



NATIONAL RURAL HEALTH MISSION

Meeting people's health needs in rural areas

Programme Implementation Plan 2006-2012

**State Health Mission
Department of Health & Family Welfare
Government of Madhya Pradesh
Bhopal**

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i. TIME LINE FOR NRHM MILESTONES

S. No.	Milestone	Phasing and time line	Means of Verification
1	Selection of Accredited Social Health Activist (ASHA) for every 1000 population/large isolated habitations in all 48 districts- 43913 ASHAs in the State.	40% by 2006 i.e. 17565 ASHA 70% by 2007 i.e. 30742 100% by 2008 i.e. 43913	Quarterly Progress Report
2	Fully trained ASHA workers	40% by 2007 i.e. 17565 80% by 2008 i.e. 35130 100% by 2009 i.e. 43913	Quarterly Progress Report and sample verification
3	<ul style="list-style-type: none"> ➤ Village Health and Sanitation Committee constituted in all 52143 inhabited villages ➤ Untied grants provided to them ➤ Village Health & Sanitation Plans prepared for local health action. 	3% by 2007 i.e. 1565 25% by 2008 i.e. 11470 50% by 2010 i.e. 13036 100% by 2012	Quarterly Progress Report
4	<ul style="list-style-type: none"> ➤ 2 ANM Sub Health Centres strengthened to provide service guarantees as per IPHS, in 8835 places upto year 3, 2 ANMs in 10493 SHCs from year 4 onwards. ➤ Untied grants provided to each Sub Centre for promoting local health action. 	7% by 2007 25% by 2008 47% by 2009 69% by 2010 100% by 2012 100% each year	State reports, District Action Plans. Facility Surveys and External assessments State Reports
5	<ul style="list-style-type: none"> ➤ 500 BEmONC facilities (including 8 Civil Hospitals, 178 CHCs and 314 PHCs) strengthened with 3 Staff Nurses to provide service 	40% by 2006 i.e. 200 BEmONCs 50% by 2007 i.e. 250 BEmONCs	Annual Facility Surveys. External assessments

S. No.	Milestone	Phasing and time line	Means of Verification
	<p>guarantees as per IPHS.</p> <p>➤ Untied grants provided to each BEmONC facility for promoting local health action.</p>	<p>60% by 2008 i.e. 300 BEmONCs</p> <p>80% by 2009 i.e. 400 BEmONCs</p> <p>100% by 2010 i.e. 500 BEmONCs</p>	
6	<p>Untied grants provided to 1152 PHCs and 266 CHCs for promoting local health action.</p>	<p>Annual activity</p>	<p>State report</p>
7	<p>➤ 124 CEmONC institutions (32 CHs and 92 CHCs) strengthened with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS.</p>	<p>40% by 2006 i.e. 50 CEmONCs</p> <p>55% by 2007 i.e. 68 CEmONCs</p> <p>75% by 2008 i.e. 93 CEmONCs</p> <p>100% by 2009 i.e. 124 CEmONCs</p>	<p>Annual Facility Surveys.</p> <p>External assessments.</p>
8	<p>48 District Hospitals strengthened to provide quality health services.</p>	<p>30% by 2007 i.e. 15 DH</p> <p>60% by 2009 i.e. 30 DH</p> <p>100% by 2010 i.e. 48 DH</p>	<p>Facility Surveys.</p> <p>External assessments.</p>
9	<p>➤ Rogi Kalyan Samitis established in all PHCs, CHCs/Civil Hospitals/District Hospitals.</p> <p>➤ One time support to RKSs at PHCs/CHCs/Civil Hospitals/District Hospitals.</p>	<p>100% District Hospitals, Civil Hospitals and CHCs; 50% of PHCs by 2006, 100% PHCs by 2007</p>	<p>State report.</p>
11	<p>➤ District Health Action Plans 2005-2012 prepared by each of the 48</p>	<p>100% by 2007</p>	<p>Appraisal process with participation</p>

S. No.	Milestone	Phasing and time line	Means of Verification
	<p>districts.</p> <p>➤ District Health Plans reflect the convergence with wider determinants of health like drinking water, sanitation, women's empowerment, child development, adolescents, school education, female literacy, etc.</p>	100% by 2007	of DPs and Gol representatives
12	Annual maintenance grant provided to every Sub Centre, PHC and CHCs.	100% by 2007	State reports
13	State and District Health Societies established and fully functional.	100% by 2007	Regular meetings and sample verification
14	State and district PMUs staff receives training.	100% by 2007	State reports
15	Sample districts able to implement M&E triangulation involving community.	None by 2006 10% by 2007 25% by 2008 50% by 2009 100% by 2010	Independent assessment
16	Procurement and logistics streamlined to ensure availability of 100% availability of at least one month's stock of essential drugs and medicines at Sub Centres/PHCs/CHs/CHCs.	100% by 2007	State reports
17	SHCs/PHCs/CHCs/Civil Hospitals/ District Hospitals fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB, HIV/AIDS, etc.	30% by 2007 60% by 2008 100% by 2009	State reports
18	Districts constitute Quality Assurance	100% by 2007	State reports

S. No.	Milestone	Phasing and time line	Means of Verification
	Committees.		
19	Facility and household surveys carried out in each and every district of the State.	20% by 2007 100% by 2008	Survey reports
20	Annual State and District specific Public Reports on Health published.	30% by 2008 60% by 2009 100% by 2010	Independent assessment.
21	Institution-wise assessment of performance against assured service guarantees carried out.	50% by 2008 70% by 2009 100% by 2010	Independent assessment
22	Mobile Medical Units provided to each district of the State.	30% by 2007 60% by 2008 100% by 2009	Quarterly Progress Report

Note : 'Year' refers to financial year ending 31st March.

1. BACKGROUND

1.1 Demographic and Socio-economic Features

Madhya Pradesh, as its name implies, is located at the geographic centre of India. It shares its border with five states, namely, Maharashtra, Gujarat, Rajasthan, Uttar Pradesh, Chhattisgarh, Covering an area of 308,000 square kilometers with the population of 60.4 million, it has a large proportion of scheduled castes and tribes (15.4% and 19.9% respectively) with 73% of the population living in rural areas. Despite significant progress in socio-economic development over the last decade, the State continues to be afflicted with some of the worst indicators in India. These include low literacy rates, especially female literacy, high levels of morbidity and mortality and 37% of the population lying below the poverty line. 89% of the population in rural areas is dependent on agriculture. The State is typically characterized by difficult terrain, high rainfall variability, uneven and limited irrigation, deforestation and land degradation.

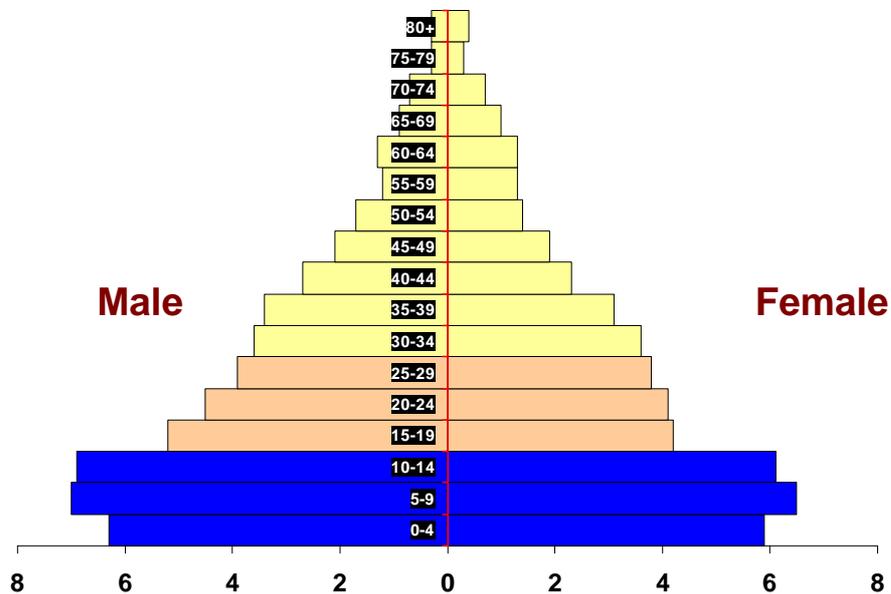
SOCIO-DEMOGRAPHIC PROFILE

INDICATORS	M.P.	India
Area (In sq. km)	3,08,245 (9.38% of India's total area)	32,87,263
Population (Census 2001)	6,03,85,118 (5.88% of India's population)	1,027,015,247
Population growth rate (1991-2001)	24.34	21.34
Population density	196	324
Literacy Rate	64.11	65.38
• Male Literacy	76.80	75.85
• Female Literacy	50.28	54.16
Sex ratio (Females per 1000 Males)	920	933
Urban population	26.67%	27.78%
Scheduled Castes	74, 78,000 (15.4%)	16, 65, 76,000 (16.20%)
Scheduled Tribes	96, 82,000 (19.94%)	8,31,88,235 (8.10%)
Maternal Mortality Rate (SRS 1998)	498	407
Infant mortality rate (SRS 2004)	79/1000	64/1000 (SRS 2004)
Total Fertility Rate (NFHS-II)	3.3	2.9

1.2 Age Distribution

The age distribution of the population in Madhya Pradesh is typical of populations in which fertility has fallen recently, with relatively low proportions of the population in the younger and older age groups. 39 percent are below 15 years of age, and 5 percent are aged 65 or older. The proportion below age 15 is higher in rural areas (40 percent) than in urban areas (35 percent), primarily because fertility is higher in rural areas.

Age & Sex composition of Population – 2001 Madhya Pradesh



1.3 Density of Population

Population density per square kilometer has increased from 158 in 1991 to 196 in 2001. Although the population density in Madhya Pradesh remains low relative to most other large states, the rising density indicates an increasing pressure on land and other resources.

1.4 Literacy Rate

According to the 2001 Census, literacy rate for Madhya Pradesh was 64.08 percent compared with 65.38 percent for India as a whole. The literacy rate for males was 76.50 percent and only 50.55 percent for females in Madhya Pradesh. Compared with the literacy rate of 1991 (44.67), there has been a considerable improvement in the last

ten years. There has been a greater improvement in the female literacy rate as compared to the male literacy rate. Education levels are much higher in urban areas than in rural areas. The proportion of illiterates is almost twice as high for rural females (63 percent) as for urban females (33 percent), and nearly thrice as high for rural males (34 percent) as for urban males (13 percent). Even in urban areas, however, only about half of the males (47 percent) and slightly more than one-quarter of the females (28 percent) of age 20 and above have completed at least high school. Illiteracy was virtually the same for women in the age-groups 35-39 to 45-49 before decreasing to 64 percent for women in age-group 20-24 and then rising slightly to 66 percent for women in age-group 15-19, undoubtedly because illiterate women are more likely to get married than the literate women at a young age.

1.5 Below Poverty Line Population

According to the Third Madhya Pradesh Human Development Report (2002), population Below Poverty Line (BPL) in 1999-2000 has been estimated at 37.43% (37.06% for rural and 38.44% for urban). This figure is higher than the national average of 26.10%. The Per Capita Income (calculated at constant prices, 1993-1994) for Madhya Pradesh was Rs.7876/- in 1999-2000, being much lower than the National figure of Rs.9739/- (Source: Dept. of Finance, GoMP). BPL population of 37% means that about 22.60 million people are classified as poor. Regionally, there is less poverty in the Gwalior region, western Bundelkhand and around Bhopal followed by moderate levels in the Malwa region and extreme poverty in the eastern and Bundelkhand areas.

1.6 Administrative Profile of the State of Madhya Pradesh

Indicator/Parameter	Nos.
Development Blocks	313
Tribal Blocks	89
No. of Towns/cities	394
No. of Municipal Corporations	14
No. of Municipalities	85
No. of Nagar Panchayats	235
No. of villages	55392
No. of inhabited villages	52143
No. Gram Panchayats	22,029
No. of Janpad Panchayats	313
No. of district Panchayats	48

2. SITUATIONAL ANALYSIS

In this chapter, situation of health and its determinants has been reviewed with reference to NFHS, RHS and such other reports. While the NFHS-2 provided state-level estimates, the RHS estimates are available at the district level. Data from these sources have been compiled by select background characteristics such as residence, caste and standard of living (SLI), in addition to analyzing the results from a qualitative study of RCH programme that was carried in the three regions of the state. All these results have been put together and presented in the following sections.

The current levels of major indicators are summarized in the following table:-

Sr.No	Indicator	Current Status
Maternal Health		
1	Percentage of pregnant women registering in first trimester	26
2	Percentage of pregnant women receiving full ANC care	51.2
3	Percentage of deliveries attended by Skilled Birth Attended	30.0
4	Percentage of Home Deliveries	79.0
5	Percentage of Institutional Deliveries	21.0
Child Health		
6	Percent of children who were exclusively breastfed for four months	36.5
7	Percent of Children (12-23 months) fully immunized	22
8	Percent of Children suffered from Diarrhea	23.4
9	Percent of Children suffered from ARI	29.2
Family Planning		
10	Met need for FP method among eligible couples	44.3
11	Unmet need for Spacing method	8.9
12	Unmet need for Limiting method	7.3
13	Contraceptive prevalence rate	42.0
14	Total demand for FP services	60.5

MATERNAL HEALTH

Antenatal Care

It can be seen from the following Table that while 6 out of ten women availed antenatal check-up, more than half received two or more tetanus toxoid injections and 8 out of 10 women have received IFA tablets or syrup during pregnancy for three or more months.

Only one third of the pregnant women received more than 3 ANC check ups. The service utilization is better in urban area as compared to rural area.

