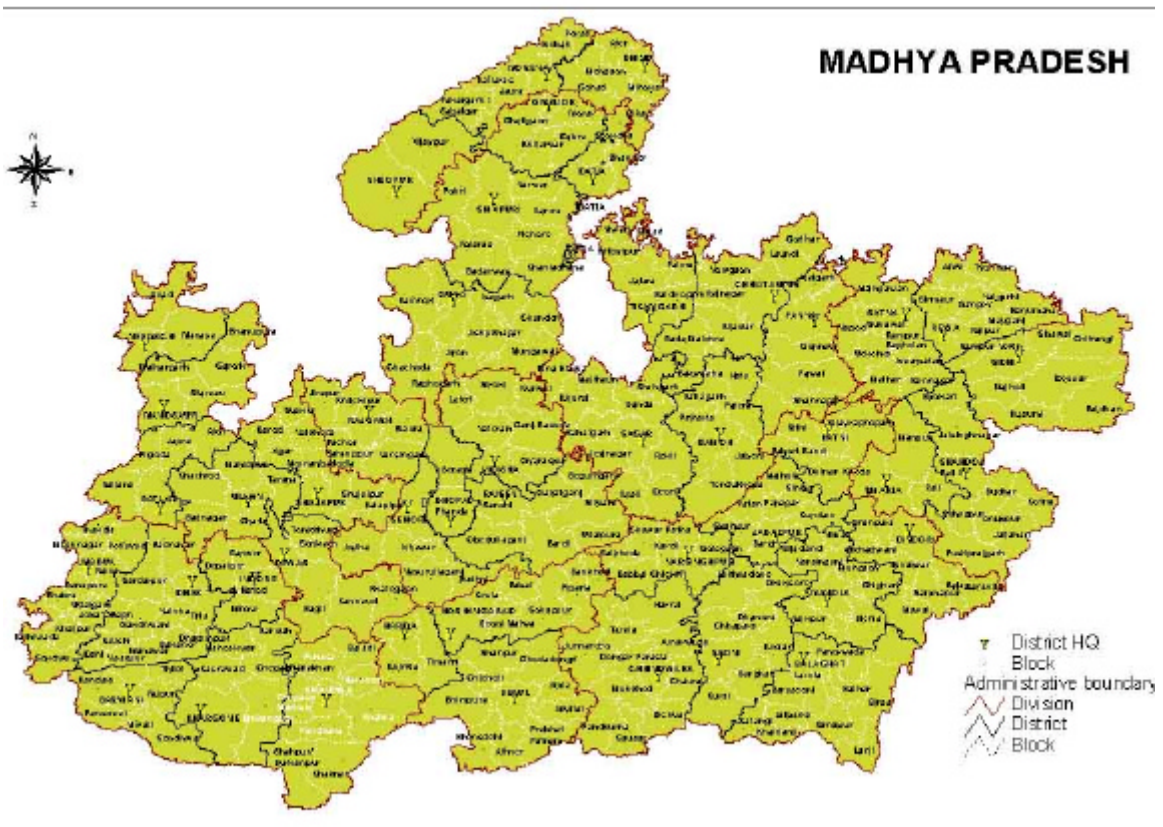
Medium Term Health Sector Strategy
Madhya Pradesh



Department of Public Health and Family Welfare
Government of Madhya Pradesh

INDEX

List of acronyms

ANM	Auxiliary Nurse Midwife
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BMO	Block Medical Officer
BPL	Population Below Poverty Line
CDR	Crude Death Rate
CEO	Chief Executive Officer
CHC	Community Health Centre
CMHO	The District Chief Medical and Health Officer
CMO	The District Chief Medical and Health Officer
CMR	Crude Mortality Rate
DFID	Department for International Development – UK
DHS	Directorate of Health Services
DPT	Diphtheria, Whooping Cough and Tetanus vaccine
DWCD	Department of Woman and Child Development
EC	European Commission
GOI	Government of India
GoMP	Government of Madhya Pradesh
GP	Gram Panchayat
HLSP	HLSP Consulting Ltd
ICDS	Integrated Child Development Services
IIHMR	Indian Institute of Health Management Research
IMR	Infant Mortality Rate
JSR	Jan Swasthya Rakshak
MMR	Maternal Mortality Rate
MP	Madhya Pradesh
MPW	Multi Purpose Worker

NFHSI	National Family Health Survey I
NFHSII	National Family Health Survey II
NGOs	Non Government Organizations
O&M	Operation and Maintenance
OP	Out-Patient (section or department of a hospital)
OPD	Out-Patient Department
RCH	Reproductive and Child Health
PHC	Primary Health Care
PHED	Public Health Engineering Department
PRIs	Panchayati Raj Institutions
PWD	Public Works Department
RGMCH	Rajiv Gandhi Mission for Community Health
RSK	Rogi Kalyan Samithi
SC	Scheduled Caste
DPHFW	Department of Public Health and Family Welfare
SHC	Sub Health Centre
ST	Scheduled Tribe
TB	Tuberculosis
TFR	Total Fertility Rate
ZP	Zilla Panchayat

BACKGROUND

The Department of Public Health and Family Welfare, Government of Madhya Pradesh (GoMP) has taken a decision to develop a medium term health strategy, intended to serve the State for next five years. The situation analysis of the State has been change in the last 3 years and the state has considered all the new initiative taken by Government of India and Government of Madhya Pradesh in planning the next five years plan. This strategy would enable the Government to better respond to the health needs of the population, in particular the poorest in the state.

This document is presented in two parts.

Section 1 is **the situation analysis** that has provided the background, findings and justification for the strategy contained in Part 2

Section 2 of this document contains the **Medium Term Health Sector Strategies** for Department of Public Health & Family Welfare of Madhya Pradesh.

