



INNOVATIVE SCHEMES AND PROGRAMME INTERVENTIONS



UNDER NRHM
Government of Madhya Pradesh
Department of Public Health & Family Welfare, Bhopal



INNOVATIVE SCHEMES AND PROGRAMME INTERVENTIONS UNDER NRHM

**Government of Madhya Pradesh
Department of Public Health & Family Welfare,
Bhopal**

INDEX

MATERNAL HEALTH

1. Vijaya Raje Janani Kalyan Beema Yojana
2. Janani Express Yojana
3. Janani Sahyogi Yojana
4. Dhanwantari Block Development Scheme
5. Prasav Hetu Parivahan Evam Upachar Yojana

CHILD HEALTH

1. Alternate Vaccine Delivery System
2. Defaulter Tracking System
3. Bal Shakti Yojana

SCHEMES FOR BPL

1. Deendayal Mobile Hospital Scheme
2. Deendayal Antyoday Upachar Yojana
3. State Illnesses Fund - District Illnesses Fund

OTHERS

1. MCP (Mother & Child Protection Card)
2. Incentive Scheme for Health Worker (Female & Male) and Anganwadi Worker
3. Swawlamban Yojana
4. Prabha Kiran Training Scheme
5. NRHM - Management Information System
6. New Drug Procurement Policy - 2006
7. Mobility Support to Block MO's
8. HMIS (Bhopal Pilot)

INNOVATIONS UNDER MATERNAL HEALTH

VIJAYA RAJE JANANI KALYAN BIMA YOJNA

With a view to promote institutional deliveries and thereby reduced maternal mortality this insurance scheme has been started. As per RGI shows that it is 379 in 2003. The main reason for high maternal deaths is high proportion of home deliveries by unskilled birth attendant in rural areas of the state. The other reasons are low acceptance of ANC services and lack of timely identification of complications during the pregnancy.

The state has initiated many interventions and incentive schemes for promoting institutional deliveries to increase the ANC coverage in



the rural areas. In addition to above interventions and schemes, the state has adopted another innovative approach for promoting institutional deliveries as well as increasing ANC coverage, (on 12th May 2006 for a duration of one year.) The scheme is known as "**Vijaya Raje Janani Kalyan Bima Yojna**".

Beneficiary:

The scheme is applicable to all BPL women in the state. **Services:**

The beneficiary gets following services free of cost under this scheme

- ? Normal delivery in accredited private hospital
- ? Rs 1000 /- discount on Cesarean on prefixed price in private hospital
- ? Rs 1000 / - in case of institutional delivery in government hospital
- ? Compensation of Rs 50,000 /- in case of death during delivery or causes related to pregnancy and delivery.
- ? Expense of Abortion of more than 16 weeks upto maximum of Rs 1000 /-.

Implementing Agency:

The United India Insurance Co.Ltd is the implementing agency with the nodal

office at Bhopal. The agencies with its 100 field level offices are ensuring that the claims are settled in timely manner. The state office is responsible for issuing of the policy.

Premium:

The state government has borne the cost of premium of Rs 11 /- per BPL Family.

Delivery in Private Hospital:

The scheme is available in only those private hospitals which are accredited by the government and ANC card verifying at-least three ANC check ups is required to be produced by the beneficiary.

JANANI EXPRESS YOJNA

Purpose:

Provision of 24 hours transport availability at field level in order to bring the pregnant women to CEmONC & BEmONC facility.

Essential Features:

- * Transport is hired locally on contractual basis for a period of one year on the basis of out source criteria.
- * Transports which is hired must possess all the pre-decided technical criteria (such as vehicles should not be of more than two year old, must have all the relevant papers, and should have the availability of comprehensive insurance).
- * Transport is made available in the concerned area of Govt. Hospital, CHC, PHC or to some other appropriate place.
- * Amount paid for rent-
 - Up to 25 KM amount paid @ Rs.150/-
 - More than 25 KM, amount paid @ Rs. 250/-
- * To establish effective communication the contractual Driver should have Mobile Phone.
- * Maintenance of contractual vehicle is done regularly and in case of any accident, the vehicle should be repaired within 48 hours.
- * Rogi Kalyan Samitis play the key role in the all issues related with contractual vehicle.
- * There is also the provision of performance based incentives to the transport agency, if the revenue generated by revenue agency crossed the month fixed limit. As per rule, the amount paid is -
 - Up to 125% - Nothing
 - 125% to 150% - 25%
 - 150% to 200% - 35%
- * Monthly supervision is done by the ANM in their respective area to make it sure that the vehicle is made available one day prior to the date of delivery.