Percentage of women receiving various types of ANC care

Indicator	Urban	Rural	Total
Women receiving any ANC check up	82.1	55.8	61.5
Women without any ANC check up	17.9	44.2	38.5
Women receiving 3 ANC check ups	51.2	21.8	28.1
Women receiving 2 or more doses of TT	73.7	49.8	55.0
Women receiving more than 100 IFA tablets	76.2	79.3	78.4

Delivery Care: Place and Assistance during Delivery

It indicates that eight out of 10 deliveries in Madhya Pradesh state are taking place at home and the remaining two deliveries either in public or private institutions. In urban areas half of the deliveries are in institutions while it is less than 1 out of 10 deliveries in rural areas. It is also seen that the proportion of deliveries attended by the health professional like Doctor, Staff Nurse or ANM is very high in urban area as compared to rural area. Half of the Home deliveries are attended by Traditional Birth Attendants.

Details of place of birth and assistance during delivery

Indicator	Urban	Rural	Total
Home Deliveries	50.1	86.5	78.7
Institutional Deliveries	49.1	12.1	20.1
Deliveries attended by Doctor	40.3	12.5	19.0
Deliveries attended by Nurse/ANM	20.8	8.2	11.0
Home deliveries attended by TBA	29.1	51.6	46.7

However, it may be mentioned here that with the introduction of schemes like Janani Suraksha Yojna, Prasav Hetu Parivahan Yojna and Vijaya Raje Janani Beema Kayan Yojna, there has been a clear spurt in institutional deliveries in the State. The State reports indicate that the institutional deliveries, which stood at 25% in April 2005 has gone up to 47% in September 2006.

Anemia among Women

The nutritional status of women in the state is low. Overall, 54 percent of women in the state have some degree of anemia, compared with 52 percent in India as a whole. About 16.6 percent of women in Madhya Pradesh are moderately to severely anemic. The percentage of anemic women is much higher in rural area as compared to urban area.

Prevalence of RTIs

The NFHS-2 depicts that four out of 10 currently married women have reported of at least one reproductive health problem. The common problems reported were abnormal vaginal discharge and symptoms of urinary tract infection. Rural women reported of these problems more frequently than their urban counterparts. Only 3 out of 10 women suffering with RTI/STI symptoms availed treatment.

CHILD HEALTH

The reproductive health survey collected information on child immunization, reasons for not availing child immunization services, and breast-feeding and weaning practices. This apart, the NFHS-2 has provided levels of infant and child mortality and the nutritional status of children at the state level.

Infant and Child Mortality

The NFHS-2 survey conducted in 1998-99 estimated the Infant Mortality Rate (IMR) to be 86 deaths of infants per 1,000 live births during the four years preceding the survey, much higher than the IMR of 68 in India. The Child Mortality Rate (CMR) in the state was 56 (deaths of children aged 1-4 years per 1,000 children reaching age one). In all, among 1,000 children born, 56 die before reaching age five. As expected, IMR in rural areas was higher than urban areas.

Child Immunization

Immunization of children is an important component of child-survival with efforts focusing on six childhood diseases of tuberculosis, diphtheria, pertusis, tetanus, polio and measles. The objective of Universal Immunization Programme (UIP) was to extend immunization coverage against these diseases to at least 85 per cent of infants by 1990, and the target now is to achieve 100 per cent immunization. However, in Madhya Pradesh, only 22 per cent of children aged 12-23 months were fully vaccinated; about 64 per cent had received some, while the remaining 14 per cent had not been vaccinated at all. Dropout rates for the series of DPT and polio vaccinations were also a problem. Sixty three per cent of children received first dose of DPT, but only 37 per cent received all three doses. Likewise, 85 per cent of children received first dose of polio but only 56 per cent received all the three doses. Coverage of measles was 35.6 per cent.

Infant Feeding Practices

Practice of breastfeeding is very poor in Madhya Pradesh. The NFHS-2 indicated that less than one-tenth of children were breastfed within an hour of birth and less than one third in the first day. Further, for 71 per cent of mothers squeezed out the first milk from the breast before feeding the baby, contrary to recommended feeding practices. Only one third of the children of less than four months of age were exclusively breastfed. The median duration of exclusive breastfeeding is only 2.6 months.

Diarrhea & ARI

Awareness and Treatment of Diarrhea

Only one third of the mothers were aware of two or more danger signs of diarrhea. About one-fourth of the children in the state had suffered from diarrhea in the two weeks preceding the survey (NFHS-2). Of them, 60 per cent of mothers reported having taken their child/children to a health facility or health-care provider but only 55 percent of mothers used ORS during the diarrheal episode.

Awareness and Treatment of ARI/Pneumonia

According to the NFHS-2, 31 per cent of children under age three were ill with fever during the two weeks preceding the survey and 29 per cent were ill with ARI. Fifty eight per cent of children who were ill with ARI were taken to a health facility. The prevalence was substantially higher in rural areas in comparison to urban areas.

FERTILITY AND FAMILY PLANNING

The levels of fertility and contraceptive use have been compiled using the NFHS-2 survey reports

Fertility

The State of Madhya Pradesh has a total fertility rate (TFR) of 3.31 still on a higher side required for replacement level fertility. The TFR in urban area is (2.61) lower as compared to rural area where it is 3.56. Among the women age 15-49, the mean number of children ever born is 2.8 for all women and 3.3 for currently married women. The mean number of children ever born increases with increasing the age and it is 5 for the age 45 -49. About thirty five percent of the women have birth order more than 4.

Contraceptive Prevalence

The awareness regarding the modern contraceptive methods is very high but the modern contraceptive prevalence in Madhya Pradesh according to the NFHS-2 was 42 per cent. Female sterilization as expected turned out to be the more popular method with about 35 per cent of currently married aged between 15 and 49 years accepting it. This was followed by condoms (3 percent), IUCD (0.8 percent) and oral pills (1.0 percent). The use of spacing methods was negligible. Contraceptive use increased with the number of living children and specifically with the presence of a son. Analysis by background characteristics of residence, caste and SLI depicted higher contraceptive prevalence among urban women (52 percent) in comparison with rural women (39 per cent).

Unmet Need for Family Planning

Currently married women who are not using any method of family planning but also do not want any more children or want to wait two or more years before having another child, are considered as having an unmet need for family planning. Current contraceptive users on the other hand are said to have a met need for family planning. The total demand for family planning is the sum of met and unmet needs. The need for spacing or limiting births depends upon, whether or not a woman wants to have a child. This concept helps in understanding the potential demand for family planning and facilitates in converting this potential demand to real demand.

The following table summarizes unmet need, met need and demand for family planning. The total unmet need in the state was 16 per cent and the unmet need for the spacing method was slightly higher than that for the limiting method. The unmet need was lower in urban areas than in rural areas.

Need for Family Planning Services

Indicator	Urban	Rural	Total
Met need for Spacing Method	4.1	1.6	2.2
Met need for Limiting Method	51.0	39.1	42.1
Unmet need for Spacing Method	7.9	9.3	8.9
Unmet need for Limiting Method	7.6	7.2	7.3
Total Demand for Spacing Method	12.0	10.8	11.1
Total demand for Limiting Method	58.6	46.3	49.4
Total demand for FP services	70.6	57.1	60.5

Source: NFHS-2, 1998-99

District Variations: (RHS-2202) The districts differ in their current status and performance. Districts like Jhabua, Shahdol and Sidhi are showing very low level for ANC check ups while the districts having the highest percentage of home deliveries are Sidhi and Shahdol. Districts like Vidisha, Jhabua, Panna, Chhatarpur and Satna show very low percentage of eligible couples using modern contraceptive method. The table below presents the current status of the various indicators across different districts:

Districts	Unmet need -total-2	Full ANC2 - (Atleast 3 visits for ANC + atleast one TT injection + 100 or more IFA tablets/syrup)	Institutional delivery	Exclusive breastfeeding atleast 4 months (children age 4-12 months)	Percentage of children age 12-35 months received Full Immunization	who had diarrhea (two weeks prior to survey)	Given ORS to children during Diarrhea	who had Pneumonia (two weeks prior to survey)	Sought treatment for Pneumonia	Women who had any symptom of RTI/STI
Indore	13.4	14.6	65.6	17.5	49.6	20.3	57.1	22.8	76.3	52.5
Dhar	14.6	4.6	27.9	0.9	38.1	29.0	21.0	27.0	52.0	53.2
Jhabua	25.6	4.9	26.2	1.3	24.8	21.2	14.7	22.8	63.3	54.1
Barwani	15.4	9.6	21.6	3.5	32.8	14.9	27.8	22.5	81.6	34.2
East Nimar	15.8	4.6	27.3	0.0	40.0	21.3	23.0	20.6	67.4	46.1
West Nimar	10.9	4.8	18.9	8.4	24.9	15.2	24.9	27.4	72.0	42.5
Ujjain	14.2	5.2	32.1	0.0	38.7	28.6	22.0	24.3	63.0	50.6
Dewas	16.9	2.5	31.7	2.7	36.1	21.9	24.9	26.9	61.0	58.3
Ratlam	17.3	6.1	25.7	0.0	42.8	22.1	32.9	16.6	70.3	27.6
Mandsaur	17.3	8.3	30.2	1.1	29.4	16.3	33.0	11.2	88.3	24.1
Shajapur	19.2	5.0	32.0	0.0	33.1	22.5	24.1	25.4	68.9	31.3
Neemuch	16.8	12.2	26.4	1.2	33.2	17.6	33.0	10.7	82.0	25.0
Bhopal	16.9	19.7	51.3	44.4	37.2	23.7	46.0	20.0	85.8	30.0
Sehore	20.3	3.1	30.7	4.2	21.3	31.1	33.3	31.3	63.2	66.8
Raisen	19.8	3.5	23.7	35.3	27.3	13.0	26.0	29.8	48.4	47.7
Vidisha	26.5	2.6	25.0	2.9	18.2	29.6	21.0	29.7	54.0	61.0
Betul	23.8	9.1	22.5	60.8	30.0	11.4	15.6	15.5	41.9	24.6
Rajgarh	19.8	3.3	35.9	8.3	26.0	13.8	31.9	18.3	71.5	30.8
Hoshangabad	14.4	9.0	36.8	9.6	66.5	25.9	22.6	8.7	59.9*	33.6
Harda	15.9	4.9	33.1	18.2	47.0	16.8	31.1	25.3	63.3	36.2
Jabalpur	16.9	13.2	42.4	5.1	50.2	11.5	43.3	19.5	68.3	27.6
Katni	23.6	2.5	18.9	7.3	39.3	22.1	20.4	15.6	61.0	31.3
Balaghat	20.6	15.2	21.5	47.7	48.2	7.2	27.4*	37.1	52.0	38.1
Chhindwara	17.4	6.1	25.9	39.6	46.8	26.8	27.9	42.2	57.7	30.1
Seoni	16.5	18.4	27.2	22.9	62.0	29.6	33.8	48.9	66.4	43.4
Mandla	15.8	2.8	20.2	24.1	55.8	19.6	17.7	25.3	33.6	42.0
Dindori	20.0	3.2	18.3	14.3	38.6	30.6	29.2	36.3	32.9	45.7

Districts	Unmet need -total-2	Full ANC2 - (Atleast 3 visits for ANC + atleast one TT injection + 100 or more IFA tablets/syrup)	Institutional delivery	Exclusive breastfeeding atleast 4 months (children age 4-12 months)	Percentage of children age 12-35 months received Full Immunization	who had diarrhea (two weeks prior to survey)	Given ORS to children during Diarrhea	who had Pneumonia (two weeks prior to survey)	Sought treatment for Pneumonia	Women who had any symptom of RTI/STI
Narsimhapur	14.2	3.8	38.3	41.4	50.1	26.8	27.3	36.5	48.3	49.1
Sagar	27.3	6.5	22.5	50.8	31.7	12.9	19.7	16.4	80.0	42.5
Damoh	18.4	3.5	23.3	3.7	25.9	20.0	16.4	18.8	46.3	26.9
Panna	25.4	0.6	28.4	5.9	17.2	17.2	28.8	17.6	46.2	30.6
Tikamgarh	23.3	2.7	20.7	12.5	10.2	21.5	18.7	26.0	51.1	31.4
Chhatarpur	37.2	0.5	17.6	51.3	34.3	11.9	9.7	12.8	65.9	51.6
Rewa	31.0	4.5	22.4	19.5	35.2	19.3	14.3	27.0	51.7	54.9
Sidhi	38.8	0.8	6.2	79.1	10.7	0.6	59.4*	9.9	3.3	16.9
Satna	26.8	1.0	20.7	63.2	23.1	13.1	20.7	12.7	46.0	29.5
Shahdol	25.1	8.6	14.1	17.3	33.8	16.8	32.8	20.3	44.5	42.6
Umaria	26.5	6.4	27.5	21.7	21.1	29.2	32.4	24.0	55.4	40.8
Gwalior	25.0	4.6	47.5	40.9	35.4	5.9	13.8*	13.7	65.9	25.4
Morena	19.5	4.1	43.2	10.9	36.1	34.7	32.3	18.3	66.5	26.2
Sheopur	22.3	5.7	29.3	25.3	37.2	28.8	30.6	20.3	64.9	21.7
Shivpuri	18.8	1.7	28.3	0.0	19.4	11.3	10.8	10.0	31.7	27.2
Guna	22.5	3.3	29.8	11.5	11.1	25.0	16.3	30.1	59.0	53.4
Datia	18.5	7.3	26.3	31.3	27.1	13.7	10.1	20.9	40.2	46.2
Bhind	30.6	1.5	23.5	6.5	14.0	16.3	12.9	15.1	75.2	35.3

Malaria

- MP is one of the 3 worst malaria affected states. MP and Orissa alone account for 50% of mortality due to malaria in India (ICRIER, 2001).
- Proportion of *Plasmodium Falciparum* malaria (associated with cerebral malaria and with higher death rate) increased from 44 % in 1996 to 55 % in 1999. (source: NMAP, MOHFW Gol data cited in ICRIER 2001).
- Rural residents are twice as likely to suffer from malaria than urban residents (10015 and 5240 respectively per lakh population – NFHS II).

Tuberculosis

- The overall prevalence of tuberculosis (TB) increased by 21% during the period 1992-93 to 1998-99 (440 in NFHS I and 602 in NFHS II).