Acknowledgements

The Strategic Planning Unit would like to place on record its gratitude to all those who shared their thoughts and ideas with us – representatives of health department, ISM, WCD, representatives of various stake holders sections and the participants of the series of workshops held at different platforms. Their views and experiences helped us understand the complexity of the issues being faced in the Health Sector. We have tried out best to analysis the present status of Health based on the previous documents[1]. The documents[2] published before and during the preparation of this document. We have tried our best to reflect in this document the future of health prospects of Health in the state of Madhya Pradesh. We specially thank Mr. Ashok Barnwal, Commissioner, Health cum Mission Director, Rajiv Gandhi Community Health Mission in getting the document a proper shape and a clear vision in completing it.

[1] The first document on MTHSS submitted on December 2002.
[2] The documents/reports related to NRHM, RCH-II, WHO, UNFPA, UNICEF, DFID and National Commission on Macroeconomics and Health.

The Process of preparation of this documents…….

The first stage started upon establishment of Strategic Planning Unit (SPU) was established on September 01, 2005. The SPU had review of Medium Term Health Sector Strategy (MTHSS) submitted by HLSP Consultants in the December 2002. The DFID had hired Mr. Javier Martinez, an international consultant for rewriting the MTHSS based on the present scenario of the State. The document was circulated among all the departmental officials for commends.

The first visits of Mr. Javier took place in the second week of October 2005 and met all the officials and discuss the document. A team was proposed by the consultant for rewriting the MTHSS. The team consists of department officials and consultants of SPU. The team worked on the documents with series of meeting with departmental officials, district officials and other stakeholders. The first document was circulated among the departmental officials and stakeholders in the month of December 2005. Then a workshop was organized in the directorate of Health & Family Welfare for obtaining suggestions and comments. On the basis of comments and suggestion received the document was once again revised with discussion and second document was prepared.

The second document was once again circulated among departmental officials, stakeholders and other national level experts and had proposed a one day workshop for obtaining the comments. This was organized in the month of January 31, 2006. The feedbacks and suggestion were obtained and was incorporated the documents. The Final draft of the MTHSS was finally circulated for observation so that it can be finalized and it took two months to finalize the documents.

The team would like acknowledge all the support received from the officials of Government of Madhya Pradesh, the donor community and the individuals who helped for completing the MTHSS document.

Introduction

Why a Medium Term Health Sector Strategy for Department of Public Health & Family Welfare of Madhya Pradesh?

The purpose of this medium term health sector strategy is to set a **manageable range of strategic themes related to core issues** for the State Department of Health and Family Welfare over the next five years. To ensure **the Department is able to deliver on its priorities**, and to focus its initiatives for poor and marginalized citizens in greater health need. To ensure **Inter-sectoral convergence** that result in making government services becoming more people oriented, effective and efficient and to enable development partners in better targeting of **development assistance**, increasing its synergy with government policy and making it more effective.

The responsibility for health care in Madhya Pradesh is the direct responsibility of the Department of Public Health and Family Welfare (DPHFW) and the Mission Statement of the department is…….

"The Mission of the Department of Health and Family Welfare is to improve health outcomes of the population, especially the disadvantaged and marginalized including poor families, women and children in Madhya Pradesh."

The Department of Health and Family Welfare will:

- Ensure that the population has access to a range of affordable essential health promotion and preventive services, and simple curative and emergency services of acceptable quality.
- Promote appropriate health seeking behaviour by all citizens.
- Ensure that the poor have access to a safety net to cope with adverse economic and social impacts of serious illness.
- Promote partnerships with civil society groups, Panchayati Raj Institutions, NGOs, donor agencies, the private sector and other development partners to achieve its aims
- Improve accountability and cost effectiveness of the public sector.

Section - 1
Situation Analysis

1. Introduction

1.1 Background

The Department of Public Health and Family Welfare (DPHFW), Government of Madhya Pradesh (GoMP) has taken a decision to develop a medium term health strategy, intended to serve the State for next five years. The strategy would enable the Government to better respond to the health needs of the population, in particular the poorest in the state.

1.2 Madhya Pradesh: A brief profile

Until recently Madhya Pradesh was geographically the largest state in the country with almost 13.5% of the total area. In November 2000, the primarily tribal eastern part was carved out to form Chattisgarh. Now MP's area has decreased from 443,000 to 308,000 square kilometres. The data given in this chapter refers to reorganized MP unless otherwise specified[3].

1.3 Demography

Madhya Pradesh has a total population of 60.4 million (2001 Census), the rural to urban ratio being approximately 73:27. Scheduled castes and scheduled tribes account for 15.4 and 19.9% respectively of the total population. Tribal population has decreased from 23.3% to 19.9% of the total population of the state after the creation of Chattisgarh. Decennial population growth rate in the state including Chattisgarh during 1991-2001 was 24.3%, about 3% higher than the national growth rate. The state is relatively sparsely populated with an average population density of 196 per square km as against the country average of 274 per square kilometre. Population density in rural areas is about 116 per square kilometre; the corresponding figure in urban areas is 1939 per square kilometre.

1.4 Social Development

Madhya Pradesh's sex ratio of 920 in 2001 is lower than the national average of 933. The sex ratio is higher in rural areas (927 females per 1000 males) compared to urban areas (899 females per 1000 males). In contrast the sex ratio in Kerala is 1058 **(Table I)**.

[3] Study on Dynamics & Structure of Private Health Care in MP by TARU November 2001. Directorate of Economics and Statistics, MP and Report on Delivery Mechanisms for Water and Sanitation Services by MSG, 2001

Madhya Pradesh has made impressive advances in literacy in the last decade. The literacy rate increased sharply from 44% in 1991 to 64% in 2001 against a national average of 65%. Nevertheless, MP's literacy rate is well below Kerala's 90.9% and ranks 16th amongst 35 states and union territories. The female literacy rate is only 50.3%, somewhat lower than the national average of 54.3% .