JANANI SAHYOGI YOJNA

(Partnership of Private and Non-government Hospitals in Delivering Safe Motherhood and Child Health Services)

Purpose

The scheme aims to increase availability of delivery and newborn care services through Private Service Providers for BPL families.

Essential Features

Private and Non-government Hospitals have been invited to render services in delivering safe motherhood and Child Health care to the families living Below Poverty Line under the Reproductive and Child Health Programme, Phase II. The criteria for selection of PSP are kept as follows:

Availability of gynaecologist, anesthetist and pediatrician

Minimum bed strength 20-30. For remotely located and inaccessible places, this may be accepted at 10-12 beds

Fully equipped and functional Operational Theater

Well-equipped labor room

Separate earmarked areas for care of newborn in delivery room and ward

A functional pathological laboratory where essential tests may be performed

24-hour availability of water

Availability of power for running Operation Theater, Labor Room and Cold Chain. Availability of inverter/generator for uninterrupted power supply

Telephone

Ambulance (owned or rented)

Blood storage facility (desirable)



The hospital interested to be accredited as PSP should have necessary equipments, specialists and medicines so that normal deliveries, C-sections, Medical termination of Pregnancies, Low Birth Weight/pre-term Newborn care may be adequately provided. In addition, the hospital should also have blood storage facility.

The accredited hospitals are remitted for the services as follows:

Delivery Services

Normal delivery	Rs. 800/-
MTP/Spontaneous Abortion	Rs. 300/-
C-Section	Rs. 4530/-
Blood Transfusion	Rs. 500/-

Newborn Care Services

Baby Warmer	Rs. 50/-per day
Phototherapy	Rs. 50/-per day
Pediatrician care	Rs. 50/-per day
LBW/pre-term newborn	Rs. 250/-per day

The application were submitted on prescribed format to the office of the Regional Joint Director following which a team of Department of Health conduct on at-site inspection of the health institution and accredit the ones that meet the mandatory and desirable criteria pertaining to availability of services, infrastructure, human resources, equipments and medicines.

DHANWANTARI BLOCK DEVELOPMENT SCHEME

Background

It is one of the most ambitious schemes of the state launched on 15th August 2005 to make it as a 'model 'of services in health sector. This scheme has been started with the vision of attaining the best management practices and effective implementation of existing different activities to ensure better health care to the women, children and marginalized people of the society.

Purpose

- To ensure best quality care health services to the women, children and under privileged section.
- To put sincere efforts to improve the healthy status for the children, women and needy.
- Make available of all the medical requirement/ services and make it reach to the last stakeholder.

Salient features

As an innovative initiation, it has been started in 50 blocks of the state on a pilot basis. A need was felt to approach holistically and integrate major activities in the form of package for under-served and under-privileged groups of society.

High performing teams are placed in the blocks and justifiable steps are taken to make them comfortable at their place of postings. Capacity building and orientation of

the personnel for commitment and positive attitude is ensured. To fill up the vacancies, a special recruitment drive is initiated. For strengthening the referral units, deputation system is adopted. Functionaries are fully equipped with upgraded study materials and literature, modern equipments etc.

The following 13 major health services are clubbed together:

- Full immunization
- Full Ante Natal care (ANC)
- All deliveries in institutions
- Full care of all malnourished children under Bal Sahkti Yojana
- Deendayal Cards for eligible families
- Extend full benefits of Janani Suraksha Yojana (JSY) and Prasav Hetu Parivahan evam UpcharYojna to all target facilities
- Ensuring of availability permanent and temporary methods of family planning to all qualified couples
- Making of depot holders for essential drugs and family planning methods
- Explain the usage of ORS to all families of the block
- Knowledge to identify the symptoms of pneumonia and due referral
- Health checkup for all school children
- Ensuring minimum age of 18 yrs for marriage of girl children
- Ensuring all the benefits availability to the poor patients in public health facilities.

PRASAV HETU PARIVAHAN EVAM UPCHAR YOJANA

In order to reduce the Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR) and to promote the institutional deliveries, the Government of Madhya Pradesh has started a scheme namely Prasav Hetu Parivahan Evam Upchar Yojana on 25 sept.2004.

Purpose

The scheme meets the need of transportation for SC/ST women to enable them to avail institutional deliveries.

Salient features

The scheme provides for payment of Rs. 300/- to pregnant women and Rs. 200/-to the person who has motivated the women for institutional delivery.

The beneficiary will get free services including free investigations and free medicines. Beneficiary will get free services related to pregnancy such as normal delivery, Cesarean section and other pregnancy related cases.