- Prevalence of TB is higher in rural areas than urban areas (669 and 405 per lakh respectively).
- Prevalence is higher for males than females (678 and 519 per lakh respectively) attributed to higher outside contacts of male population and their smoking habit.

Diarrhea

- MP recorded the highest incidence of diarrhea in the country at 63 per 1,000 (as per NCAER 1995 data cited in TARU report) and 28% of state's IMR was due to diarrhoeal deaths. Rajiv Gandhi Mission for Control of Diarrhoeal Diseases is credited with contributing to the decrease of diarrhoeal deaths from 4387 p.a. in 1991 to 610 by 1997 (source: TARU report).

Nutritional deficiency

Nutritional deficiency is a major cause for concern in MP:

- 38% of women have chronic energy (nutritional) deficiency indicated by body mass index (BMI) < 18.5.
- Anemia is higher amongst breastfeeding women (58%) than non-pregnant/non breastfeeding women.
- Anemia prevalence is higher amongst scheduled tribes (70.3%) (NFHS II).

Nutritional deficiency amongst children

Malnutrition of children and anemia increases susceptibility towards morbidity/mortality:

MP has the highest rate of undernourished children in the country:

- More than 55% of children (6-35 months) are underweight due to chronic/acute under nutrition.
- 51% are stunted due to chronic under nourishment/ recurrent diarrhea.
- 20% are wasted due to acute under nourishment or illness.
- 75% of children age 6-35 months have anemia; 53% suffering from acute anemia.

Gender Disparity

Women/girl children are distinctly worse off in MP:

- Women have a limited role in key decisions related to maternal and child health: only 37% of women take decisions affecting their healthcare and only 24% of women discuss family planning with husband/somebody else;
- Mortality rates for girls are higher than for boys except during early infancy when girls have a biological advantage, as the following table shows:

Sex of child	NMR	PNMR	IMR	CMR	U5M
Male	67.3	29.8	97.2	49.4	141.7
Female	51.7	35.9	87.5	66.3	148.0

- % of boys getting vaccinated (27%) was greater than girls (18%);
- Boys are more likely to get at least one dosage (26%) than girls (23%);
- 16.5% of girls did not get any vaccination as compared to 11.5% for boys.

Health Status of Poor/Socio Economically Disadvantaged

The poor/socio economically disadvantaged are worse off in MP:

- IMR is double and CMR is more than five times in poor families having a low standard of living index;
- 12% of children in poor families were vaccinated compared to ~50% for economically better off families;
- 67% of deliveries in rich families were assisted by doctor/trained healthcare personnel compared to 17% in poor families;
- 11% of ST children received vaccinations compared to 22.4% in total MP;
- 70.3% ST women suffered from anemia compared to 54.3% in total MP.

Water and Sanitation Services

Physical installation of water facilities (PHED data, April 2000) in MP is quite impressive. 86% of a total of 111,780 habitations are fully covered (@ 40 lpcd), 13% are partially covered, while only 1% do not have any safe water source. There are 283,651 hand pumps, 2321 spot sources and 3589 piped water supply systems; 2-8% of these installations are reported by PHED to be temporarily non-functioning due to drying up of water sources, while 13% of installations are classified as irreparable. The data does not include wells/pumps installed by households and GPs through their own funds; however the number of such installations is relatively low.

STATUS OF WATER SUPPLY INSTALLATIONS IN MP

Description	Hand pumps		Spot source		Piped water supply	
	Nos.	%	Nos.	%	Nos.	%
Total installations	2,83,651		2,321		3,589	
In working condition	2,42,034	85	1,839	79	2,924	81
Temporarily non functioning due to drying of water sources	6,296	2	180	8	208	6
Irreparable	35,321	13	302	13	457	13
		100		100		100

Source: PHED, 2001.

Although coverage is largely satisfactory in terms of physical installations, the reduced availability of safe water is a cause for concern. There are three issues:

- Over-exploitation of water sources, especially in west MP, where a number of villages face the problem of drying up of water sources. Water is not available even at a depth of 800 feet in Neemuch district.
- Preventive maintenance of hand pumps is practically non-existent. Further, inappropriate operational practices such as installing additional pipes results in a collapse of the vertical column of the pipeline.
- Average downtime for repairs when needed is 4-5 days and up to a month in remote areas; a contributory factor being a shortage of hand pump mechanics with PHED.

Sanitation facilities and coverage

Sanitation in the rural context is perceived as physical provision of latrines. Solid waste management, effluent disposal and surface water drainage are considered to be of even lower priority although some GPs have provided drains for effluent from households.

Since 1992-93 PHED has been the nodal agency for implementing sanitation programmes in MP. According to PHED, 215,080 toilets have been constructed for households below poverty line (BPL), whereas the corresponding figure for APL households is 240,569. These numbers do not include privately constructed septic tank type latrines. Less than 8% of all rural households are estimated to have an IHL.

Sanitation is perceived primarily as the presence of a physical latrine (Delivery Mechanisms for Water and Sanitation in MP, MSG, 2001):

- The installed IHLs (purchased through a subsidy scheme) are typically used for storage, bathing etc.
- Attitudinal barriers: The community is used to the traditional practice of defecating in the open and does not readily accept small latrines.
- Low priority : Even in large crowded villages where there is a lack of open space, sanitation is low priority; a TV typically takes precedence over an IHL.
- Lack of water: Use of existing facilities is often reduced due to lack of water for flushing/cleaning.
- Low awareness levels: While communities have an appreciation of the link between drinking safe water and health, awareness of the importance of hygiene practices is low.
- Technical issues: Key concerns include collapse of brick lining, lack of ventilation, flooding of pits during rains, use of one pit model etc. These experiences adversely affect demand for latrines.

3. VISION, GOALS, OBJECTIVES AND ENVISAGED OUTCOMES

3.1 State's Mission

The State's vision statement is as follows:-

'All people living in the state of Madhya Pradesh will have the knowledge and skills required to keep themselves healthy, and have equity in access to effective and affordable health care, as close to the family as possible, that enhances their quality of life¹, and enables them to lead a healthy productive life'.

Thus, it may be observed that the State's vision has primarily two components, namely empowering the people living in the State with knowledge and skills required to keep them healthy and equity in access to effective and affordable health care.

The State of Madhya Pradesh also subscribes to the vision adopted by the National Rural Health Mission. Consequently, the adapted vision components to be pursued by the State are presented in the box below:

- Equip people with knowledge and skills required to keep themselves healthy.
- Provide effective healthcare to rural population throughout the State with special focus on worst performing districts, which have weak public health indicators and/or weak infrastructure. These districts will receive special focus. These are: **Dindori, Damoh, Sidhi, Badwani, Anuppur, Chhindwara, Rewa, Betul, Raisen, Seoni, Chhatarpur, Morena and Sheopur.**
- Raise level of public spending on health from 0.89% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling.
- Undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the State.
- Revitalize local health traditions and mainstream AYUSH into the public health system.
- Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.
- Address inter-district disparities.
- Pursue time bound goals and publish report to the people of the state on progress.
- Improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.

Vision Statement of State Rural Health Mission, MP

¹ Quality of life is the perceived physical and mental health of a person or group over time.

3.2 Goal of NRHM

The goal of National Rural Health Mission is to improve the availability of and access to quality health care by the people especially for those residing in rural areas, the poor, women and children. The main aim of National Rural Health Mission is to provide accessible, affordable, accountable, effective and reliable primary health care, especially to poor and vulnerable sections of the population. It aims at reduction in Infant Mortality Rate and Maternal Mortality Ratio, universal access to public health services such as women's health, child health, water, sanitation and hygiene, immunization and nutrition, prevention and control of communicable and non-communicable diseases including locally endemic diseases; access to integrated comprehensive primary health care; population stabilization; gender and demographic balance; revitalize local health traditions and mainstream AYUSH and promotion of healthy lifestyle.

3.3 Objectives of State Programme Implementation Plan under NRHM

The State Programme Implementation Plan under the National Rural Health Mission shall pursue the following objectives by the year 2012: -

- Reduction in Infant Mortality Rate to 60 per 1000 live births
- Maternal Mortality Ratio reduced to less than 220 per 1,00,000 live births
- Total Fertility Rate is reduced to 2.1.
- Morbidity and mortality due to common communicable diseases such as malaria, dengue, leprosy, and tuberculosis is reduced as per the objectives set in the National NRHM document.
- At least 36% of Community Health Centres are upgraded to meet IPHS by 2008 and 100% by 2010.
- 170 Comprehensive Emergency Obstetric Care institutions are strengthened and made functional, 40% by 2006, 55% by 2007, 75% by 2008 and 100 % by 2009 and 500 Basic Emergency obstetric Care institutions are strengthened and 40% made functional by the year 2006, 50% by 2007, 60% by 2008, 80% by 2009 and 100% by 2010.
- 40% of Accredited Social Health Activists (ASHA) are identified by 2006, 70% by 2007 and 100% by 2008 and 40% trained by 2007, 80% by 2008 and 100% by 2009.
- The proportion of institutional deliveries is increased to 50% by year 2007, 65% by year 2008 and 75% by year 2009.

- Janani Suraksha Yojana for below poverty line families is effectively implemented to improve institutional deliveries through provision of referral transport, escort and improved hospital care to all BPL families by the year 2007.
- To improve outreach of health services through Mobile Medical Units in difficult to reach areas and disadvantaged population groups.

3.4 Envisaged Outcomes from the Mission in terms of Programme Indicators

- IMR reduced to 60/1000 live births by 2012.
- Maternal Mortality reduced to below 220/100,000 live births by 2012.
- TFR reduced to 2.1 by 2012.
- Malaria Mortality Reduction Rate - 50% up to 2010, additional 10% by 2012.
- Filariasis/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012 and elimination by 2015.
- Dengue Mortality Reduction Rate - 50% by 2010 and sustaining at that level until 2012.
- Cataract operations-increasing to 46 lakhs until 2012.
- Leprosy Prevalence Rate –reduce from 1.8 per 10,000 in 2005 to less than 1 per 10,000 thereafter.
- Tuberculosis DOTS series - maintain 85% cure rate through entire Mission Period and also sustain planned case detection rate.
- Upgrading all Community Health Centers to Indian Public Health Standards.
- Increase utilization of First Referral units from bed occupancy by referred cases of less than 20% to over 75%.
- Engaging 43913 female Accredited Social Health Activists (ASHAs).

3.5 The expected outcomes at Community level

- Availability of trained community level worker at village level, with a drug kit for generic ailments.
- Health Day observed at Aanganwadi level on a fixed day/month for provision of immunization, ante/post natal check ups and services related to mother and child health care, including nutrition.
- Availability of generic drugs for common ailments at sub Centre and hospital level.
- Access to appropriate and guaranteed hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level and

assured referral-transport-communication systems to reach these facilities in time.

- Improved access to universal immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization services under the programme.
- Improved facilities for institutional deliveries through provision of referral transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the below poverty line pregnant women.
- Availability of assured health care at reduced financial risk through pilots of Community Health Insurance under the Mission.
- Availability of safe drinking water.
- Adoption of household toilets.
- Improved outreach services to medically under-served remote areas through mobile medical units.
- Increased awareness about preventive health including nutrition.

3.6 The core strategies of the Mission

- Capacity building of Panchayati Raj Institutions (PRIs) to recognize their stakes in the public health system.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Promote formulation of Village Health Plans for each village through Village Health & Sanitation Committees of the Gram Sabhas.
- Strengthening sub-centre through better human resource development, clear quality standards, better community support and an untied fund to enable local planning and action and more ANMs.
- Strengthening existing (PHCs) through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.
- Provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (IPHS defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels).

- Preparation and implementation of an inter-sector District Health Plan prepared by the District Health Mission, including drinking water, sanitation, hygiene and nutrition.
- Integrating the management of vertical Health and Family Welfare programmes at district level.
- Provisioning of technical support to State and District Health Missions for improved public health management.
- Strengthening capacities for data collection, assessment and review for evidence- based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of human resource for health.
- Developing capacities for preventive health care at all levels for promoting healthy life style, reduction in consumption of tobacco and alcohol, etc.
- Promoting involvement of private and corporate non-profit sector particularly in underserved areas.

3.7 Supplementary Strategies

- Regulation for private sector including the informal Rural Medical Practitioners (RMP) to ensure availability of quality service to citizens at reasonable cost.
- Promotion of public-private partnerships (PPP) for achieving public health goals.
- Mainstreaming AYUSH – revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of medical care and medical ethics.
- Effective and visible risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

3.8 The Special Focus Districts

While the Mission is state-wide, 10 districts having very poor indicators, low population density and weak infrastructure shall receive special attention. These districts are ***Dindori, Damoh, Sidhi, Badwani, Anuppur, Chhindwara, Rewa, Betul, Raisen, Seoni, Chhatarpur, Morena and Sheopur***. While all the Mission activities are the same for all the districts, the high focus districts would be more closely monitored by the State apart from providing them with increased technical assistance in implementing the respective district PIPs.

3.9 The efforts so far

The emphasis in the first six months since the launch of the mission has been on the preparatory activities necessary for the laying the ground work for implementation of the Mission such as:

Institutional Framework

- The State and district level societies have been merged. State and District Missions have been set up. The institutional framework including Executive Committee at the State level has been put in place.
- State has organized the launch workshop.
- Mission Document; Guidelines on Indian Public Health Standards; Guidelines for ASHA; Training Modules for ASHA; Guidelines for District Health Mission and merger of societies have been disseminated to the districts.
- MoU has been signed with GoI. It spells out the reform commitment of the State in terms of its enhanced public spending on health, full staffing of management structures, steps for decentralization and promotion of district level planning and implementation of various activities and achievement of milestones.