Table I[4]

Key Demographic Indicators

Indicator	**Unit**	***Madhya Pradesh***	**All India**	**Kerala**
Total population	Million	60.4	1027.0	31.8
Rural	%	73.3	72.2	74.0
Urban	%	26.7	27.8	26.0
SC	%	15.4	16.5	9.9
ST	%	19.9	8.1	1.1
Decennial population growth rate 91-01	%	24.3	21.3	9.4
Male-Female ratio	Female/1000 male	920	933	1058
Literacy (2001)				
Literacy level	%	64.1	65.4	90.9
Female literacy level	%	50.3	54.3	87.9

1.5 Poverty

Population below poverty line (BPL) in MP including Chattisgarh has been estimated to be 43% (as per a survey conducted in 1987-88) while the Planning Commission arrived at a figure of 42.5% in 1995. However, the Madhya Pradesh Human Development Report, 1998 indicates a much lower figure of 31% (vis-à-vis national average of 33.5%).This still means that about 18.8 million people are classified as poor.

1.6 Livelihoods

In the state 89.8% of the population in rural areas is employed in agriculture, mining and related fields. In contrast 20.3% of the urban population is engaged in

[4] All figures are based on Census, 2001 except for SC/ST percentages for India and Kerala which are based on Census, 1991.

agriculture and related activities - the corresponding figures for the secondary and tertiary sectors being 26.5% and 53.2% respectively.

1.7 Structure

Madhya Pradesh has 48 districts and hence an equal number of elected Zilla Panchayats. There are almost 52,000 inhabited villages grouped under 21,999 Gram Panchayats and 313 Janpad or Block Panchayats *(Table II)*. Average rural population under the purview of a Zilla, Janpad and Gram Panchayat works out to 984,000, 142,000 and 2010 respectively. A revenue village could consist of a number of separate habitations known as tola or falia especially in tribal areas. The total number of such habitations in MP is estimated to be about 112,000. The urban sector falls under the purview of 334 urban local bodies, out of which the number of Nagar Panchayats (235), Nagar Palikas (85) and Municipal Corporations (14).

Table II
Administrative and Political Divisions

Administrative and Political Divisions	Population	Nos.
Revenue		
Districts		48
Tehsils		260
Inhabited villages		51,806
Total villages		55,841
Rural Development		
Zilla Panchyats		48
Janpad Panchyats/Block		313
Gram Panchyats		21,838
Urban Administration		
Municipal Corporations	>100000	14
Nagar Palikas	20000 -100000	85
Nagar Panchyats	<20000	235

2. Health Status

2.1 Life Expectancy

Life expectancy at birth is the most comprehensive indicator of health. The estimate for Life Expectancy at Birth in Madhya Pradesh was 55.2 years for the period 1992-96.[5] It is far behind the national life expectancy of 60.7 years at birth. Within the state there are geographical differences in life expectancy, with rural life expectancy of 53.7 years substantially less than urban life expectancy of 63 years. Male life expectancy in 1992-96 is little higher than that of females (55.1 years to 54.7 years). The female have biological superiority in terms of better survival and therefore to compare male and female life expectancies, we assume that female life expectancy should be about five years more than males. Therefore the near equal life expectancy of males and females in effect show that females in comparison to men do not enjoy an equal health status.

2.2 Death rate

The death rate of Madhya Pradesh in 2000 was 10.25 per 1000 population, and this is 20 percent higher than the Death rate for all India. Over the last two decades there has been a sharp decline in the death rate from 15.2 in 1980 for the undivided state to 10.2 for the new state today. The death rate in rural Madhya Pradesh was assessed at 11.0, while urban death rate was 7.5.
Key components of CDR by age at death are:

- Infant mortality: CDR[6] for age < 5 years is 32.3, thrice the CDR across all ages.
- Maternal mortality: During 1996-98, females accounted for 56% of medically certified deaths in the reproductive age group 15-34, compared to an average of 38% across all age groups[7]. These deaths are related to pregnancy and increased susceptibility to other diseases during pregnancy.
- CDR for age 50–59 increased from 8.1 to 14.2, although there is not much change in total CDR. This could indicate slight reduction in age of death since 1990-91.

Communicable diseases[8] including malaria, tuberculosis, typhoid fever, diarrhoea, gastroenteritis, tetanus, viral hepatitis, infectious colitis, septicaemia, rabies, etc. account for 35% of medically certified deaths. Non communicable diseases account for about 55%, including:

[5] The best estimates for life expectancy are provided by the Sample Registration Scheme (SRS) of the Registrar General of India, and reference to any data from this scheme will be referred to as SRS.
[6] Sources : SRS 1997, NATIONAL FAMILY HEALTH SURVEY-I and II
[7] Sources : Medically certified deaths cited in special study report, IIHMR, 2001
[8] Special Studies Report IIHMR 2001

- Circulatory diseases (cardiovascular, heart, myocardial infections) and those related to blood and blood forming organs (26% of medically certified total deaths);
- Respiratory diseases (pneumonia, chronic bronchitis, asthma) account for 4-8%;
- Diseases of the digestive system (nutritional, metabolic diseases, immunity disorder) account for 5%;
- Injuries and poisoning account for the balance 10% of the medically certified deaths.

An estimated 20% of rural deaths are due to respiratory disorders[9]. Other diseases, which cause more deaths in rural area compared to urban, include malaria and typhoid.

2.3 Infant and Child Mortality

The Infant Mortality Rate for the new Madhya Pradesh has been estimated by SRS at 88 in 2000. The rural IMR is 94, while urban IMR is 54. The national IMR at the same time was 68. Madhya Pradesh falls amongst the lowest in IMR compared with other states. Although, biologically, the girl child is stronger than the male child, the female infant mortality rates were higher than male infant mortality rates. According to the, SRS data of 2000, the male and female IMRs were estimated at 89.6 and 89.5 for entire state, and 94.9 and 96.8 for rural areas. It is only in urban areas that the female IMR of 50.7 is lower than the male IMR of 59.6.