Normally the beneficiary under the scheme is allowed to stay for 3 days and during the stay, free treatment and care is provided to the pregnant woman and new born.

The payment to the beneficiary is made by the facility In-charge.

Utilization of the scheme

A total number of 2.64 lakh women have been benefitted from the scheme since its inception. After the changes in Janani suraksha yojna, the scheme is going to be abolished from first April, 07.



INNOVATIONS UNDER CHILD HEALTH

ALTERNATE VACCINE DELIVERY SYSTEM

Rationale

The State Government geared towards improving the immunization coverage of the state to attain the objective of protecting the children from 6 vaccine preventable diseases and thereby lowering the IMR of the state in consistence with the MDGs. One of the major challenges towards attaining this objective has been in addressing the mobility for the vaccinator and also



maintaining the cold chain and potency of the vaccines. Alternative Vaccine Delivery Transportation System was launched to meet these crucial requirements.

Purpose

- Reaching vaccines at the out reach sites on specified day and time
- Providing quality time to immunization activity by reducing the time due to transportation.
- Closer follow up and monitoring of the vaccines sessions by MOs and sector supervisors.

Salient Features

Village level route maps are drawn from the block HQ to the outreach site. Similarly, village level session-wise indent and action plan are prepared. The micro-plan includes the names of the vaccinator and the supervisor. On the Village Health and Nutrition Day, the vehicles are hired as per the route charts to carry the vaccines up to the immunization sites. Each vehicle has supervisors to take the responsibility of dropping the vaccine carrier at the immunization sites and monitor the progress. The ANM is supposed to reach the immunization site as per the micro-plan and the vaccine is sent to the site.

The activity is budgeted in the immunization component under of NRHM. Earlier, Rs.507- was budgeted for every village per out reach session. During the appraisals held in 2006, the rates were revised to Rs120/-(Rs. 50/- by state government & Rs. 70/- under the DFID) per village per session given the remoteness and low-density habitations of the villages.

DEFAULTER TRACKING SYSTEM

In recent times the state has witnessed drop in the coverage of full immunization, in spite of all efforts of the health service delivery system. The prime cause of this dip, being the failure to address the high drop out rates owing to various systemic and cultural factors. Where cultural factors need long range strategic interventions, while the supply and other systemic factors can be addressed with some efforts. One of the major causes of this high drop outs is failure in regular follow up and supervision as well as poor management of immunization card.

With a view towards addressing the gap, UNICEF, innovated Defaulter Tracking system at the sub health centers of the state and it has given immense outcome. It comprises a card holder with multi pockets where cards are kept. In each pocket, cards of children/beneficiaries to be vaccinated in a particular session is kept. Once the child is vaccinated, the card is shifted to another pocket when he /she is due for the next session. The system has facilitated in easy tracking of children. It is user friendly and has also given the ANMs as well as otherwise not so literate Anganwadi workers in proper tracking of children and also session wise indenting for immunization.

The success in the initiative has prompted to give a thought of having the same type of card holder for every village, which can be useful to the ANMs during vaccination. DFID has supported in providing the card holder in every Anganwadi Centers of the state.

Objective of the card:

- To decrease the drop out rate
- Management of immunization card at the village level
- Concurrent follow up of immunisation

BAL SHAKTI YOJNA

Scheme for Medical Treatment and Nutritional Rehabilitation of Severely Malnourished Children

Background

Bal Sanjeevni Campaign is organised in the state of Madhya Pradesh in two rounds every year. This scheme of Bal Shakti Yojna has been envisioned following the Bal Sanjeevni Campaigns under which as many as 10913 under-5 children were identified to be suffering from Grade 4 level of malnutrition and 67352 from Grade 3 level malnutrition and that majority of these children belong to poor and weaker sections.

Purpose

The scheme aimed at arresting the rate of severe malnutrition seeks to bring

about reduction in Grade 4 and Grade 3 levels of malnutrition among all children by one per cent.

Essential Features

1. All children identified as Grade 4 and Grade 3 levels of malnutrition under each round of Bal Sanjeevni Campaign are provided requisite medical treatment.

2. Parents/guardians of the identified malnourished children are provided

counselling regarding the significance of nutritional diet. Also, they are trained in preparing nutritional diet from low-cost and locally available foods.