Programmes

- Reproductive and Child Health Programme – II (RCH-II), the Janani Suraksha Yojana (JSY), Prasav Hetu Parivahan Yojna (PHPY) and Vijaya Raje Janani Kalyan Beema Yojna have been launched.
- Operationalisation of CEmONC facilities is being stepped up under the EC-supported Sector Investment Programme, which is in its last leg this year.
- Polio eradication programme has been intensified.
- Sterilization insurance scheme has been introduced.
- Routine Immunization programme is being strengthened through alternative vaccine delivery system and Auto Disabled Syringes have been introduced.
- State's RCH II Programme Implementation Plan RCH II has been appraised by the National Programme Coordination Committee of the GoI.

Infrastructure

- Facilities have been identified for detailed survey.
- Repair and renovation of Sub Centres taken up under RCH- II.

- Untied fund of Rs. 10,000 provided to 8835 SHCs in the Joint accounts in the names of Sarpanch and ANM.
- 2 CHCs in each district for upgradation to IPHS have been selected.
- Upgradation of CHCs as Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) and Primary Health Centres for Basic Emergency Obstetric and Neonatal Care (BEmONC) for 24 hours and 7 days a week delivery services have been taken up.
- Funds for upgradation of two CHCs per district to IPH Standards have been released.

District Plans

- Integrated district health action plans have been developed and appraised for all the 48 districts. The appraisal has been done by the State Appraisal Committees.
- ASHAs selection for the year 2006 has been completed. Selection for the year 2007 is in progress.
- Training of the state/district level trainers of ASHAs completed. District level training has been initiated.

Technical Support to the Mission

- State Programme Management Unit (SPMU) and District Programme Management Units established. These bodies will get subsumed in to the State Health Systems Resource Center (SHSRC).

Training and Capacity Building

1. Integrated training calendar prepared.
2. Training modules for Skilled Birth Attendants finalized.
3. Training of medical and para medical staff in BEmONC and CEmONC initiated.
4. Public health management courses started. First two batches completed.

4. CRITICAL AREAS FOR CONCERTED ACTION

4.1 The launch of NRHM has provided the Central and the State Governments with a unique opportunity for carrying out necessary reforms in the health sector. The reforms are necessary for restructuring the health delivery system as well as for developing better health financing mechanisms. The strengthening and effectiveness of health institutions like SHCs/PHCs/CHCs/CHs/district hospitals should necessarily lead to positive consequences for the health programmes like TB, Malaria, HIV/AIDS, Filaria, Family Welfare, Leprosy, Disease Surveillance etc. as all programmes are based on the assumption that a functioning public health system actually exists. In order to improve the health outcomes, it is necessary to give close attention to critical areas like institutional mechanism, service delivery, finances (including risk pooling), resources (human, physical, knowledge technology) and leadership. The following are identified as some of the areas for concerted action:-

- Well functioning and responsive health system;
- Quality and accountability in the delivery of health services;
- Need to acknowledge the rights perspective in respect of the poor and vulnerable sections of the society and their empowerment;
- Prepare for health transition with appropriate health financing;
- Effective public private partnership for expanding choice and access;
- Intra- and inter-sector convergence for effectiveness and efficiency.
- Responsive health system meeting people's health needs.

4.2 The Priorities and constraints

The table given below brings out an analysis of the priorities and constraints in addressing the concerns:

S. No.	Priorities	Constraints
1.	Functional facilities - Operationalizing Sub Health Centers / PHCs / CHCs / CHs / District Hospitals	<ul style="list-style-type: none"> • Dilapidated or absent physical infrastructure. • Non-availability of doctors / paramedics. • Vacancies / absenteeism • Lack of skills and skills mismatch • Shortage of drugs, vaccine and supplies. • Lack of equipments, non-functioning equipments. • Choked fund flows

S. No.	Priorities	Constraints
		<ul style="list-style-type: none"> • Lack of accountability framework. • Inflexible financial resources. • Facility specific service packages are not defined
2.	Ensuring requisite availability of skilled human resources	<ul style="list-style-type: none"> • Large jurisdiction and poor monitoring. • Lack of any plan for career advancement or for systematic skill upgradation. • Lack of articulation HR policies.
3.	Accountability of health system	<ul style="list-style-type: none"> • Panchayati Raj institutions / ULBs / user have little say in health system. • Lack of decentralization.
4.	Empowerment for effective decentralization and flexibility for local action	<ul style="list-style-type: none"> • Only tied funds. • Local initiatives have no role. • Centralized management and schematic inflexibility. • Lack of mandated functions of PRIs/ULBs/users. • Lack of financial and human resources for local action. • Lack of indicators and local health status assessments that can contribute to local planning. • Poor capability to design and plan programmes.
5.	Reducing maternal and child deaths and population stabilization	<ul style="list-style-type: none"> • Lack of 24X7 facilities for safe deliveries. • Lack of facilities with emergency obstetric care. • Unsatisfactory access and utilization of skilled assistance at birth. • Lack of equity / sensitivity in family welfare services / counseling. • Non-availability of Specialists for anesthesia, obstetric care, pediatric care, etc. • No system of new born care with adequate referral support. • Lack of referral systems. • Gender inequity adversely influencing utilization of health services. • Socio-cultural practices and taboos affecting health-seeking behavior.
6.	Action for preventive and promotive health	<ul style="list-style-type: none"> • No action on promoting healthy lifestyles whether it be fighting alcoholism or promoting tobacco control or promoting positive actions like sports / yoga etc. • Week school health programmes. • Absence of health counseling / early detection. • Compartmentalized IEC of every scheme.
7.	Disease Surveillance	<ul style="list-style-type: none"> • Vertical programmes for communicable diseases.

S. No.	Priorities	Constraints
		<ul style="list-style-type: none"> • No integrated / coordinated action for disease surveillance at various levels in place yet. • Lack of block and district level epidemiological data.
8.	Health Management Information System.	<ul style="list-style-type: none"> • Poorly designed and poorly administered system.
9.	Planning and monitoring with community ownership	<ul style="list-style-type: none"> • Lack of involvement of local community, PRIs, RKSs, NGOs in monitoring public health institutions like SHC / PHC / CHC / CH / District Hospitals.
10.	Work towards women's empowerment and securing entitlements of SCs / STs / OBCs / Minorities	<ul style="list-style-type: none"> • Insensitivity and neglect of service providers with other socio-economic barriers for accessing public health services.
11.	Convergence of programme for combating / preventing HIV / AIDS, chronic diseases, malnutrition, providing safe drinking water etc. with community support.	<ul style="list-style-type: none"> • Vertical implementation of programme. • Only curative care. • Inadequate service delivery. • Non-involvement of community.
12.	Chronic disease burden	<ul style="list-style-type: none"> • Lack of integration of programmes with main health programmes. • Poor IEC / advocacy. • Inadequate Policy interventions.
13.	Social security to poor	<ul style="list-style-type: none"> • Large out of pocket expenditures even while attending free public health facilities - food / transport, escort, livelihood loss etc. • Lack of financial security in the event of catastrophic illness.

5. BROAD FRAMEWORK FOR IMPLEMENTATION

5.1 Based on the analysis of the priorities, constraints and the action to overcome them, a broad framework of implementation of NRHM is proposed as follows:

State's Leadership

The State has determined to decentralize planning and implementation arrangements to ensure that need-based and community-owned District Health Action Plans become the basis for interventions in the health sector. The State has also taken steps to introduce innovative schemes to deal with local issues. The State has taken steps to devolve requisite administrative and financial powers at various administrative levels. The State is also seeking to increase its expenditure on health sector by at least 10% every year over the Mission period. The State would be guided by the mutually agreed milestones as are reflected in the MOU signed with the Govt. The State would undertake rigorous capacity building initiatives to ensure that integration of programme management bodies and the use of untied funds is most effectively optimized so that complex health issues are competently addressed.

Institutionalizing community led action for health

The State is committed to achieve the goals enshrined under the NRHM and MDG keeping the community in focus. It is the stated agenda of the State that PRIs, right from the village to district level, would have to be the central stakeholders of the public health delivery system in their respective jurisdiction. Other vibrant community organizations and women's groups like SHGs will also be associated in communitization of health care.

The NRHM would seek to involve the PRIs at each level i.e. Gram Panchayat, Janpad Panchayat and Zila Panchayat and enhance their capacities for ensuring community mobilization efforts for appropriate health seeking behaviour.

- The Village Health and Sanitation Committee (VHSC) will be formed in each village under each Gram Sabha ensuring adequate representation to the disadvantaged categories like women, SC / ST / OBC /minority communities.

- The Sub Health Centres shall function in close coordination with village health and sanitation committees as well as the village development committee at the Gram Panchayat level.
- Similarly, the Primary Health Centres and Community Health Centres will also work in close conjunction with Janpad Panchayats.
- The RKSs will undertake the day-to-day management of PHCs and CHCs and the capacities of these RKSs will be suitably enhanced.
- The District Hospital and the Civil Hospital would be accountable to District Health Society and their Rogi Kalyan Samitis will undertake their day-to-day management functions. The capacity of RKSs of district and civil hospitals will also be suitably enhanced.

To institutionalize community led actions for health; the village health and sanitation committees will be constituted in each village in a phased manner. These committees will prepare village health action plans. These village action plans will be synthesized at Gram Panchayat and Janpad Panchayat levels before being refined into integrated district health action plans. Each village health and sanitation committee will be provided untied fund of Rs. 10000/- per year for initiating and implementing local health actions based upon its approved village health action plans.

Promoting Equity

This is one of the main challenges under NRHM. Empowering those who are vulnerable through education and health education, giving priority to areas/hamlets/households inhabited by them, running fully functional facilities, exemption for below poverty line families from all charges, ensuring access, risk pooling, human resource development / capacity building, recruiting volunteers from amongst them are important strategies under the Mission. These are reflected in the planning process at every level. Under the NRHM, The State would make conscious efforts to address the issue of inequity. The percentage of vulnerable sections of society using the public health facilities would be a benchmark for the performance of these institutions.

Promoting Preventive Health

The NRHM would increase the range and depth of programmes on Health Education / IEC activities which are an integral part of activities under the Mission at every level. In addition it would work with the departments of education to make

health promotion and preventive health an integral part of general education. The Mission would also interact with the Ministry of Labour for occupational health and the Ministry of Women and Child Development to ensure due emphasis on preventive and promotive health concerns.

Dealing with Chronic Diseases and Mental Health

Tobacco, cancer, diabetes and renal diseases, cardio vascular diseases, neurological diseases and mental health problems and the disability that may arise due to the chronic diseases are major challenges before the NRHM. Special emphasis will be given on mental health programme so that specific psychiatric health needs are adequately addressed. It may be mentioned here that by addressing the mental health, the social health would also be automatically addressed thereby fully meeting the premise of health definition as provided by WHO. It is also proposed to integrate the disease surveillance and mobilize preventive and curative care with the regular health care programmes at all levels.

Reducing child and maternal mortality rates and reducing fertility rates – population stabilization through quality services

NRHM provides a thrust for reduction of child and maternal mortality and in reduction of the fertility rates. The approach to population stabilization is to provide quality health services in remote rural areas along with a wide range of contraceptive choices to meet the unmet demand for these services. Efforts are on to provide quality reproductive health services (including delivery, safe abortions, treatment of Reproductive Tract Infections and Family Planning Services to meet unmet needs, while ensuring full reproductive choices to women). Also, it is the strategy to promote male participation in Family Planning. Efforts would also be made to suitably reorient the service providers at all levels to deal with the needs of victims of domestic violence.

Reduction of IMR requires special and sustained attention in respect of integrated management of neonatal and childhood illnesses (IMNCI). Keeping in view the continued high proportion of domiciliary deliveries, special attention is required on home based newborn care particularly in rural areas and in urban slums. In addition, greater convergent action is called for in order to influence the wider determinants of health care like female literacy, safe drinking water, sanitation, gender and social empowerment, early childhood development, nutrition, marriage after 18 / 21, spacing of children, and behavioral changes etc.

The main strategy for maternal mortality focuses on promotion of institutional deliveries at health facilities both in the government as well as private sectors. Efforts would also be made to concomitantly develop competencies needed for Skilled Birth Attendants (SBAs) in the entire cadre of ANMs, LHV's and Staff Nurses. Further essential obstetric care competency is required to be imbibed by select medical officers posted at BEmONC and CEmONC institutions. Regular training of select Medical Officers to administer anesthesia has also been taken up. Also, multi skill training of Medical Officers, ANMs and Para-medics will be initiated to bridge gaps in skills and performance. Intense IEC would be pursued to ensure behavioral changes that relate to better child survival and women's health i.e. exclusive breast feeding, timely initiation of complementary feeding, young child feeding, spacing, age at marriage, education of the girl child etc. CHCs are being upgraded to CEmONC / BEmONC for providing referral services to the mother and child and taking care of obstetric emergencies and complications for provision of safe abortion services and for prevention, testing/counseling in respect of HIV AIDS.

Adolescent health is another significant thematic area of attention under the NRHM. Adolescent friendly health services will be provided in identified primary health centres and community health centers to address the specific health needs of adolescents for both in and out-of-school adolescents.

Management of NRHM activities at State / District / Sub district level

Block Level Pooling

The success of decentralization experiment would depend on the strength of the pillars supporting the process. It is imperative that management capacities be built at each level. To attain the outcomes, the NRHM would provide management costs up to 6% of the total annual plan approved for a State/district as has been introduced under the RCH-II programme. Apart from medical and para-medical staff, such services would include skills for financial management, improved community processes, procurement and logistics, improved collection and maintenance of data, the use of information technologies, management information system and improved monitoring and evaluation etc. The NRHM would also establish strong managerial capacity at the block level as blocks would be the link between the villages and the districts. At the district level the Mission would support and insist on developing health management capacities and introducing

policies in a systematic manner so that over time all district programme officers and their leadership are professionally qualified public health managers. Management structures at all levels will be accountable to the Panchayati Raj institutions, the State Level Health Mission and the National Level Missions/Steering Group.

The amount available under the management cost could also be used for improving the work environment as such improvements directly lead to better outcomes. The management structure holds the key to the success of any programme and priority would be given to direct efforts to develop appropriate arrangements for effective delivery of NRHM. Clarity of tasks, fund flows, powers, functions, account keeping, audit, etc. will be attempted at all levels.