Over the past years, there has been a decline in post natal infant mortality. However, the neo-natal mortality rates continue to remain high. In order to have a significant impact on infant mortality rates, it is essential that there is a reduction in the neo-natal infant mortality rates. Some of the most important causes of early neo-natal and neo-natal mortality are tetanus, complications in birth, birth related injuries, sepsis, etc. These can be directly controlled by early tetanus immunization of mothers during pregnancy and child after birth and proper attendance during delivery, preferably institutional deliveries.

2.4 Age Specific Death rates

The maximum deaths occur in the age group of 0-4, a share of 37 percent of all deaths. Assuming that all deaths in the age group 50 and below are the main concern for the health system, then the child deaths (0-4 years) make up for 62 percent of such mortality. Any attempt to improve health will therefore have to re-emphasise and focus to address pre-mature mortality between the ages of 0-4 years with priority. A comparison of the age specific death rates for India and Madhya Pradesh shows that the substantial difference in death rates between India and Madhya Pradesh is up to the ages 0-24 years. The difference in death

[9] Source :State of Health in MP 1988 by Dr. Alok Ranjan Chaurasia

rates remains more moderate after that. The high differential in early years clearly points out to the main areas of weakness in the health of the state.

Poor immunization, poor nutrition, poor medical and general care during childhood, neglect of girl child and poor infrastructure in terms of road network are some of the contributory factors of high mortality in the early years.

2.5 Fertility, Birth Rates and Maternal Health

In 1997, the fertility rate in Madhya Pradesh was 4.0[10]. This was much higher than the national Total Fertility Rate (TFR) of 3.3, and far from the targeted net replacement rate of TFR of 2.1. The Total Fertility Rates for rural Madhya Pradesh was 4.4, and 2.6 for urban areas.

In Madhya Pradesh the maternal mortality rate was 498 SRS in 1998. The 52nd survey of NSS in 1995/96[11] found that 41.7 percent pregnant women were actually registered for prenatal care in Madhya Pradesh. Only 16.4 of all deliveries took place in a health institution. Further, 36 percent deliveries did not have any attendance during delivery (39 percent in rural Madhya Pradesh). This large number of unattended deliveries is a significant contributory factor in the high infant mortality rate.

Various studies have shown that the number of women seeking pre-natal basic care is low. A large number of women are not protected from tetanus and anemia and hence are exposed to risks of childbirth. Another contributing factor to women's health is low age at effective marriage. NFHS 2 found that age at effective marriage in rural Madhya Pradesh is was 15.5 years with average age of first born 18.1 years. Low age at effective marriage puts girls at risk of motherhood in early ages.

2.6 The Disease Burden

Exact rates of morbidity or disease affliction are difficult to estimate. There is a paucity of good quality information on many of the major health conditions. The Report of the National Commission on Macroeconomics and Health has tried to arrive at estimates for 17 major classes of health conditions. Together, these priority conditions accounted for over 80% of the overall disease burden in India in 1988. In the absence of specific data, it can be assumed that the conditions are likely to be more or less similar for Madhya Pradesh.

[10] SRS Estimates for 1997
[11] Sarvekshana, 82nd Issue, NSSO, Government of India, page 31

Disease/Health Condition	Current Estimate of cases – 2005/lakhs	Projected number of cases 2015/lakhs
I. Communicable Diseases, Maternal & Prenatal Conditions		
Tuberculosis	85(1000)	NA
HIV/AIDS	51(2004)	190
Diarrheal Diseases episodes/year	760	880
Malaria and other Vector Borne Conditions	20.37(2005)	NA
Leprosy	3.67(2004)	Expected to be eliminated
IMR/1000 births	63(2002)	53.14
Otitis media	3.57	4.18
Maternal Mortality/100000 births	440	NA
II. Non-Communicable Conditions		
Cancers	8.07(2004)	9.99
Diabetes	310	460
Mental Health	650	800
Blindness	141.07(2000)	129.96
Cardiovascular Diseases	290(2000)	640
COPD and Asthma	405.20(2001)	596.36
III. Other Non-Communicable		
Injuries – deaths	9.8	10.26
No. Hospitalizations	170	220

2.7 Communicable diseases

As far as, communicable diseases are concerned, Tuberculosis is the largest killer among adults in India, affecting those in the productive age groups disproportionately more than others. 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. While no future projections for TB in Madhya Pradesh are currently available, it is expected that a rise in HIV cases will lead to a large increase in the number of TB patients. The economic burden that a patient with TB can potentially impose on a poor family whose main sources of earning is physical labour, is huge.

At present, Madhya Pradesh is a low prevalence state, as far as HIV is concerned. Since 1988 a total of 1662 AIDS cases have been reported till December 2005.The number of HIV positive cases reported since January 1985 is 7123.

However, the State cannot afford to remain complacent and constant efforts to spread awareness are required to keep the epidemic in check.

MP is one of the three worst malaria affected states. While malaria seems to be prevalent both in Urban and rural areas and throughout the country in varying degrees, the areas having an annual parasite index (API) of more than 2 are estimated to be about 100 districts in eight states. MP and Orissa alone account for 50% of mortality due to malaria in India. Rural residents are twice more likely to suffer from malaria than urban residents[12] (10015 and 5240 respectively per lakh population).

2.8 Reproductive and Child Health

Maternal, perinatal and childhood conditions account for a significant percentage of the disease burden as discussed earlier.

2.9 Non-communicable diseases

Non communicable diseases include cancers, cardiovascular diseases, diabetes, respiratory conditions such as asthma and chronic obstructive pulmonary disease and mental health conditions. They account for about 55% of medically certifiable deaths, including circulatory diseases, respiratory diseases and diseases of the digestive system. These conditions are on the rise. The prevalence of such diseases in the rural areas is still comparatively less than the urban areas

2.10 Injuries/Trauma

Road accidents are another major killer of young, and often poor, adults in India and Madhya Pradesh. Many of the measures to address accidents and their impacts lie in realms outside the health sector, and may have to do with urban planning, road designs, vehicle quality and design features, driving skills, non-use of helmets and poor control of speed. These require improved regulatory design as well as better enforcement of the law against violators of traffic rules. The status is has be mentioned in Table VII.