3. The Scheme is implemented in following stages:

a. Organising of Health Check Camps

- One day health check camps are held at block levels wherein all malnourished children. The camps are organised by CM&HOs in coordination with DWCDOs. Services of 2 pediatricians are made available at these camps and if required private pediatrician's services are hired @Rs.800/- per day. A provision of Rs. 20,000/- per camp is made for organising these camps. The amount includes expenditure in respect of mobilizing doctors, camp arrangements, transport of children from their homes to camp and back, camp to hospital and back to home and medicines.
- Those children requiring emergency medical attention are admitted in near by appropriate hospitals on the same day.
- Those children who are not admitted, their parents are advised regarding home-based care, given medicines and their mothers are included in training on nutritional rehabilitation.

b. Training in Nutritional Rehabilitation

- One member of each family of those children who are not admitted, particularly the mother are given a one day training at the sector level. The training includes care of malnourished children and preparation of low-cost and local foods based nutritional diet.
- A provision of Rs.60/- per participant is made for these trainings.

c. Institutional Medical Care and Nutritional Rehabilitation

- This includes hospitalization of children from 7 to 14 days under the care of pediatricians. Mothers of these children are required to be with the children who are given training in preparation of low cost nutritional diet.



- Mothers are given an amount of Rs.100/- per child for expenses in respect of transportation of children to the hospital.
- At the time of discharge, a follow up card is given to the mother and the ANM. The children are followed up by the ANM and AWW for 6 months during which 4 visits are made, one in the first week, second in the first month, third in the third month and fourth in the sixth month.

d. Modes of Institutional Medical Treatment and Nutritional Rehabilitation

The institutional medical treatment and nutritional rehabilitation are implemented in three modes as follows:

Model: Medical care and nutritional rehabilitation is provided by the selected NGOs. The NGO is contracted for a period of three months by the District Health Society. A provision of Rs. 10007/- per child is made. Also, expenditure on sector level training in nutritional rehabilitation should not exceed Rs.60/- per child.

Mode 2: Care of children and nutritional rehabilitation is provided by the selected NGOs contracted for a period of three months by the District Health Society. The medical treatment is given by the government hospital. The NGO would be given an amount of Rs.5000/- per month towards honorarium for the trainer in nutritional rehabilitation. Also, a provision of Rs. 60/- per child would be made for expenditure on sector level training in nutritional rehabilitation.

Mode 3: Medical care and nutritional rehabilitation is provided by the government hospital. The treatment may be given up to 20 days (beyond 14 days) with the permission of the head of the hospital. If specialist attention is called for in very serious cases, the children may also be referred to medical college hospitals and expenditure is met from State Illness Fund. Provision of Rs.5000/- is made for kitchen for preparation of food for the children and training in nutritional rehabilitation.

Financial Allocation

Untied fund of Rs.1 lakh per district medicines, camps etc.

An amount of Rs. 15,000/- is provided for block level camps.

Ward incharges are given an amount of Rs. 5000/- for emergency purchase of medicines.

An amount of Rs. 100/- per child is given to the mother of the child by the hospital incharge towards transportation.

No-recurring amount of Rs.5000/- is given to each hospital for starting kitchen and meals.

An amount of Rs.20,000/- is given to the ward incharge for suitably equipping the ward.

In government hospital, an amount of Rs.50/- per child is provided for towards the daily food out of which an amount of Rs.35/- is given in cash to the mother.

The NGO trainer for nutritional rehabilitation is given a monthly honorarium of Rs. 5000/- per month during the term of the contract.

An incentive amount @Rs.50- per child is equally shared by the trainer and the female cook on completion of treatment and nutritional rehabilitation.

A provision of Rs. 60/- per malnourished child is made for organising sector level training in nutritional rehabilitation. Where skilled trainers are hired at block level camps, a separate provision for honorarium is made at the rate of Rs. Rs.400/- per day per trainer. This amount is charged to the budget of the Department of Women & Child Development whilst the others is remitted from the DFID account.

INNOVATIONS FOR BPL

DEENDAYAL MOBILE HOSPITAL SCHEME

(A Mobile Health Clinic Scheme in Partnership with NGOs)



The Madhya Pradesh Government launched a mobile health clinic scheme popularly known as Deen Dayal Arogya Rath on 29th May 2006 to provide health services in remote tribal areas. Eleven tribal blocks have been selected for the first phase of the scheme. Private service providers are engaged in management of the mobile health clinic.

Purpose

The mobile health clinics serve the remote tribal areas across the select 11 blocks to render free of cost services for medical examination, treatment, consultation and necessary medicines.

Salient features

The mobile clinics function in their respective jurisdiction for six days a week as per the prescribed programme. Each mobile health unit includes a doctor, a nurse and a compounder. The timings of these mobile clinics are from 10 am to 6 pm. Each vehicle is equipped with facilities for antenatal and post-partum tests, malaria test, TB detection etc.