Based on the outcomes expected in NRHM, the organization structure of the health department at different levels would be carefully reviewed. The State will constantly undertake review of management structure and devolution of powers and functions to carry out any mid course correction. Block Level Pooling will be one of the priority activities under the NRHM. Keeping in view the time line needed to make all facilities fully functional, specialists working in PHCs would be relocated at CEmONCs to facilitate their early synchronization. Outreach programmes are being organized with "block pooled" CHCs as the nodal point. NRHM will attempt to set up Block level managerial capacities as per need. Creation of a Block Medical Officer's office to support the supervision of NRHM activities in the Block would be a priority. Support to block level CHCs will also aim at improving the mobility and connectivity of health functionaries with support for Ambulances, telephones, computers, electric connection, etc.

Human resources for rural areas

Improvement in the health outcomes in the rural areas is directly related to the availability of the trained human resources. The Mission aims to increase the availability through provision of trained women as ASHAs/Community Health Workers (resident of the same village/hamlet for which they are appointed as ASHA). The Mission also seeks to provide minimum two Auxiliary Nurse Mid-wives (ANMs) against one at present at each Sub Health Centre (SHC) to be fully supported by the Government of India. Similarly, against the availability of one staff nurse at the PHC, it is proposed to provide three Staff Nurses to ensure round the clock services in every PHC. The Outpatient services would be strengthened through posting/ appointment on contract of AYUSH doctors over and above the

Medical Officers posted there. The State would integrate AYUSH by relocation at PHC and/or by new contractual appointment. GOI support will be for all new contractual posts and not for existing vacancies that State has to fill up. The Mission seeks to bring the CHCs on a par with the Indian Public Health Standards (IPHS) to provide round the clock hospital-like services. As far as manpower is concerned, it would be achieved through provision of seven Specialists as against four at present and nine staff nurses in every CHC (against seven at present). A separate AYUSH set up would be provided in each CHC/PHC. Contractual appointment of AYUSH doctors will be provided for this purpose. This would be reflected in the State Plans as per their needs.

Given the current problems of availability of both medical as well as paramedical staff in the rural areas, the NRHM seeks to try a range of innovations and experiments to improve the position. These include incentives for compulsory rural posting of Doctors, a fair, transparent transfer policy, involvement of Medical Colleges, improved career progression for Medical / Para Medical staff, skill upgradation and multi-skilling of the existing Medical Officers, ANMs and other Para Medical staff, strengthening of nursing / ANM training schools and colleges to produce more paramedical staff, and partnership with non governmental stakeholders to widen the pool of institutions. The Ministry has already initiated the process for the upgradation of ANMs into Skilled Birth Attendants (SBA) and for providing six-month anesthesia course to the Medical Officers. Convergence of various schemes under NRHM including the disease control programmes, the RCH-II, NACO, disease surveillance programme, would also provide for optimum / efficient utilization of all paramedical staff and help to bring down the operational costs.

State level Resource Centres for capacity development

Decentralized Planning, preparation of district plans, community ownership of the health delivery system and inter-sectoral convergence are the pillars on which the super-structure of the NRHM would be built. The implementation teams particularly at district and state levels would require development of specific skills. The State Health Resource Centre (SHRC) will act as the complementary technical capacity in the improved programme management and service delivery.

The NRHM would also require a comprehensive plan for training at all levels. The States would closely review its training infrastructure and identify the investment required so that effective HRD is put in place.

Drug supplies and logistics management

Timely supply of drugs of good quality which involves procurement as well as logistics management is of critical importance in any health system. The GoMP has recently issued its Drug Policy wherein the State plans to institute a system of drug supplies and logistics management on the lines of Tamil Nadu. The State would also seek to build capacity so that it may effectively take up scale procurement of goods and services.

Monitoring / Accountability Framework

The NRHM proposes an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal monitoring. Facility and Household Survey, NFHS-II, RHS (2002) would act as the baseline for the mission against which the progress would be measured.

While the process of communitization of the health institutions itself would bring in accountability, the NRHM would help this process by wide dissemination of the results of the surveys in a language and manner which could be understood by the general population. It would be made compulsory for all the health institutions to prominently display information regarding grants received, medicines and vaccines in stock, services provided to the patients, user charges to be paid (if any) etc, as envisaged in the Right to Information Act. The community as well as the Rogi Kalyan Samitis would be expected to monitor the performance of the health facilities on those parameters. Health Monitoring and Planning Committees would be formed at PHC, Block, District and State levels to ensure regular community based monitoring of activities at respective levels, along with facilitating relevant inputs for planning. Organization of periodic Public Hearings or dialogues would strengthen the direct accountability of the Health system to the community and beneficiaries. The State Health Society/Mission will also monitor progress periodically. Both at State and district levels, Public Reports on Health would be published to report to the community at large on progress made. The State would involve NGOs, resource institutions and local communities in developing this monitoring arrangement. The Mentoring Group on ASHA, the National Advisory Committee on Community Action (which have been constituted with the leading

NGOs as their members) and the Regional Resource Centres would provide valuable inputs to the Mission. A wide network of MNGOs, FNGOs / SNGOs would also be providing feedback to the Mission.

The periodic external, household and facility surveys would track the effectiveness of the various activities under the NRHM for providing quality health services.

The requirements of audit will apply to all NRHM activities. The State and District Health Missions will be subject to annual audit by the CAG as well as by a Chartered Accountant and any special audit that the GoI may specify. Special audit by agencies like the Indian Public Auditors of India could also be undertaken. All procedures of government regarding financial grants including Utilization Certificates etc. would apply to the State and District Health Societies.

For the accountability framework to be truly community-owned, the effort will be to ensure that at least 70 percent of the total NRHM expenditures are made by institutions and organizations that are being supervised by an institutional PRI/community group.

Monitoring outcomes of the Mission

- Right to health is recognized as inalienable right of all citizens as brought out by the relevant rulings of the Supreme Court as well as the International Conventions to which India is a signatory. As rights convey entitlement to the citizens, these rights are to be incorporated in the monitoring framework of the Mission. Therefore, providing basic Health services to all the citizens as guaranteed entitlements will be attempted under the NRHM.
- The village health records would be maintained and updated by village health and sanitation committees. These records would form the basis for development and the implementation of respective village health plans.
- Periodic Health Facility Survey at SHC, PHC, CHC, District level to see if service guarantees are being honored. [By district /Block level Mission Teams/ research and resource institutions].
- Formation of Health Monitoring and Planning Committees at PHC, Block, District and State levels to ensure regular monitoring of activities at respective levels, along with facilitating relevant inputs for planning.
- Sharing of all data and discussion at habitation/ village level to ensure full transparency.

- Display of agreed service guarantees at health facilities, details of human and financial resources available to the facility.
- Sample household and facility surveys by external research organizations/NGOs.
- Public reporting of household and health facility findings and its wider dissemination through public hearings and formal reporting.

Convergence within the Health Department

Special programmes have been initiated as per need for diseases like TB, Malaria, Filariasis, HIV/AIDS etc. While the disease specific focus has helped in providing concerted attention to the issue, the weak or absence of integration with other health programmes has often led to lack of coordination and convergent action. All central programmes have worked on the assumption that there is a credible and functional public health system at all levels in all parts of the country. In practice, however, the public health system has not been in a satisfactory state. The challenge of NRHM, therefore, is to strengthen the public health institutions like SHC/PHC/CHC/Sub Divisional and District Hospitals. This will have positive consequences for all health programmes. Whether it is HIV/AIDS, TB, Malaria or any other disease, NRHM attempts to bring all of them within the umbrella of a Village/District/State Health Plan so that preventive, promotive and curative aspects are well integrated at all levels. The intention of convergence within the Health Department is also to reorganize human resources in a more effective and efficient way under the umbrella of the common District Health Society. Such integration within the Health Department would make available more human resources with the same financial allocations. It would also promote more effective interventions for health care.

The pandemic of HIV/AIDS requires convergent action within the health system. By involving health facilities in the programme at all stages, it is likely to help early detection, effective surveillance and timely intervention wherever required. The NACO has presence only from district level upwards. The NRHM would enable the NACO to provide necessary investment and support to the programme at district and sub district levels. NACO will provide Counselors at CHCs and PHCs along with testing kits as part of the NACP-III. It would also help to integrate training on HIV/AIDS to ASHA, ANMs, LHVs, para-medicals, lab technicians and medical officers. Common programmes for condom promotion and IEC are also planned. NRHM seeks to improve outreach of health services for common people through

convergent action involving all health sector interventions. The RTI / STI management services will be strengthened at PHCs by ensuring availability of testing and counseling services on identified PHCs and appropriate behaviour change communication interventions for adoption of healthy practices and life styles.

Convergence with other departments

The indicators of health depend as much on drinking water, female literacy, nutrition, early childhood development, sanitation, women's empowerment etc. as they do on hospitals and functional health systems. Realizing the importance of wider determinants of health, NRHM seeks to adopt a convergent approach for intervention under the umbrella of the district plan. The Anganwadi Centre under the ICDS at the village level will be the principal hub for health action. Likewise, wherever village committees have been effectively constituted for drinking water, sanitation, ICDS etc. NRHM will attempt to move towards one common Village Health Committee covering all these activities. Panchayati Raj institutions will be fully involved in this convergent approach so that the gains of integrated action can be reflected in District Plans. While substantial spending in each of these sectors will be by the concerned Department, the Village Health Plan/District Plan will provide an opportunity for some catalytic resources for convergent action. NRHM household surveys through ASHA, AWW will target availability of drinking water, firewood, livelihood, sanitation and other issues in order to allow a framework for effective convergent action in the Village Health Plans.

The success of convergent action would depend on the quality of the district planning process. In MP, the District Health Action Plans reflect integrated action in all section that determine good health – drinking water, sanitation, women's empowerment, adolescent health, education, female literacy, early child development, nutrition, gender and social equality. At the time of appraisal of District Health Plan, care would be taken to ensure that the entire range of wider determinants of health have been taken care of in the approach to convergent action.

Role of Non Governmental Organizations

The Non-governmental Organizations are critical for the success of NRHM. With the mother NGO programme scheme, 24 MNGOs covering 37 districts have

already been appointed. Their services are being utilized under the RCH-II programme. The Disease Control programmes, the RCH-II, the immunization and pulse polio programme, the JSY make use of partnerships of variety of NGOs. Efforts are being made to involve NGOs at all levels of the health delivery system. Besides advocacy, NGOs would be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, developing innovative approaches to health care delivery for marginalized sections or in underserved areas and aspects, working together with community organizations and Panchayati Raj institutions, and contributing to monitoring the right to health care and service guarantees from the public health institutions. The effort will be to support/ facilitate action by NGO networks of NGOs in the State which would contribute to the sustainability of innovations and community participation in the NRHM.

Grants-in-aid systems for NGOs will be established at the District and State levels to ensure their full participation in the Mission.

Risk pooling and the poor

While setting up of effective health insurance system is clearly a very important mission goal, it is realized that the introduction of such a system without the back up of a strong preventive health system and curative public health infrastructure would not be cost effective. Such a venture would only end up subsidizing private hospitals and lead to escalation of demand for high cost curative health care. The first priority of the Mission is therefore to put the enabling public health infrastructure in place.

While the public and private insurance companies would be encouraged to bring in innovative insurance products, the Mission would strive to set up a risk pooling system where the State and the local community would be partners. This could be done by resource sharing, facility mapping, setting standards, establishing standard treatment protocols and costs, and accreditation of facilities in the non-governmental sector.

Primary health care would be made accessible to all. However, in the case of need for hospitalization, CHCs would be the first referral unit. Only when the CHC is not in a position to provide specialized treatment, a patient would be referred to an accredited private facility/teaching hospital. The BPL patients would have the choice of selecting any provider out of the list of accredited hospitals as provided

under various schemes of GoMP. Reimbursement for the services would be made to the hospitals based on the standard costs for various interventions decided by the experts from time to time.

It is envisaged that the hospital care system would progressively move towards a fully funded universal social health insurance scheme. Under such a system, the government facilities would also be expected to earn their entire requirement of recurring expenditure including the salary support out of the procedures they perform, while taking care that access to those who cannot pay is not compromised. This system would obviously work only when the personnel working in the CHCs are not part of a state cadre but are recruited locally at the district level by the District Health Mission on contract basis. Since evolving such a system is likely to take some time, it is proposed that the RKSs take greater charge of day-to-day management of the health institutions for improving the quality of care.

Reforms in Medical / Nursing Education

The medical / para medical education system would require a new orientation to achieve these objectives. While the existing colleges would require strengthening for increased seat capacity, a conscious policy decision would be required to promote new colleges in deficient states. A fresh look also needs to be given on the norms for setting up new medical colleges under the regulations framed under Indian Medical Council Act to see whether any relaxation is necessary for such areas. The viability of using the caseload at district hospital for setting up Govt. / private medical colleges would also be examined. Apart from creating teaching infrastructure at the district level, it would also promote much needed investment and improvement in tertiary care in the district hospitals.

The curriculum in the Medical Colleges perhaps gives undue emphasis on specialization and tertiary care which is available only in large cities. In the syllabus, the primary health care as well as preventive aspects of health are largely ignored. It is therefore natural for the students to aspire for a career in a big hospital in urban setting. In the process the health care in the rural areas suffers. The Mission would look at ways and means to correct the situation.

The NRHM also recognizes the need for equipping medical colleges and other suitable tertiary care centres – including select district hospitals, select not for profit hospitals and public sector undertaking run hospitals for a variety of special

courses to train medical officers in short term courses to handle a large number of essential specialist functions in those states where medical colleges and postgraduate courses are below recommended norms. This includes courses from multi skilling serving Medical Officers, especially for anesthesia, emergency obstetrics, emergency pediatrics especially new born care, safe MTP services, mental health, eye care, trauma care etc. Further short-term programmes are needed to upgrade skills of nurses and ANMs to that of nurse-practitioners for those centres/regions which potentially have adequate nurses, but a chronic shortage of doctors over at least two decades.