Table VII
Accident in Madhya Pradesh

Status of Road accident in Madhya Pradesh				
Year	**Accidents**	**Persons Killed**	**Persons Injured**	**% Increase/decrease**
1999	30559	5627	31296	-7
2000	23805	3810	26247	-22
2001	24895	3863	27700	5

Source: Annual Progress Report Police department, MP, 2006

[12] National Family Health Survey-II

2.11 Structure of Health Care Delivery

Like the rest of the country, the state of Madhya Pradesh has also tended to focus more on selective vertical programmes aimed at specific diseases, rather than comprehensive health care at the Primary level. The state has focused on Reproductive and Child Health and other National Programmes aimed at controlling TB, Blindness, Malaria etc. However, there is a growing realization at the national as well as state level, that such an approach, though successful in terms of specific diseases such as Polio and Leprosy, has not yielded desired results in many cases. It has also kept the community involvement away from health care. The National Rural Health Mission aims at integrating the vertical programmes and providing horizontal linkages that will strengthen the health delivery system and lead to greater involvement of the community. The state of Madhya Pradesh is also moving in a similar direction.

Health care delivery options are available in the public sector as well as the private sector. These include allopathic, Indian system of medicine (Ayurvedic, Unani) and Homeopathy. However, Allopathy is the dominant system in both public and private sectors.

3. Public sector

The allopathic health care delivery system in rural areas is based on a network of 8835 sub health centres, 1194 private health centres and 227 community health centres. These have been set up in accordance with GoI policy/guidelines:

- Sub Health Centre (SHC): staffed by a MPW (male) and a MPW(female)/ANM, the SHC is envisaged to cater to a population of 5000 (3000 in hilly areas), provide limited primary care and act as a stock point for basic medical and family welfare supplies. In MP, a population of 5000 could be scattered across 6 villages. There is minimal curative service at the SHC.
- Primary Health Centre (PHC): is envisaged to have a qualified medical officer, cater to a population of 30,000 (20,000 in hilly areas), provide in patient services (6 beds) and act as a referral unit for 6 SHCs;
- Community Health Centre (CHC): is envisaged to have 4 medical specialists (including surgeon, physician, gynecologist, pediatrician), 30 beds, operating theatre, laboratory facilities and act as a referral centre for 4 PHCs.

In urban areas there are 48 district and 57 civil hospitals, which are also expected to act as referral centres for CHCs. In addition, there are specialized hospitals (TB, leprosy, mental) as well as hospitals attached to medical colleges.

Tertiary health care is provided almost exclusively by specialist and medical school teaching hospitals and by the district and civil hospitals in the larger cities.

ISM&H has a parallel health delivery system consisting of about 1622 dispensaries spread across the state in both rural and urban areas as well as hospitals and teaching colleges.

The total number of public health facilities is summarized in Table V. As shown, the allopathic public sector is estimated to have a total of about 26,000 beds including 9300 beds in rural areas.

4. Private sector

The private sector health care delivery system consists of:

- Traditional Practitioners including herbalists who are based in the village and provide low cost treatment for minor ailments; payment is quite often in kind and can be deferred;
- Dais (traditional birth attendant) are also based in the village and are normally the most experienced person available for assistance during child birth. They provide a personal touch and offer a convenient and affordable method of payment;
- Registered Medical Practitioners (RMPs)/unqualified practitioners are again accessible since they would be based in the same or nearby village. Quite often, they are the only help available during emergencies especially for those who cannot travel large distances
- Qualified Private Practitioners, both allopathic and ISM&H (ayurvedic, unani and homeopathy);
- Private nursing homes and hospitals including those for profit and non-profit;
- Private tertiary health care establishments.

In addition, there are a number of pathological laboratories/diagnostic centres. Pharmaceutical chemists would also quite often provide diagnostic/prescriptive services. Public sector doctors also practice privately.

Qualified private practitioners, nursing homes/hospitals and tertiary health care establishments are based in urban areas, while traditional practitioners, dais and RMPs are present in both rural and urban areas.

Table X
PUBLIC HEALTH FACILITIES IN MADHYA PRADESH[13]

	Allopathic			ISM & H		
	No.	**Avg. no. of beds**	**Total beds**	**No.**	**Avg. no. of beds**	**Total**
Rural						
1. SHC	8835					
2. PHC	1194	2	2400			
3. CHC	227	30	6900			
4. ISM & H				1622	N A	N A
Urban						
5. Civil dispensaries	97					
6. Post partum centres	96					
7. Civil hospitals	57	48	2700			
8. District hospitals	39	214	7700			
9. ISM & H hospitals				34	30	N.A
10. Specialised hospitals	11	53	600			
11. Disease specific units	90					
12. Teaching hospitals	6	939	5600	9		
			26000			

Note:

- Specialised hospitals (allopathic) includes TB hospitals(7), TB sanatoriums(1), mental hospitals(2).
- Disease specific units include malaria control units (34), blindness (51), and leprosy treatment clinics (5).
- Rural family welfare centres, which will typically be a part of PHC/CHC have not been shown above.

5. Reach of public health facilities in MP

The reach of public sector health facilities in MP is poor compared to GoI norms/other states in India:

- As of October, 2001 MP had established only 53% of CHCs required in accordance with GoI norms. For SHC, PHC and district hospitals, the corresponding figure was 84, 71 and 80 percent respectively (Table VII);
- Average number of villages and rural area covered by a SHC in MP is 5.99 and 36.46 km^2, the corresponding all India average being 4.27 and 22.81 km^2 respectively (Bulletin on Rural Health Statistics in India, 2000, Rural Health division, MOHFW, GoI);
- health workers cover on an average six villages and have to cover a radical distance of 3.3 kilometres for delivery of primary health care services

[13] Source : Annual Report 2004-2005 of H&FW, ISH&H documents and IIHMR 2002

- Only 16 percent rural households had to travel less than half a kilometer to access a primary health centre, whereas 29 percent had to travel between 2-5 kilometres and forty percent had to travel 5-10 kilometres in 1993[14]

6. Quality of services

In virtually every district, the district hospital is well short of the personnel and "equipment checklist" norms for almost all items, but is functional and has to cope with considerable demand for services. The PHCs and CHCs show a great diversity in functionality, with some being little more than meeting sites for block workers and outreach activities, while others have busy OPDs and inpatient services. SHCs, which are closest to most patients homes, are the most likely to not have any dedicated facilities. There is a shortage of manpower at all levels, from Doctors and nurses to paramedical and field staff such as ANMs. Poor attendance by staff in institutions worsens the situation. The quality of training of staff is not up to the mark and many of the field functionaries are not well trained in the basic skills required from them.