The eleven blocks selected under the scheme are those where only one or two doctors are available. These blocks (districts) are Bhimpur (Betul), Karahal (Sheopur), Mawai (Mandla), Sondwa (Jhabua), Bajag (Dondi), Budhar (Shahdol), Pushprajgarh (Anooppur), Birsa (Balaghat), Pali (Umaria), Kundam (Jabalpur) and Kusmi (Sidhi).

Impact of the scheme

The clinics have benefitted 2.53 lakh people by 30 November 2006). Each day 125 to 150 patients turn up at the mobile clinic to avail the medical care services.

The scheme has been well received in 11 districts during last months and the government has geared up for the success of second phase of the scheme. 79 new tribal blocks have been identified for second phase of the scheme.



DEENDAYAL ANTYODAY UPACHAR YOJANA

Background

The Government of Madhya Pradesh has designed and implemented an innovative scheme for socially and economically disadvantaged people of the society for providing access to quality health care to the needy people like SC, ST and BPL families. The Scheme, known as Deendayal Antyodaya Upchar Yojana was instituted on 25th September 2004. It was further modified in the month July, 2006 to extend the coverage to all below poverty line (BPL) people in the state.



Purpose

The scheme aims to provide access to SC, ST and BPL population to health care services. **Salient features**

Free of charge health services upto the maximum limit of Rs. 20000/- in a financial year in government health institutions is provided to all BPL families of the state.

Under the scheme, one family health card is issued to each BPL family. This unique card consists of a photograph of the head of household with details of all other family members. Hospitalization and medical checkup details are registered in the card.

Impact of the scheme

So far, about 2.85 lakh persons have availed the benefits of this scheme.

MADHYA PRADESH RAJYA BIMARI SAHAYATA NIDHI

The Government of Madhya Pradesh launched 'MP Rajya Bimari Sahayata Nidhi' on 2nd September 1997 with a budget of Rs 10 Crores under the chairmanship of Hon. Minister, Public Health and Family Welfare.

Purpose

The scheme is targeted towards all BPL families who are bonafide residents of the state. The scheme renders free treatment to one ailing member of the BPL families who suffers from one of the specified serious diseases.

Salient features

The eligible and deserving persons are provided financial aid for treatment equivalent to a minimum amount of Rs. 25000/- to a maximum Rs. 1,50,000/- depending on the gravity of the disease. The benefits can be availed in the accredited health institutions within MP and across the country. The payment is directly made by cheque to the health institution where the patient undergoes the treatment. The State Health society is authorized for sanctioning medical cases.

The diseases covered under the scheme include cancer, breast surgery, renal surgery, hip replacement, knee replacement, spinal surgery, complicated deliveries, heart surgery, renal detachment and neuro surgery.

Looking in to the issue of timely care in case of such difficult diseases, the state government has decentralized the processing of applications with the creation of district level committees in every district of the State with effect from 25th January 2006. The committees have powers to sanction up to Rs. 75000/- as assistance in above mentioned illnesses to the deserving beneficiaries.

Impact of scheme

So far, 3150 persons have availed benefits under the scheme.

OTHER INNOVATIONS

MCP (MOTHER & CHILD PROJECTION CARD) CARD

Mother & Child Protection card is a comprehensive card providing complete

शुश्रूषणी महिला का फोटो चिपकायें		बच्चे का फोटो चिपकायें	
परिवार का परिचय			
महिला का नाम	जन्म	<input type="checkbox"/>	
पति का नाम	श्री/श्री	<input type="checkbox"/>	
जाति	पता		
माँ की शिक्षा: अनपढ़ / प्राथमिक / माध्यमिक / हाईस्कूल / स्नातक			
जन्म का विवरण			
बच्चे का नाम			
जन्म तिथि	जन्म के समय वज्रन	ग्राम	

information right from the Antenatal test to growth monitoring of the newly born baby in continuation. This card is prepared by the joint efforts of Health Department and Women & Child Development Department in collaboration with UNICEF. This card not only gives the information about pregnant women & child but also give the comprehensive information about the pregnant women, vaccination of child, child nutritional status and prevention of main diseases.

The main purpose of this card are as follows-

1. Providing the comprehensive information about the- Antenatal checkup, vaccination, Neonatal checkup and growth monitoring.
2. In order to save time & expense a comprehensive card is developed. To establish the better coordination at the village level with the support of the Health & Women & Child Development Department.