The Mission would continue to support strengthening of Nursing Colleges wherever required, as the demand for ANMs and Staff Nurses and their development is likely to increase significantly. This would be done on the basis of need assessment, identification of possible partners for building capacities in the governmental and non governmental sectors in each of the States/UTs, and ways of financing such support in a sustainable way. Special attention would be given to setting up ANM training centres in tribal blocks which are currently para-medically underserved by linking up with higher secondary schools and existing nursing institutions.

Efforts to improve skills of Registered Medical Practitioners would also be introduced. The NRHM recognizes the need for universal continuing medical education programmes, which are flexible and non-threatening to the medical community, but which ensures that they keep abreast of medical advances, and have access to unbiased medical knowledge, and adequate opportunity to refresh and continuously upgrade existing knowledge and skills.

Pro-people partnerships with the non-governmental sector

The Non-governmental sector accounts for nearly 4/5 of health expenditure in India. In the absence of an effective Public Health System, many households seek health care from the Non-governmental / organized private sector also. A variety of partnership modes are proposed to be undertaken by the State.

Public Private Partnerships would be evolved, modeled and operationalized with the objective of expanding the service base so that access to under-served and under-reach population may be ensured. A system of accreditation would be evolved to ensure quality and service responsiveness amongst these partnerships.

The other model pertains to working in close collaboration with professional bodies such as IMA, FOGSI, IAP and IPHA. The idea behind this partnership is to focus on the development and sustenance of best practices and observance of standard treatment protocols. These bodies would also be involved in capacity building of service providers both in public and private sectors.

The third model of partnership pertains to deriving coordinated technical assistance from development partners with a view to refining programme planning, implementation, monitoring and evaluation of various programme interventions as envisaged under NRHM. Further, representatives of these development partners would also be the members of various committees / bodies so that the decision-making functions may be appropriately facilitated.

6. CORE STRATEGIES AND PROGRAMME IMPLEMENTATION PLAN

1. Selection and Training of ASHA

The NRHM envisages that every village/large habitat will have a female Accredited Social Health Activist (ASHA) chosen by and accountable to the Panchayat to act as the interface between the community and the public health system. The States have been given freedom to determine state-specific model in operationalizing this bridge between the ANM and the village community through the Panchayat.

Functioning as an honorary and a volunteer worker, she would be granted a performance-based compensation for promoting universal immunization, referral transport and escort services under RCH II, construction of household toilets and other healthcare delivery programmes.

At the national level, Standing Mentoring Group supports the design of training of these ASHA workers. The emphasis of this training is on best practices in public health that are to be steered through the network of community-based health resource organizations.

The ASHA workers would play a central role in facilitating the development of Village Health Plan, working in close conjunction with the Anganwadi Workers (AWWs), ANM, local level functionaries of other departments and in particular the Self-Help Groups towards centrestaging the health agenda for the health committee of the Gram Panchayat and, in reference to the State of Madhya Pradesh, she would be the catalyzing resource for the Development Committee of the Gram Sabha.

The GoI will bear the cost of training, incentives and the drug kits and the remaining activities would be covered under the financial envelope given to the States by the GoI. The drug kit will include generic medicines under allopathic and AYUSH for treating common ailments.

The following activities constitute the Programme Implementation Plan for this component:

- Development and issuance of guidelines for selection and appointment of ASHA workers and determination of district-wise number of required ASHA Workers.
- Identification of ASHA Workers.
- District level orientation workshops for BMOs, Facilitators, PRIs and NGOs.
- Identification of ASHA Workers through the Facilitators.
- Training of State Level master trainers
- Training of District Level master trainers
- Training of Block level master Trainers
- Training of ASHA Workers
- Supply of drug kits for treatment of common ailments
- Performance based incentive for ASHA Workers
- Establishment of work routines for ASHA workers

Out of the total 43913 ASHAs in the State, 40 percent ASHA workers will be selected in the year 2006, 70% by 2007 and 100% by 2008. The training of 40% ASHAs will be completed by the year 2007, 80% by year 2008 and 100% by year 2009. It is proposed that their selection would be facilitated through 10 Facilitators in each of the 313 blocks. The process of facilitation would be supported by 10 accredited mother NGOs through the active involvement of Gram Panchayats and Gram Sabhas. The guidelines have been issued vide a government order and the process of identification and selection of ASHA Workers has been initiated.

2. Village Health and Sanitation Committee constituted in all 52143 inhabited villages and untied grants provided to them

Under this activity, Gram Sabhas shall be called upon to constitute Village Health & Sanitation Committees. These committees shall steer the preparation of Village Health & Sanitation Plans.

Each village and community participating in a Village Health Plan initiative needs to establish a committee at the local level. Such committees are essential for broad approaches to health improvement that involve a wide range of activities and individuals. A committee can coordinate and support the different activities, provide leadership for the community and can serve as the community contact point with local and district government functionaries under the NRHM programme. These committees can also facilitate broad community

participation in the programme, something that may be difficult to achieve by outsiders. Local committees are therefore crucial for promoting the village health approach in a community.

The composition of a local committee is crucial for a successful outcome. Committee members should be such people who are respected, are able to represent the interests of all sections of the community. It is also helpful if ANM/MPW/ASHA/Anganwadi Workers and such local staff from the development department of the government are also included as members of the committee.

The committee should be accountable and transparent both to the community and to local government or NGOs that may provide support. The committee should take minutes of all meetings, record the decisions made and make sure that the community members have access to this information. A regular feedback mechanism to the Gram Sabha should also be established, along with a broader debate by the community about major activities and issues. Since the committee would be managing untied funds, accounts will need to be kept and made available to other community members and external support agencies. To do this, the committee should elect executive officers, such as a chairperson, treasurer and secretary, and meet regularly.

Some of these committee members may also be on the committees at Sub Health Centre/PHC/CHC levels. Both in individual capacities as well as through the Village Health & Sanitation Committees, these community representatives shall have an interface with the field functionaries of government and receive technical support and guidance from them. Essentially, the primary roles of the Village Health & Sanitation Committees may be summarized as follows:

- Disseminate, encourage and empower the community with regard to knowledge and skills required to keep it healthy by addressing its health seeking behavior outcomes.
- Generate community demand for health care services.
- Act as social monitors on quality and appropriateness of health care services.

There are 52143 inhabited villages in the State. It is proposed to gradually build up this village level institution, beginning with a sample coverage of 3% (1565

villages) by year 2007 and thereafter increasing to 25% (13035 villages) by year 2008, 50% (26071 villages) by year 2010 and 100% (52143 villages) by year 2012.

The activities to the run up to the operationalisation of Village Health & Sanitation Committees would include the following stages:

- Development of guidelines
- Orientation of district, block and Janpad Panchayats and corresponding government functionaries from the departments of health, women & child development, public health engineering and Panchayats and rural development.
- Identifying and orienting facilitators for organizing and leading village level consultative processes.
- Election of members to the Village Health & Sanitation Committees
- Development of Village Health & Sanitation Plans by the Village Health & Sanitation Committees.
- Approval of Village Health & Sanitation Plans by respective Gram Sabhas.
- Implementation and monitoring of village plans.

These village health and sanitation committees would be provided with an untied grant of Rs. 10,000/- per year which would be used for developing the village health plans and carrying-out the approved activities therein.

3. Strengthening of Sub Health Centers

National Rural Health Mission proposes to provide to each Sub Health Center a sum of Rs. 10,000/- as an untied fund to facilitate meeting urgent yet discreet activities that need relatively small sums of money. For this purpose a fund will be kept in a joint bank account of ANM and Sarpanch. This fund will be utilized and spent on the activities approved by Village Health Committee and administered by Auxiliary Nurse Midwife. In areas where the Sub Health Center is not coterminous with Gram Panchayat and Sub Health Center covers more than one Gram Panchayat, the Village Health Committee of the Gram Panchayat where the Sub Health Center is located will approve the action plan. However, the funds can be used for any of the villages, which are covered by the Sub Health Center. The untied funds could be used only for the commonly good and not individual needs except in case of referral and transport of emergency situations. The untied funds could be used for undertaking local

health activity as envisaged under the village health plan. The indicative purposes for which this fund could be used by the village health and sanitation committee would include but be not limited to the following:-

- Ad hoc payments for cleaning up Sub Health Center, especially after childbirth.
- Transport of emergencies to appropriate referral centers.
- Transport of samples during epidemics.
- Purchase of consumables such as bandages in Sub Health Center.
- Purchase of bleaching powder and disinfectants for use in common areas of the village.
- Labour and supplies for environmental sanitation, such as clearing or larvicidal measures for stagnant water.
- Payment / reward to ASHA for certain identified activities.

According to the NRHM guidelines it is clear that the untied funds cannot be used for payment of salaries, purchase of vehicle, to meet any recurring expenditure or to meet the expenses of Gram Panchayat.

The state of Madhya Pradesh has 8835 Sub Health Centers. A sum of Rs. 10,000/- will be allocated per Sub Health Centre in the district plan of each district. The CMHO of the district will be advised to transfer this fund to the ANMs with the instructions that this fund will be kept in a joint account of ANM and Sarpanch and will be administered and utilized by the ANM for the activities approved by Village Health Committee. The guidelines will include the directions for keeping the record and replenishment of this fund.

Likewise, every SHC will also get maintenance grant of Rs.10,000/- per year for undertaking infrastructure related need based maintenance.

The State has also decided to bring about communication connectivity with SHCs and accordingly telephones will be installed at each SHC. The telephone connections will be installed in 8835 SHCs during year 1 to year 3 and 1658 connections in year 4.

Out of the total 8835 SHCs in the State, 3253 SHCs are functioning from rented premises. In addition, as per 2001 population there is a shortfall of 1658 SHCs. Thus in all 4911 SHC buildings are required to be constructed during the NRHM programme period. The State proposes to construct 200 SHCs in year 1, 1000 SHCs in year 2 and 3711 SHCs in year 3 as per the latest guidelines of Gol.

As provided under NRHM guidelines, services of second ANM would be made available at each SHC by appointing additional ANM on contractual basis. This would ensure that the SHC will always be open for serving the clients. It is proposed that during year 1, 600 ANMs will be appointed, 1600 in year 2, 2000 in year 3, 3000 in year 4 and 3293 in year 5.

4. Strengthening of PHCs

Every PHC will get an untied grant of Rs.25,000/- for undertaking planned local health activity. Likewise each PHC will receive annual maintenance grant of Rs. 50,000/- as provided under NRHM guidelines of the Gol.

There is a shortfall of 450 PHCs as per 2001 population. These PHCs will be constructed during the NRHM programme period. It is proposed to construct 100 PHCs in year 2, 150 PHCs in year 3 and 200 PHCs in year 4.

5. Strengthening of CHCs

Every CHC will get an untied grant of Rs.50,000/- for undertaking planned local health activity. Likewise each CHC will receive annual maintenance grant of Rs. 1,00,000/- per year as provided under NRHM guidelines of the Gol.

There is a shortfall of 120 CHCs as per 2001 population. These CHCs will be constructed during the programme period. It is proposed that construction of 60 CHCs will be undertaken in year 2 and year 3 respectively.

The State has also identified two CHCs per district for up-gradation to meet IPHS criteria. The remaining CHCs will be upgraded to meet IPHS in phased manner during the NRHM programme period.

Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per one lakh population for improved curative care to a normative standard,

Indian Public Health Standards (IPHS) which defines personnel, equipments and management standards: The Community Health Centres were designed to function as institutions to provide secondary level of health care to the rural population. The state has 227 Community Health Centers. However, most of these are not fulfilling their envisaged tasks. The National Rural Health Mission has developed Indian Public Health Standards to ensure that the Community Health Centers are able to provide good quality specialist health care to the rural population. These standards describe the services that should be available at Community Health Center. It includes routine and emergency care in surgery, medicine, obstetric and gynecology and pediatrics and all the National Health Programmes. These standards also prescribe the standards for support services at CHC level. The minimum requirements in terms of staff, skills, equipment, drugs, investigated facilities, physical infrastructure including electricity, telephone, water and sanitation have been prescribed.

The state has decided that a minimum of 2 Community Health Centers per district will be identified for strengthening to meet IPHS in the year 2006 and remaining Community Health Centers by year 2007.

The state has identified the gaps in human resource and skills. A process of recruitment of specialists, Medical Officers and nursing staff on contractual basis has been initiated. It is proposed that specialists in gyne. and obstetric, anesthesia and pediatrics will be hired on contract basis on a fixed emolument of Rs. 18000/- per month. In addition a provision has been made to pay an incentive of upto Rs. 10000/- per month based on performance. The Medical Officers and nursing staff will also be hired on contract basis. The skill gaps in existing staff and newly recruited staff will be addressed by offering in-service training.

The earlier experience of the state indicates that despite offering higher remuneration and incentives specialists in gynecology and obstetric and anesthesia do not join public services particularly in less developed areas. To overcome this problem it is also proposed that Medical Officers will be trained for a longer duration (4-6 months) in anesthesia, pediatrics and gynecology. These Medical Officers after successful completion of training in the medical colleges of the states will be posted in CEmONC facilities till qualified specialists in these specialties are not available.

A facility survey of all CEmONC institutions have been undertaken to identify the infrastructure gaps and assess the need for equipments and drugs. Based on the findings this survey necessary maintenance, repair renovation work will be undertaken to improve the infrastructure. The availability of running water and power will be ensured by providing a genset. The necessary equipments, drug and supplies as per IPHS will be ensured at all CEmONC facilities.

The blood bank at District Hospitals and blood storage facilities at other CEmONC facilities will be developed or strengthened. The guidelines for blood storage units prepared by MOHFW, GoI will be followed.

The hospital waste management system will be strengthened in each hospital using the national guidelines on hospital waste management, which are based on the bio-medical waste (management and handling) rules 1998. Accordingly, the Infection Management and Environment Plan (IMEP) guidelines of GoI would be followed by each institution. The staff involved in collection segregation, transportation, treatment and disposal of hospital waste will be trained and provided adequate safety equipments.