7. Factors determining choice of health service provider

Depending on the nature and perceived severity of the illness, a combination of factors determine choice of health service provider, including: accessibility in terms of distance/time spent in reaching health care facility, availability of infrastructure/services i.e. health personnel, equipment, supplies, effectiveness of treatment (diagnosis/prescription) and cost - including credit and possibility of payment in kind. While seeking health care, people increasingly prefer approaching private health care, if they can afford it. The reasons for this, apart from the problems associated with distance, are the poor quality of services, lack of availability of doctors and their unsympathetic attitude.

8. Inter Sector Convergence

The overall well-being of the citizens depends upon the synergistic functioning of the various sectors in the socio-economy. The health status of the citizens would be dependent on various factors besides the health care service delivery i.e. adequate nutrition, safe drinking water, basic sanitation and a clean environment especially for the women and girl child. From the policy perspective, it is therefore imperative that the independent policies of each of these inter-connected sectors, be in tandem, and that the interface between the policies of the two connected sectors, be smooth.

The intersectoral convergence would ensure specific active and effective involvement of government departments, especially development departments, in order to improve health outcomes. The different sectors can work in close

[14] Sarvekshnana, 78th issue, January-March 1999, NSSO (49th survey) Government of India

coordination with each other to bring about a common objective, and then outcomes can be achieved in a shorter span of time and in a cost-effective manner. The following matrix outlines the linkages and the extent of impact that it can have in the DPH&FW.

Sector / Issues	**Child Health**	**Maternal Health**	**Disease Control**	**Newborn care**
Rural development	High	Very High	High	High
Women and Child Development	Very High	High	Moderate	Very High
PHED	High	High	Very High	Moderate
Education	Very High	Very High	Very High	Very High
Public-Private partnerships	Very High	Very High	Very High	Very High

The above is only illustrative and not exhaustive and this can be very clearly brought out only after consultations with the different departments and after analyzing their programs and objectives.

Section - 2
Medium Term Health Sector Strategies

The Programmatic and Financial areas have been described under the heads as given below.

1) Health Care Service delivery.

2) Strengthening of Health Institutions.

3) Improving the Maternal and Child Health Care.

4) Population Stabilization.

5) Major diseases control programmes.

6) Reducing out of pocket expenditure.

7) Addressing related issues like Environmental health and Nutrition.

A. Financing Strategy

B. Resource Allocation Strategy

D. Payments Strategy

1) Health Care Service Delivery

The state of Madhya Pradesh is characterized by high mortality and morbidity figures. Moreover the low levels of health expenditure make it impossible to provide quality health care for all. It is also noteworthy that there is a need for enhancing the health facility coverage and staffing as per norms. The coverage and service deployment strategies must focus on local health needs. Utilization of Government facilities must be enhanced. The presence of adequate number of grass root level health functionaries like ASHA, ANM & Aanganwadi Worker (AWW) is to be ascertained to ensure community participation.

1. **Improved quality of services through adequate infrastructure, appropriate staffing and capacity building:-** The number of institutions will be increased as per population norms (as per 1991 census) and the package of services offered will be upgraded. In order to ensure improved quality of services efforts will be made to ensure that 90% of the staff is available across all cadres. A proper data bank will be maintained about the manpower and details such as promotions and retirement of staffs. This data bank will also help in timely assessment of requirement of staffs. Regular programmes for capacity building, knowledge upgradation and skill development for present staff as well as the newly recruited manpower will be conducted.

2. **Promoting access to improved health care at Household and Community level through involvement of ASHA, PRIs, CBOs, etc:-** The required number of ASHA will be selected trained and made functional in the stipulated time to ensure that improved health care is available at the household level. The village plan will be developed with the involvement of PRIs and CBOs and it will be based on the actual needs of the community.

3. **Strengthening supportive supervision, monitoring and reporting mechanism to ensure accountability and optimize outputs:-** A Monitoring and Evaluation Cell will be set up in the Directorate of Health & Family welfare. This will network with all the districts and will collect and compile information about all the health programmes being run by the department. The manpower available in the department under Strategic Planning Unit (SPU) and State Programme Management Unit (SPMU) will be responsible for generating reports and monitoring.

4. **Introducing Audits like Referral audit, Maternal and Child death audit, Medical audit, Resource utilization audit, etc. on a sample basis to validate the authenticity of services**:- In order to ensure the authenticity of services and verify and validate the information about various health programmes, the department will establish a Quality Assurance Team (QAT). An Audit System that looks at issues like referral, maternal and child death, medical services offered and resources utilization will also be setup.

5. **New initiatives like introducing Public Health Course and placement of Hospital Management professionals at Government Health Facilities:-** The department will identify institutions where Public Health courses for existing doctors can be introduced. Efforts will also be made to appoint Hospital Management (HM) professionals in the key government health facilities.

6. **Develop a Drug Policy to increase efficiency of procurement, streamline distribution mechanism and ensure timely supply of quality drugs in the public health system:-** The draft Drug policy of the state is under preparation and will be soon finalized by the Government. Once the finalization of the drug policy is done the same will be implemented in the State.

7. **Implementation of Medical Insurance Scheme:-** The department is looking at different models of medical insurance schemes. These will be finalized and implemented within the next five years.

