point to develop State vs. district score card in case district and State level data available for indicators. It is advised that only one source of data to be used for one indicator for India vs. State & to be Dashboard and score card analysis of all the States will be analyzed and shared with respective States for further follow up with RMNCH+A implementation.

Maternal Death Review

The process of maternal death review has been initiated in the State and would be strengthened further to identify gaps in service delivery and take appropriate measures. The analysis of maternal deaths would be used to help identify delays contributing to maternal deaths at various levels and the information used to adopt measures to prioritise and plan for intervention strategies and reconfigure health services.

Infant and Child Death Review

Infant death review has already been initiated in the State. The review of infant deaths would also be utilized for policy formulation to reduce infant death rate in future. The child death review would be initiated soon and used similarly.