6. Mainstreaming of AYUSH Systems in the National Health Care Delivery System

The term AYUSH covers Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy. These systems are popular in a large number of States in the country. The Ayurveda system is popular mostly in the States of Kerala, Himachal Pradesh, Gujarat, Karnataka, Madhya Pradesh, Rajasthan, Uttar Pradesh and Orissa. The Unani system is particularly popular in Andhra Pradesh, Karnataka, Tamil Nadu, Bihar, Maharashtra, Madhya Pradesh, Uttar Pradesh, Delhi and Rajasthan. The Siddha system is widely acceptable in Tamil Nadu and Kerala. The Homeopathy is practiced all over the country but primarily popular in Uttar Pradesh, Kerala, West Bengal, Orissa, Andhra Pradesh, Maharashtra, Punjab, Tamil Nadu, Bihar, Gujarat and North-Eastern States. This is to imply that the AYUSH systems of medicine and its practices are well accepted by the community, particularly, in rural areas. The medicines are easily available and prepared from locally available resources, economical and comparatively safe. With this background, the GoI has proposed to mainstream/integrate AYUSH systems in National Health Care Delivery System under "National Rural Health Mission (NRHM)".

Presently, there are 194 AYUSH Hospitals and dispensaries existing in the rural areas of the State. These include 8 hospitals and 186 AYUSH dispensaries.

For mainstreaming of AYUSH in NRHM, the personnel of AYUSH shall work under the same roof of the Health Infrastructure, i.e., PHC, CHC. However, separate space would be allocated exclusively for them in the same building. The Doctors under the Systems of AYUSH are required to practice as per the terms & conditions laid down for them by the appropriate Regulatory Authorities. Following provisions have been made under the NRHM:

- Provision of one Doctor of any of the AYUSH systems as per the local acceptability assisted by a Pharmacist in PHC.
- Provision of one Specialist of any of the AYUSH systems as per the local acceptability assisted by a Pharmacist in CHC.
- Supply of appropriate medicines pertaining of AYUSH systems.
- The already existing AYUSH infrastructure to be mobilized. AYUSH dispensaries *that are not functioning well* should be merged with the PHC or CHC barring which, displacement of AYUSH clinic is not advised.
- Cross referral between allopathic and AYUSH streams shall be encouraged based on the need for the same.
- AYUSH Doctors shall be involved in IEC, health promotion and also supervisory activities.

NRHM implementation guidelines provide integration of AYUSH with community health centers and district hospitals. The adequate space will be provided at CHCs and District Hospitals for the doctors of AYUSH and the drugs of AYUSH system will also be procured and arranged.

AYUSH has a wide network of practitioners in the State and it provides reliable, effective and economic alternative health services to the people. Considering the fact that AYUSH systems of medicine which include Ayurveda, Unani and Homeopathy are popular and acceptable to people, mainstreaming this system in the health care delivery could contribute better synergy and utilization of AYUSH practitioners in the State. NRHM envisages for mainstreaming of AYUSH in health care delivery system of the State. There are 17 district level ayurvedic hospitals located at Bhopal, Hoshangabad, Betul, Shivpuri, Morena,

Mandla, Khargone, Jhabua, Dhar, Ratlam, Mandsaur, Sagar, Damoh, Chhatarpur, Sidhi, Shahdol and Satna. There are four ayurvedic hospitals at tehsil level at Rau (Indore), Tamia (Chhindwara), Beihar (Balaghat) and Lakhnadoan (Seoni) and two homeopathy hospitals at Navegaon Sanitorium (Chhindwara) and Pithampur (Dhar), in addition to these institutions there are 1427 single doctor ayurvedic dispensaries of which 61 are urban and 1366 are rural. Likewise there are 50 Unani dispensaries, of which 27 are located in urban area and 23 are located in rural area. There are 146 single doctor dispensaries of which 64 are in urban areas and 82 in rural areas.

NRHM guidelines provide that each Community Health Center must provide adequate space for AYUSH practitioners and also make provisions for AYUSH medicines. In the State out of 265 CHCs only 28 CHCs have AYUSH doctors. It is proposed that 200 AYUSH doctors will be engaged on contract basis for CHCs / PHCs along with 200 Pharmacists. Adequate provisions will be made in the NRHM programme for AYUSH drugs and documentation of traditional practices, promoting healthy life styles and other related activities.

7. Support to Rogi Kalyan Samitis for community management of hospitals and annual maintenance of the facilities

The National Rural Health Mission guidelines provide a corpus grant for hospital management societies. It is proposed that a sum of Rs. 5 Lakhs per district hospital, Rs.1 lakh each per Civil Hospital, CHC and PHC will be provided as an incentive formation and operationalisation of hospital management societies. It is envisaged that the hospital management societies will promote social audit for provision of quality health services and will contribute to creation of a fund at the facility level through levy of user charges on the services available at the institution.

Madhya Pradesh is one of the pioneering states where hospital management societies (Rogi Kalyan Samitis) were established and operationalized at all health institutions up to the level of primary health centres. To take advantage of the scheme of MOHFW, GoI of providing corpus grant for hospital management societies all CHCs, sub-district hospitals and district hospitals where the Rogi Kalyan Samitis have been registered and are operational, will be eligible for this grant.

8. Mobile Medical Units

NRHM guidelines propose that one Mobile Medical Unit will be provided in each district to improve outreach of services.

The state had been using mobile medical services to increase the reach of medical and health services to inaccessible areas and disadvantaged population groups. The state launched a scheme called Jeewan Jyoti Yojana in 1988-89 with the assistance from Govt. of India to provide mobile medical services in tribal areas on Hat-Bazaar days. Under this scheme 39 mobile medical units were obtained and provided to the districts. Later in the year 2003 10 mobile health units were provided 2 per district in 5 IPDP districts namely Chhatarpur, Panna, Rewa, Satna and Sidhi. These mobile health units were equipped with generator, inverter, minor OT with OT table and lights, oxygen cylinder and facilities for running water. These mobile health units had facilities for examining patients and conducting minor surgical interventions. The experience of the state of using mobile medical units and mobile health units for providing medical and health services in unreached areas had been a mix one. Organizing health services through mobile medical / health units requires intensive management inputs and sustained provisions for POL, maintenance and availability of staff and provisions for drugs. Considering the constraints faced by the state and learning from previous experiences this time the state proposes to involve private sector in running mobile medical / health units in the state.

The mobile medical / health units will be run in all 48 districts. For this purpose one mobile health unit with diagnostic facilities and a staff vehicle per district will be procured as per the guidelines of NRHM.

The mobile health units will be used to improve the access and availability of health services in remote and difficult reach areas. These units will be run through RKS / NGOs / Public Private Partnerships. Appropriate budget provisions as per the guidelines for recurring expenditure have been made in the proposal.

9. Preparation of District Health Action Plan

The NRHM provides for an allocation of Rs.20 lakhs per district for preparation of District Health Action Plans. The amount can be used for surveys,

workshops, studies, consultations, orientation in the process for preparation of District Health Action Plans.

The State has already instituted the mechanism and process for preparation of district plans since year 2004. Going by the experiences of the recently concluded appraisal of 48 districts' action plans, the State plans to institutionalize the process of preparation of integrated district health action plans. Consequently, it is proposed that the planning for formulating the district plans for 2007-08 shall be initiated in the month of December 2006. The State intends to utilize the allocation for plan preparation in terms of the following:

- Enhancing capacities of programme managers at State, district and sub-district levels.
- Development and updation of district data sets.
- Development of computerized authoritative specifications for equipments, instruments and supplies.
- Development of computer-aided standard civil and architectural designs for building constructions.

10. Setting up State Health Systems Resource Centre

The NRHM provides an allocation of Rs. 1 Crore for this. The detailed ToRs on its functionality and its linkage with the State Government would be determined. The state proposes to establish the State Health Systems Resource Center to enable innovations and channelise coordinated technical assistance in the areas of strategic planning, technical assistance and operational support. The State desires that the UNFPA, being the assigned Development Partner for the state may be requested for creation, supporting and backstopping the SHSRC. The similar resource centers would be created at the district and block levels subsequently and the State Health Systems Resource Centre will function as an apex resource centre in the State.

11. Preparation of State and district public report on health

The NRHM provides for Rs. 2 lakhs for the State and Rs. 25,000/- per district for this activity. The respective reports would be generated based on a standardized format through outsourcing. Initially, it is proposed to prepare this report for 10 districts in year 1 and the State Report. From year 2 onwards the State Report and the District Reports for all the districts will be prepared on annual basis.

12. Strengthening of ANM Training Centers

The State has 27 ANM training centers with a capacity to train 1620 trainees. Considering the requirement of ANMs in the State, State needs to augment its training capacity. It is proposed that ANM training school will be created in all the districts of the State, for this 21 new training centers will be created. The existing 27 training institutions also need strengthening in terms of repair / renovation, extension, training equipments, furniture and other basic amenities. Out of 27 existing ANM training centers, 7 are running in rented and / or makeshift accommodation like DTC, District Hospital and CHC, which are inadequate for the purpose of training. Therefore it is proposed that buildings for 28 ANM training schools are constructed and equipped. Each ANM Training School will be provided with mobility support for transporting trainees to the attached hospital and community for training purpose.

13. Enhancing Training Capacity for Training ANMs through Public Private Partnership

There is a wide gap between the demand of trained ANMs and the available capacity in the public sector in the State. Even after setting up new ANM training centres in remaining 19 districts the gap between demand and supply will continue to exist. To further enhance the training capacity, the State proposes to promote public private partnership. Upto 10 ANM training schools will be supported for three consecutive batches of ANM training.

14. Strengthening of LHV Training Centres

There are two LHV training centres in the State. These centres need strengthening in terms of repair / renovation, maintenance of the building and training equipments and upgrading library facilities. For this purpose it is proposed to provide Rs. 50,000/- each during year 1, Rs. 2.5 Lakhs each during year 2 and Rs. 2 Lakhs each in year 3.

15. Strengthening of Nursing Training Schools

There are 11 Nursing Schools in the State.

S.No.	Name of the Training Center	Capacity
1.	Hamidia Hospital, Bhopal	35
2.	M.Y. Hospital, Indore	41
3.	J.A. Hospital, Gwalior	41

4.	Medical College Hospital, Jabalpur	47
5.	G.M. Hospital, Rewa	32
6.	Victoria Hospital, Jabalpur	25
7.	District Hospital, Chhindwara	10
8.	District Hospital, Ujjain	17
9.	District Hospital, Khandwa	10
10.	District Hospital, Sagar	10
11.	District Hospital, Ratlam	10
	Total	278

These nursing schools needs strengthening in terms of repair / renovation, extension, equipments and basic amenities. In the year 1 a need assessment study will be undertaken. Based on the study findings the strengthening activities will be undertaken during year 2 and year 3 for which a sum of Rs. 2 Lakhs per Nursing School will be provided respectively except for the nursing schools in Jabalpur and Ujjain. For these nursing schools a separate has been received from Gol for upgrading them to Nursing Colleges.

16. Quality Assurance

A system of accreditation will be introduced on a pilot basis in two districts. The Quality Counsel of India will undertake this work. Based on the experience of this pilot a decision for up-scaling this intervention will be taken. All the districts will be covered under this programme in phased manner. This intervention will also be coordinated with timeline of strengthening health institutions under IPHS standards.

17. Health Melas

Swasthya Melas will be organized one per district and one at block level in all the districts. This way 48 district level and 265 block level health melas will be organized. For district health melas a sum of Rs. 5 Lakhs per mela and for block level melas Rs. One lakh per mela will be sanctioned. These melas will be organized every year from year 2 onwards.

18. Mobility Support for Block Medical Officers

Block Medical Officers need to conduct supervisory visits to the sub centers and primary health centers as well as maintain contact with PRIs. In order to facilitate their mobility, it is proposed to provide hired vehicle on a monthly basis

to all the Block Medical Officers. This will not only improve the monitoring and supervision of different national health programmes but will also help in promptly investigating disease outbreaks and organizing rapid response. A provision of Rs. 15,000/- per month per block is proposed. For the year 2006-07 a provision has been made for mobility support for 3 months only.

19. Health Insurance

19.1 Social Insurance

Recognizing that the poor are quite vulnerable to diseases, natural and other disasters, the State has considered it prudent to bring them under the net of social insurance. It is proposed to purchase an insurance cover for 45 Lakhs BPL families at a premium of Rs. 51/- per family per year, this insurance coverage will cover medical and surgical disease conditions.

19.2 Maternity Insurance

The State has introduced Vijaya Raje Janani Kalyan Beema Yojana from July 2006 with the objective promoting institutional deliveries amongst all BPL women. Both the response and uptake of the scheme has been very encouraging. The State has therefore decided to continue with the scheme so that its advantages may accrue to all pregnant women belonging to BPL. During the year 2006-07, Rs. 6 Crores has been paid to the insurance company as the initial installment of the premium from the DFID funded project. The balance amount of premium will be paid from the NRHM.

20. Supply of Essential Drugs for PHCs and CHC

The State provides a budget of Rs. 5,000/- per sub center, 1,00,000/- per PHC and 2,00,000/- per CHC per annum for procurement of drugs. To enhance the availability of all essential drugs and to ensure that all poor patients are provided free drugs, a need has been appreciated for augmenting this budget. An additional allocation of Rs. 10000/- per sub centre, Rs. 2 Lakhs per PHC and Rs. 4 Lakhs per CHC has been proposed.

21. Drug Stores

The State has drug stores at 28 districts out of the total 48 districts. The State has decided to introduce a centralized procurement and distribution system based on the Tamil Nadu Drug Corporation. In order to have smooth distribution and storage of drugs in all the districts it is proposed to construct

drug stores at remaining 20 districts. Cost of construction a drug store will be Rs. 40 Lakhs. The construction of the new drug stores will be undertaken in the year 2007-08.