2) Strengthening of Health Institutions:-

The strengthening of the health institution would focus on optimal expert care to the community, ensuring quality of care and above all making the services more responsive and sensitive to the needs of the beneficiaries. In order to provide a complete package of services adequate inputs will be channelized in terms of human resources, equipments, additional funds, etc. This will result in adequate upgradation of the system to handle the demand generated and will ensure patient's satisfaction.

1. **Equipping Health Institutions/facilities through appropriate provision of manpower (for e.g. regular & contractual staffing), fiscal (for e.g. regular and untied funds) and physical resources (e.g. repair/renovation, extension, equipments):-** In the first step, 96 CHCs will be upgraded as per Indian Public Health Standard norms and will be fully equipped. Efforts will be made to ensure deployment of sufficient manpower as well as ensure availability of fiscal and physical resources in the remaining institutions.

2. **Introduce a Logistics Management System (LMS) to enhance functionality of Health Institution:-** The state will design and establish a LMS at the State level and district level. This will ensure adequate availability of medicine, vaccines and equipments at health institutions.

3. **Administrative & Human Resources reforms in the department e.g. Appraisal system, incentives, promotions, transfers, etc.:-** The state has already conducted a Workforce Management study under the Sector Investment Programme and the same is under circulation for obtaining the

comments and suggestions. The recommendations of the study will be discussed and implemented soon.

3) Improving Maternal & Child health care

Maternal & Child Health holds the key to addressing overall reproductive and child health problems. Madhya Pradesh has the second highest MMR (498 as per SRS data) and highest IMR (82 as per SRS data) in the country. Therefore, it is imperative to ensure proper facility and services within the reach of people through the following programme strategies.

1. **Improving Maternal Health through enhancing quality of ANC & PNC and increasing institutional deliveries:-** Skill upgradation of ANM and other para medical staff is being carried out. In NRHM selection of 40% ASHAs has been completed and in the next year the balance number of ASHAs will be selected. The training of ASHAs will start in the current year. Availability of emergency obstetric care services in the identified health institutions of the state will be ensured in the next five years. Special efforts are being made to increase the number of institutional deliveries. Schemes like Janani Suraksha Yojana (JSY) and Prasav Hetu Pariwhan Ayam Upchar Yojana (PHPAUY) have been introduced to provide cash incentives to the population living below poverty line. Cash incentives are being introduced for the staff working in health institutions where safe deliveries are taking place. It is hoped that these interventions will help in increasing the number of institutional deliveries and reducing the maternal and infant morality rates.

2. **Improving Child Health to reduce Mortality, Morbidity and Malnutrition:-** The department will strive at improving the quality of child health care, particularly new born care by ensuring better implementation of the Integrated Management of Neonatal and Childhood Illness Programme. The department will work with Women and Child Development Department in the implementation of Infant and Young Child Feeding norms. The department will also strengthen the referral system in the state. New schemes like Bal Shakti Yojana are also being implemented to take care of adverse effects of malnutrition. Skill enhancement of ASHA and ANM regarding child health will also be carried out.

3. **Public Private Partnership to enhance accessibility and availability of MCH services:-** The department is working on Public Private Partnership (PPP) for establishing mobile health clinics in remote inaccessible areas. The PPP for outsourcing government health institutions and accreditation of Private Health Providers is under consideration.

4) Population Stabilization

The Family Welfare Programme is vital for controlling and stabilizing the population. A favourable political and administrative climate is vital for successful implementation of population stabilization programme. The department will aim at achieving the state's population policy goals by focusing on

1. **Enhancing the awareness, choice, acceptance and quality of family planning services:- T**he department will establish well equipped sterilization wards cum counseling centers at health institutions. It will improve the social marketing of contraceptives. Behaviour Change Communication activities for socio-economic issues and utilization of family welfare services will be intensified. Skill training of ANMs on IUD insertion and Medical Officers and Staff Nurses for injectable contraceptives will be carried out on a pilot basis. Special efforts will be made to meet the existing unmet demand for family planning services by increasing the availability of contraceptives. Awareness levels about safe abortion will be raised by involving NGOs, CBOs and SHGs. Efforts will also be made to provide good facility for safe medical termination of pregnancy.

2. **Increasing Male participation in Family Planning:-** The department is actively promoting Non Scalpel Vasectomy Technique (NSVT) to increase male participation in family planning services. This is aimed at correcting the present gender imbalance in the acceptance of family planning services which places an overwhelmingly high burden on women.

3. **Strengthening the Adolescent Reproductive and Sexual Health (ARSH) services:-** The department will establish multipurpose youth friendly centers and incorporate the health components recommended in National Youth Policy 2003 on pilot basis**.** The Adolescent Reproductive and Sexual Health services (ARSH) will be incorporated in schools through involvement of teachers, parent and students. Improved BCC activities on issues such as child marriage, age at marriage and precautions for preventing RTI/STI among adolescents will be carried out.

5) Major disease control programmes

The implementation of various National Programmes for the control of specific diseases is being done through registered societies at the state and district level. All the existing vertical societies have been integrated into State and District Health Societies. The State would focus on effective implementation through an integrated Society in order to avoid duplication of activities and ensure optimum use of resources at State and District level. It would have a positive impact on the overall purpose i.e. reduction of morbidity and mortality and providing quality care.

1. **Increase the awareness of IDSP:-** The department will establish and operationalize a central level Disease Surveillance Unit and will strengthen

disease surveillance at the state, district and sub district levels through improving laboratory supports and trainings.

2. **AIDS Control Programme:-** The department will strengthening the existing counseling centres in the district hospitals established by State AIDS Control Society and will establish counseling centres in the remaining districts depending on availability of resources. Effective implementation of the awareness programme in identified high risk areas and monitoring of NGO activities in the state.

3. **The Malaria control programme needs to be reassessed in terms of its priorities, the data collection process and effectiveness.** The department will ensure the identification of hotspot areas and will develop specific plans based on local needs which would improve the data collection, sample collection, testing, treatment.