INCENTIVE SCHEME FOR HEALTH WORKER (FEMALE & MALE) AND ANGANWADI WORKER

The incentive scheme has been introduced under RCH II from the year 2005-06. Under the scheme, the Sub Health Centers rendering an excellent performance are identified based upon achievements against a set of criteria. The health workers of these SHCs are rewarded as follows:

Female Health Worker: Male Health Worker: Anganwadi worker: Selection criteria for SHCs

**Rs. 1000/- per month
Rs. 500/- per month
Rs. 500/- per month**

Minimum quarterly achievement for computation of incentive amounts:

S. No.	Objectively Verifiable Indicator	Means of Verification	Weightage %	Expected Minimum Quarterly Achievement
1	Proportion of beneficiaries availing JSY and PPHY schemes	Report of SHC and BMO	20	10 beneficiaries from general and 6 from SC/ST
2	Proportion of pregnant women who get full ANC done	Report of SHC and AWC	10	30 beneficiaries from general and 18 from SC/ST
3	Proportion of institutional deliveries (at CEmONCs and BEmONCs)	Report of SHC and the health institution	10	15 beneficiaries from general and 9 from SC/ST
4	Proportion of couples getting sterilization	Report of SHC and BMO	20	15 beneficiaries from general and 9 from SC/ST
5	Proportion of under 1 year children who receive full immunization	Report of SHC	20	25 beneficiaries from general and 15 from SC/ST
6	Proportion of children under 5 whose growth charts are maintained and those of grade 3 and 4 malnutrition referred under Bal Shakti	Report of AWC and BMO	10	Growth Charts of 120 children from general and 72 from SC/ST and 90% of those in grade 3 and 4 referred under the Bal Shakti
7	Preparation of cards under Deen Dayal Upchaar Yojna and their distribution	Report of AWC and BMO	10	100% of the eligible couples

In the SHCs where there are 2 ANMs are posted, computation for the second ANM is done by treating the SHC as an additional unit.

There will be a negative marking in the event of the following:

Death due to measles:	10 points
Tetanus case being reported:	5 points
Polio case being reported:	5 points
Case of Diphtheria being reported:	5 points

SWAWLAMBAN YOJANA

Sponsored Students for B.Sc & M.Sc in Private Nursing Colleges and Lab. Technicians & X-ray Technicians

"Health for all" is motto for the department of public health and family welfare. To provide quality services and better implementation of the National Health Programmes, doctors as well as nurses have an important role to play. As per Indian council norms for teaching institution staff nursing, requirement is 1:3 + 30 percent and for non-teaching staff requirement ratio is 1: 5. Total requirement of staff nurses are 18000 in state. All community health centers needs to be upgraded as per Indian Public Health Standards under National Rural Health Mission. Minimum requirement of 6000 staff nurses in ratio of 1:10

The state government has come up with decision to strengthen the nursing cadre by sponsoring M Sc, B Sc and post basic B.So,nursing students. These students have to serve compulsorily in rural areas for 7 years after completing the course. All passed out students has to sign the bond of Rs.2 lakhs with state government to serve for minimum 7 years in rural areas then after the M.P Nursing council will release registration certificate.

At present there is only one Government B. So, nursing college in the state which is not fulfilling the demand of state. Government of India has agreed to upgrade the Ujjain and Jabalpur general nursing training school to the B. So, nursing college. There are 39 private nursing colleges in the state and total sanctioned seats are 1965. State government has decided to sponsor 500 students to private nursing college. Out of 39 colleges 20 has accepted the proposal.

Fees structure is as under:

1. M.So, nursing 2 years course Rs. 90000/- per annum per student
2. B.Sc, nursing-4 years course Rs. 50000/-per annum per student
3. Post Basic nursing course Rs. 25000/- per annum per student

Criteria of qualification for applying to the nursing college are 12th pass with minimum 50% of marks with subject's physics, chemistry, biology and English. All applicants have to be resident of M.P in the age group of 17 to 25. Selection of the candidates is done on the basis of merit and roster applicable in state.

PRABHA KIRAN TRAINING SCHEME

(Orientation of Medical Officers in Referrals and Training of ANMs in Core Skills)

Purpose

The scheme aims to enhance capacity building of Medical Officers and ANMs in core skills so that better management of emergency obstetric care and effective referrals are ensured. **Essential Features**

Team training of Master Trainers for all 48 districts.

The training of Medical Officers on select core skills is preparatory to their training on BEmONC. Likewise, the training of ANMs on select core skills is preparatory to their SBA Training.



The training of Medical Officers is in three modules in a year, one module per day; thus thrice a year. The two consecutive modules are placed one month apart.