The drug procurement cell of the Directorate will be strengthened with the introduction of e-procurement. A provision for covering the cost of setting of the office and its running cost has been made.

22. Facility Survey of CHCs / PHCs

It is proposed to undertake a facility survey of all 48 district hospitals, 54 civil hospitals, 127 CEmONC and 500 BEmONC institutions and non-BEmONC PHCs to identify gaps and infrastructure, repair / renovation requirements, gaps in human resource and equipments. The study will cost approximately Rs. 1.5 crores for district hospitals, Rs. One crore for civil hospitals, Rs. 2.54 crores for CHCs and Rs. 5 crores for PHCs. It is proposed that during 2006-07 the facility survey will be conducted for 2 district hospital, 5 civil hospitals, 12 CHCs and 50 PHCs, during year 2 for 46 district hospitals, 49 civil hospitals, 115 CHCs and 450 PHCs.

23. Research and Evaluation

Role of operations research needs to be optimized for improving programme performance as well as for improving the quality of programme implementation and monitoring. The State would establish an Operations Research Cell, which will coordinate all operational researches and maintain a catalogued documentation. This cell would be appropriately manned with requisite professionals having expertise in public and related disciplines including research methodology. The State would also seek to strengthen monitoring and evaluation system so that effective HMIS is put in place. In addition, the state proposes to develop and document best practices so that the programme implementers can benchmark their performances. The state Government would also specifically include E-governance and telemedicine in its operations research agenda. The detailed work plan would be developed to address these initiatives.

The Cell would specifically undertake a pilot project on prevention of anemia among tribal women. This project would seek to meet the IFA supplementation

needs of seven lakhs pregnant women and lactating mothers across 89 tribal blocks through consumption of double fortified common salt. Baseline and endline surveys will be conducted to determine the performance of the intervention.

It is also proposed to commission a series of studies, both short term and long term in order to continually assess maternal health outcomes. Towards this end process indicators captured through institution based MIS would be analyzed and interpreted through such analytical studies. The appropriate TORs shall be developed for these studies and an amount of Rs. 1.5 crores shall be kept apart for remitting to the individual experts / agencies who are assigned these studies.

In addition, the other activities under research and evaluation would include developing and instituting e-governance, HMIS and Tele-Medicine.

24. Networking with NGOs and Professional Organizations

With a view to strengthening grass root level advocacy as well as availability of health care services, the State proposes to strengthen the network of NGOs in health and allied sectors. These NGOs would include all such non-government organizations whether they are new or old and they may be functioning as voluntary organizations (VOs), community based organizations (CBOs) and such other civil society organizations (CSOs). It is important here to underline the fact that when it comes to NGOs, it would not be necessary for them to be registered organizations, *per se*. What is more important in the proposed networking of civil society organizations to bring about synergistic action amongst them so that effective advocacy in health and allied sectors can become more pronounced. The efforts will be made to identify such purposive organizations / movements (like White Ribbon Alliance for Safe Motherhood, Breastfeeding Promotion Network of India etc.). However, social clubs like rotaries, lions, inner-wheel club etc. would not be considered as NGOs for this purpose. The professional organizations like FOGSI, IMA, IPA, IPHA, IAPSM, Private Practitioners' Association etc. would be having primacy in their roles in this networking.

25 Addition of Gyne. And Pediatric Ward in District Hospitals

Institutional deliveries have registered a significant increase of 20% in last year as a result of various innovative schemes implemented in the State to promote institutional deliveries. It is expected that proportion of the institutional deliveries will increase to a level of 50% by next year. To meet the increased demand of institutional deliveries there is an urgent need for expansion of capacities of district hospitals especially terms of bed capacity in Gynec. and Pediatric Wards. It is proposed to add 20 beds in each speciality in each district hospital. During the year 1, the expansion work will be undertaken in 5 districts and in year all district hospitals will be covered. The recurring expenditure on the enhanced bed capacity will be borne by the State from its own sources and / or different other programmes.

26 Behavioural Change Communication (BCC)

Behavioural change communication is an important thrust area under NRHM. The State intends to determine behavioural change communication needs of the community on different thematic areas apart from identifying and supporting the specific communication roles which different committees are required to play at different levels of governance. Following the identification of BCC needs, district and region specific communication plans for different audience segments would be developed and implemented. It is also a perceived need that the tenets of NRHM require to be widely disseminated. For this purpose, both at the block as well as district levels, intensive programme communication drive would be carried-out by way of workshops for different stakeholders.

27 Capacity Building of PRIs

The PRIs constitute the third-tier of governance and have crucial roles in surveillance in public health system in mobilizing the community for positively altering its health seeking behaviour. Given the fact that these elected representatives are changed every five years, it is necessary to have a continuity of communication and dialogue with them so that they may effectively discharge their roles vis-à-vis the NRHM programme. The State has therefore determined to institute a continued initiative of capacity building of the PRIs at village, Gram Panchayat, Janpad Panchayat and Zila Panchayat levels. It is hoped that with this investment the PRIs would be able to play their designated roles in planning, implementation and monitoring of community health plans.

28. Support to FOGSI

RCH-II Programme guidelines provide that FOGSI will coordinate and organize training of medical officers in emergency obstetric care including caesarian sections. These trainings will be organized by FOGSI specialists for the MOs of both public and private institutions. To strengthen the training sites Rs. 40 Lakhs will be required. The training sites at two medical colleges will be developed and strengthened, one during 2006-07 and the other in 2007-08. One of these sites will be upgraded to the level of similar unit at CMC Vellore.

29. Strengthening Blood Banks

The State proposes to strengthen the management of State Blood Transfusion Council so that it may effectively play its mandated role. The requisite facilities including manpower on contract would be made available to the council's office which will be located in the Directorate of Health Services.

The State has 5 blood banks in the medical colleges, 36 blood banks in district hospitals and 50 blood banks in private sector. It is proposed to network these blood banks so as to optimize the availability of blood especially of rare groups. All the blood banks will be inter-connected through a network of computers and a special software will be developed. For this purpose Rs. 40 Lakhs will be required for developing software and training.

The five blood banks are providing blood components. The medical social workers (10) of these blood banks will be trained on donor motivation and social marketing by an agency 'Prathima Blood Center, Ahmedabad (Gujarat)'. It is a 15-day training. Cost of one training for 10 participants including training fee, TA/DA of participants and per diem is Rs. 1,27,500/-. This training will be done in a batch of 3 participants per training programme.

30. Creation of Disaster Management Cell

It has been decided that a state level Disaster Management Cell will be created in the Directorate of Health Services, Bhopal as per the guidelines of National Disaster Management Authority, this cell will formulate and implement state contingency plan to deal with disaster situations arising out of changes in climate, accidents, chemical and industrial hazards and geological and biological disasters. This Cell will also plan and manage the appropriate resource inventory and position identified emergency wards both in the public

as well as private hospitals. The initiative will also include constitution multi-disciplinary rapid response teams which will be duly trained in taking proactive as well as responsive steps in managing natural and man-made disasters. On the similar lines district level rapid response teams will also be created, trained and equipped. It involves the following:-

- Identification of appropriate physical space for the Cell, provision for its furnishing and procurement of communication equipments.
- The training of district and state level rapid response teams.
- Preparation of district and state level disaster preparedness plans which should include inventorization of resources and the logistics involved therein.
- Enabling structures for ensuring inter-sectoral coordination both at the state and district level.

31. School Health Programme

The school health programme will be further strengthened to provide regular health check-up and health care services for all school going children. Sick children suffering from common illness will be treated by the local institutions while sick children requiring higher level of care will be referred to secondary and tertiary care health institutions. Health education and improving the hygiene will be an important component of the programme.

32. Ambulance Services

It has been decided that two ambulances per District Hospital and one ambulance per Civil Hospital, CHC and PHC will be procured and provided to these institutions for being run through RKS / PPP mode. During the year 1, 48 ambulances for district hospitals, 50 ambulances for CHCs, 10 ambulances for civil hospitals will be procured. During the year 2, 48 ambulances will be procured for district hospitals, 216 ambulances for CHCs, 45 ambulances for civil hospitals and 383 ambulances for PHCs. During year 3, 769 ambulances will be procured for PHCs. Thus in all, 108 ambulances will be procured during 2006-07, 383 ambulances during 2007-08 and 769 ambulances during 2008-09. A provision has been made in the proposal for providing running cost for these ambulances @ Rs. 15000/- ambulance per month.

33. District Mental Health Programme

The prevalence of mental disorder is one of the major Mental Health Problem of the state as we know more than 2% of the population of the state suffers from serious mental disorder and another 15-20% of the population suffers from minor mental disorders. As per WHO, depression is the 4th leading cause of morbidity all over the world. Apart from this 30-40% of the patients who attend general OPD of various other clinical department require psychiatric consultation. Not only this, after delivery more than 50% of the women develop either depression or other psychiatric disorder. As regards school mental health, there are no facilities for early identification and treatment of various psychiatric disorders among children. As we know 15-20% children require psychiatric help. One percent of the population of the country is suffering from severe mental retardation. Drug addiction is another major mental health problem, which requires early intervention and treatment. There is no proper rehabilitation facility in the state of Madhya Pradesh for mentally ill patients including mentally retarded ones. As we know, psychiatric problems are quite common among old age people and they need better care. The magnitude of the problem is very high but the facilities are inadequate.

Each district of Madhya Pradesh must have mental health unit, which must be headed by a psychiatrist. Unit should have one psychiatrist, one psychologist, one psychiatric social worker and 10 beds for admission. District Hospitals should have needed infrastructure and staff as per norms. For proper investigation and treatment, EEG, ECT and psychological tests facilities should be provided in the district hospitals.

For meeting the demand of psychiatrists in the districts, the department of psychiatry in medical colleges should start teaching and training program of medical officers and P.G. (MD) in Psychiatry. Required technical assistance may be sourced from the department of psychiatry, NIMHANS Bangalore and AIIMS New Delhi. The State Government may recruit required staff on contract.

34. Convergence with MPSACS

Keeping in view the fact that presently National Aids Control Organization does not have sub-district institutional presence, it is proposed to institute appropriate strategies for bringing about integration between RCH and AIDS

Control Programme at sub-district levels. The proposed convergence will include the following activities:-

- Orientation training of ASHA workers in consultation with MPSACS
- Orientation of ASHA workers in consultation with MPSACS.
- Sensitization of ANMs, LHVs, Staff Nurses, Lab. Technicians and Medical Officers.

These activities will be undertaken in conjunction with programme implementation plan of MPSACS.

35. Strengthening Referral Services and Tertiary Care Units

The tertiary care health institutions play an important role in providing critical health care to women and children. The primary and secondary health institutions refer serious and complicated cases for further management. The current system of referral needs improvement and strengthening at the tertiary care level. To fulfill this objective it is proposed that all the 5 medical colleges will be strengthened appropriately during year 2 and year 5 of the programme.

36. NRHM Management

NRHM guidelines provide for 6% of the total budget to be utilized for programme management costs. It is proposed that the State would utilize these funds for creating and supporting appropriate management structures at State, district and block levels. It is also proposed that the management costs would also be used for defraying the costs towards recently created divisional level offices of Joint Directors apart from strengthening the offices of CMHOs and BMOs.

ABBREVIATIONS

AIIMS	All Indian Institute of Medical Science
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWW	Aanganwadi Worker
AYUSH	Ayurved Siddha and Homeopathy
BEmONC	Basic Emergency Obstetric Neonatal Care
BPL	Below Poverty Line
CBO	Community Based Organization
CEmONC	Comprehensive Emergency Obstetric Neonatal Care
CH	Civil Hospital
CHC	Community Health Centre
CMHO	Chief Medical and Health Officer
CMR	Child Mortality Rate
CSO	Civil Society Organization
DFID	Department for International Development
DH	District Hospital
DP	Development Partners
DTC	District Training Centre
EEG	Electro Encephalogram
FNGO	Field Non-Governmental Organization
FOGSI	Federation of Obstetric and
GOI	Government of India
HMIS	Health Management Information System
HRD	Human Resource Development
IAP	Indian Association of Pediatrics
IAPSM	Indian Association of Preventive and Social Medicine
ICDS	Integrated Child Development Scheme
ICRIER	Indian Council of Research
IEC	Information Education and Communication
IFA	Iron Folic Acid
IMA	Indian Medical Association
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPDP	Integrated Population and Development Project
IPHA	Indian Public Health Association
IPHS	Indian Public Health Standards
IUCD	Inter Uterine Contraceptive Devices
JSY	Janani Suraksha Yojana
LHV	Local Health Visitor
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MNGO	Mother Non-Governmental Organization
MOHFW	Ministry of Health and Family Welfare
MoU	Memorandum of Understanding
MP	Madhya Pradesh
MPSACS	Madhya Pradesh State AIDS Control Society
MPW	Multi-Purpose Worker
MTP	Medical Termination of Pregnancy

NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NCAER	National Council for Applied and Economic Research
NFHS	National Family Health Survey
NIMHANS	National Institute of Mental Health and Neuro Sciences
NMR	Neonatal Mortality Rate
OBC	Other Backward Class
OPD	Outdoor Patient Dispensary
PG	Post Graduate
PHC	Primary Health Centre
PHED	Public Health Engineering Department
PHPY	Prasav Hetu Parivahan Yojana
PIP	Programme Implementation Plan
PMU	Programme Management Unit
POL	Petrol Oil and Lubricant
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RHS	Rapid Household Survey
RKS	Rogi Kalyan Samiti
RMP	Registered Medical Practitioner
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendant
SC	Scheduled Caste
SHC	Sub Health Centre
SHSRC	State Health Systems Resource Centre
SNGO	Service Non-Governmental Organization
SPMU	State Programme Management Unit
ST	Scheduled Tribe
STI	Sexual Tract Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TT	Tetanus Toxoid
U5M	Under 5 Mortality
UIP	Universal Immunization Programme
UNFPA	United Nations Population Fund
UT	Union Territory
VHSC	Village Health and Sanitation Committee
VO	Voluntary Organization