The training of ANMs is in two modules of 3 days duration each. The two modules are placed two weeks apart.

District hospital is the venue for the trainings. A specialist associated with MCH is assigned to be the training in charge. The Incharge leads the team of district trainers and coordinates with CMHO/CS in getting the participants and in organising the trainings.

All training incharges have been oriented with regard to the design and implementation of trainings under the Scheme. The trainee ANMs are assigned to the OPD of maternity ward, delivery room, OT and post partum ward so that they may have requisite practical hand-on exposure. All trainings are residential.

NRHM - MANAGEMENT INFORMATION SYSTEM

Background

The State has launched the NRHM activities in the state in a performance-based and performance-focused mode. It was thus considered crucial to monitor physical as well as the financial progress on a routine and ongoing basis in order to take effective and timely corrective measures and achieve the set targets under the programme. The state had faced severe problems in monitoring the activities under RCH I programme and also found it difficult to get SOEs from the districts in a timely manner. Hence, it was decided to develop a software-based Management Information System for planning and monitoring of the activities.

A tailor-made offline MIS has been developed through a software agency with technical inputs from UNFPA MP, State office in September 2006.

Salient features of the MIS:

- > The software addresses all approved State and district action plans for the current year.
- > As the computers and the data entry operators are not available at the block level, hence the data is collected from all blocks on monthly basis at the district in a fixed format and the same data is entered in the software by the DPMUs.
- > The DPMUs enter the data on daily basis and on 5th of every month send the data files to the SPMU through E-mail.
- > The data files received from the districts are saved in the database file of the software, which automatically merges the recent data in old database.
- > To prevent mishandling of the software and data, the level of entry is defined for various levels of officers.
- > Districts do not have authority to change the sanctioned budget or the planned interventions and changes can be made only at the state level.
- > The software provides physical and financial progress against planned activities. The status of the pending advances by activity-wise and party-wise can be captured:
 - **Intervention-wise**
 - District level
 - Division level
 - State level.
- > Software also helps in preparing district and state action plans for next year based on previous year trends and expenditure patterns.
- > Various analytical reports are generated. These include:
 - Status of progress under various heads such as training, infrastructure, hiring of service and professional staff etc.

- Comparison of progress of an activity across all the districts.
- Percentage wise financial progress of activity.
- Intervention wise progress such as maternal health, child health etc.
- Field / supervision / monitoring visits undertaken by the state and district officials with visit reports.
- Trend of implementation of activities can be viewed.

Achievements

- > First and second round of hands-on training has been given to all DPMU staff of 48 districts.
- > MIS has been uniformly implemented in all 48 districts.
- > State has started getting the physical and financial progress from each district on 5th of every month.
- > The state and district officials are able to take focused monthly review meetings of the staff.

MP STATE DRUG POLICY, 2006

The Government of Madhya Pradesh has formulated an elaborate State Drug Policy in year 2006. It aims to achieve the following objectives:

1. Ensure timely availability of quality medicines and supplies in health institutions in keeping with the needs of the patients; and
2. Promote rational and adequate use of drugs in all state health institutions.

Towards this end, the State has included following major activities for implementation of the State Drug Policy:

Adoption of Essential Drug List (EDL) by level of institution as follows:

Health Institution	No. of Medicines
District Hospital	234
Civil Hospital	197
Community Health Center	128
Primary Health Center	72
Sub Health Center	22

This list shall be updated every 2 years.

All health institutions have been provided with Standard Treatment Protocols which would be appraised and updated every two years.

On the lines of Tamil Nadu, software would be introduced through the MP Laghu Udyog Nigam.

80% of procurement budget would be used through central purchase mechanism and 20% would be through district and other hospitals in a decentralised mode.

Medicines shall be procured only in generic names.

The drugs shall be stored in Drug Stores on the pattern of drug stores constructed under DANIDA-supported Basic Health Services Programme. Additional drug stores shall be constructed as may be required.

MOBILITY SUPPORT TO BLOCK MEDICAL OFFICERS

Purpose

The scheme is aimed at facilitating the Block Medical Officers to undertake periodic supervisory visits to the sub centers and Primary Health Centers as well as maintain contact with PRIs.

Salient Features

The BMOs are allowed to hire vehicles on a monthly basis so that they may undertake their monitoring and supervisory visits in their area of jurisdiction.

The facilitation is also of significance as it enables them to promptly investigate disease outbreaks as well as mobilize prompt and effective response.

An amount of Rs. 15000/- per month per block is provided to all blocks under the NRHM.

PILOT HMIS PROJECT

With Health Information Systems Programme (HISP, India,), India and AVNI HEALTH FOUNDATION

INTRODUCTION:

DHS (The district Health services), requires the development of a comprehensive HMIS and skills of personnel to effectively use the information in making programmatic interventions with integration of all the activities/programs of the department and an efficient flow of information from the Health Sub Centre to the State level so as to assess the status of implementation of various programs, to figure out corrective measures to be taken to fill in the gaps and also to help in the planning process.

This will be a joint pilot conducted by HISP India (responsible for the HMIS component) and AVNI (responsible for the Leadership capacity building component) in Bhopal, and following which they will jointly develop a model for implementation and scaling of both the HMIS and Leadership capacity building processes in the entire state of MR

Goals:

1.1.1. To develop in Bhopal District a pilot comprehensive HMIS and Leadership capacity amongst personnel to effectively use the information in programmatic interventions, conceptualizing and operationalising the integration of all the activities/programs of the DHS, and developing leadership in public health practices. The development of such systems and capacity will help to facilitate and streamline the sharing and analysis of the knowledge and information, which in turn will help improve the accessibility and quality of the service delivery.

1.2. Objectives

- 1.2.1. To develop an institutional framework to streamline and standardize the process of data entry, data compilation, its analysis, generation of the relevant reports and flow of this information.
- 1.2.2. To strengthen institutional capacity for evidence based public health programming. (Through conducting workshops/courses in Leadership in Public Health Practice)
- 1.2.3. To integrate the HMIS with NRHM at the program as well as functional levels.
- 1.2.4. To generate information and analytical reports to facilitate prompt and effective corrective actions being taken at all levels in the department and for the purpose of planning, (improved program design, implementation and monitoring).
- 1.2.5. To create a one window system to access all the routine data and reports right from the level of Health Sub Centres to the State level.
- 1.2.6. Spatial analysis of the data from the Sub Centre level using the Geographical Information System (GIS).
- 1.2.7. Capacity building of the relevant functionaries of the DHS and key stakeholders (district administration, NGOs, CBOs, community workers etc)

9. Duration and Components of the Project

- 2.1. The duration of this project will be for 6 months from the date of signing of this MoU.
- 2.2. Project will officially commence from 1st of February 2007.
- 2.3. The project would be implemented in three phases. Phase 1: Initiation and Capacity building: 2 months Phase 2: Deployment and Capacity building: 3 Months Phase 3: Develop a working model for scaling up the systems to the whole state: 1 Month.

4. Promised Deliverables

At the end of the project period, the following will be the deliverables:

- 3.1. A fully developed and working HMIS based on the principle of a data warehouse ie. a system that is capable of supporting the complete HMIS needs of the district.
- 3.2. Staff at the PHC who are capable of independently handling the HMIS and responsible for its monthly outputs and training of their staff.
- 3.3. A detailed plan for the scaling of the system to the other districts in the state.
- 3.4. Capacity built staff who will be in a position to use the information for better program implementation and management. Capacity building will include 5 key components and case studies and assignments based on RCH II, HIV/AIDS, Tuberculosis and any other public health issue faced by the district. Fieldwork and hands on training on data management will be integral parts of the program.

Assessments will include MCQ from these modules.

MODULES

- I. Leadership and Management
- II. Health Communication including (BCC)
- III. Research Methodology
- IV.- Monitoring and Evaluation
- V. HMIS

Responsibility

- AVNI
- AVNI
- AVNI
- AVNI
- HISP

4. Capacity Building

- 4.1. As a part of the HMIS component, HISP system facilitators will be placed in each CHC, and each facilitator will be responsible for CHC and 2-4 PHCs under it.
- 4.2. The system facilitation process will primarily take place on site, on job, and continuous.
- 4.3. In consultation with the Medical Officers, the system facilitators will create schedules for training so that staff from each PHC is at least supported for a minimum of two sessions per week.
- 4.4. The content of the training would be starting from basics of computers, use of email and internet, basics of dhis2, data entry and report generation, exporting and importing data, use of excel pivot tables, and basic concepts around the use of information for action including the use of indicators, and what are numerators and denominators. In addition, since the system facilitator is present in the block, they can identify other local needs and meet them.
- 4.5. HISP will also conduct some group training sessions primarily with the aim of enabling sharing of experiences, learning from each other, and the creation of a more coherent HI MS community and identity. For example, PHC supervisors from the different PHCs will have periodic meetings so as to share their experiences. Similarly, periodic meetings will be held at the District Office.
- 4.6. In addition to on site capacity development, AVNI will conduct focused capacity building programs on Leadership in public health practice (as per modules described above)