4. **The TB control programme to be strengthened and effective implementation at community level through DOTS:-** The department is already running the TB control programme in the state. More effective IEC of DOTS will be carried out to ensure community involvement, early detection and timely treatment.

5. **Improve the data collection strategy to enable accurate assessment of coverage of immunization:-** The department will develop a computerized monitoring system for immunization which will improve the assessment of immunization coverage and regular and timely supply of vaccine based on the actual requirement. To achieve 100% coverage of immunization effective IEC will also be done for community mobilization.

6) Resource allocation strategy for reducing out of pocket expenditure

The department will need a better allocation of public resources. Public funds are currently not put to optimal use. Resources are not allocated in a cost effective manner. A high proportion of benefits goes to the better off and there is evidence of inefficiency. A key challenge will be to move towards a situation where resources are allocated on the basis of need and clearly identified priorities rather than on an incremental basis at present. Another aspect is a lack of cost consciousness at all levels. Resources allocation should have a pro rural and pro poor bias. This strategy will comprise of the following:-

1. **A public expenditure review will be carried out to capture expenditure against various heads classified as fixed, semi-variable, variable; by target group (Poor/SC/ST) and by urban and rural. Health institutions will be opened according to the 2001 census population norms in the State:-** The department will appoint a team of experts to identify and reallocate the funds available from different sources like GoMP, GoI and external donors. The team will develop a strategy to ensure effective use of

available funds. The team will also work on identification of new areas for opening of new centres.

2. **Organizing regular Health Melas in out reach areas:-** The department is already organizing Health Melas as per the integrated District Plans. The state will instruct the district to prepare a calendar for the districts based on local needs in outreach areas. The annual calendar will be displayed and proper IEC will be done for the success of the Melas.

3. **Extending the existing pro-poor scheme like the Dindayal Antyodaya Upachar Yojana (DDAUY), Janani Suraksha Yojana(JSY), Prasav Hetu Parivahan Evam Upachar Yojana (PHPEUY) and starting new scheme like Health Insurance:-** The department has already implemented the DDAUY, JSY and PHPEUY in the state. The success of these programmes is being monitored closely. The department has taken these programmes on top priority and hence effective implementation, monitoring and feedback needs to be strengthened. The Health Insurance schemes are being prepared.

4. **New schemes for Health check up, Maternal & Child Health, Adolescent reproductive and sexual health and Family Welfare programmes for poor, urban slums and other areas:-** The schemes which need immediate review will be identified and necessary amendments will be made. New schemes will be developed to fill the gaps.

5. **Mobile units to be established between rural areas and referral centers:-** Nineteen districts have been identified for running the Mobile units. The department has identified 170 CEmONC as referral centres which will be upgraded in the coming years.

7) Addressing related issues like Environmental health and Nutrition

The better health status of the people is vital to economic well being. The concept of holistic approach to community health management emphasizes the need to address Environmental Health (safe drinking water and sanitation, waste management, hygiene, indoor air pollution and health care waste management) and Nutrition issues in coordination with department of PHED & WCD respectively. The department will develop a pragmatic strategy on these issues and identify the capacity building needs for effective implementation.

1. **Enhanced Intersectoral Convergence with Department of W&CD (for Nutrition, Gender & Equity Issues, Adolescent Health etc.); Department of PHE (for Environment Health), DP&SW (for involvement of PRI's) and DISM for integrating AYUSH) etc.:-** A team of representatives from all the departments will assess the availability of funds in each department. Based on this assessment the responsibility of each department will be clearly outlined. This will avoid duplication and waste of

resources. The team will conduct Joint review meeting, finalize priority issues, ensure grass root involvement and carry out joint training programmes. A website interlinking these departments will be created and will display the progress of common activities based on a new GIS.

2. **NGO Partnerships for Community Mobilization:-** The department is promoting the involvement of NGOs in the health sector. Organizations working in the field of environment health, nutrition and issues related to AYUSH as well as health awareness will be activity encouraged in community mobilization.

A. Financing Strategy

The Department receives funding from the Government of Madhya Pradesh, the Government of India, External Aid Agencies and Rogi Kalyan Samitis. Other potentially important sources of funds can be Community Contribution, MP & MLA Local Area Development funds.

In order to achieve the health policy goal it is necessary to increase the present level of resource allocation. The present allocation of Health Department is Rs.901 crores and the Finance Department is committed to increase it by 10% every year. The funds available with Medical Education Department & …….will also be pooled. The Government of India is supporting under NRHM for National Health Programmes. The department can receive additional funds under NRHM if performance on key indicators is good. External Aid agencies like DFID, EC, UNICEF, UNFPA, JICA, etc. are also providing funds for specific activities.

The Rogi Kalyan Samitis (RKS) try to raise resources through commercial use of assets and donations from local citizens. The RKS will also get the matching grants under NRHM.

Valuable contribution for infrastructure development can also come in from MP/MLA local area development fund. Other departments like Tribal Welfare and Rural development can also contribute significantly in this respect.

C. Payments Strategy

Presently the payment of staff in the department is based on cadre and seniority. This strategy will comprise of:

1. Review of Human Resources of the department.
2. Review of payment structure and shift from salary to salary plus performance based incentive system.
3. Policy formulation in regard to Public Private Partnership (PPP). This policy will include the identification of areas for development where PPP can be undertaken, implementation mechanism and monitoring.
4. Formulation of Health Insurance Schemes that will benefit the poor, disadvantaged and other vulnerable groups.
5. Policy formulation for differential payment structure for rural and difficult areas.

Log Frame for Medium Term Health Sector Strategy (2006 TO 2011)

1) Health Care Service Delivery

STRATEGY	ACTIVITY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERFICATION
Improved quality of services through appropriate Staffing, Infrastructure & Capacity building.	• Ensuring 90% of the staff available across all cadres • Upgrading the institutions as per population norms and package of services to be offered.	• Status of manpower. • No of Institutions established and upgraded against requirement.	• Department reports.
Promoting access to improved health care at Household and Community level through involvement of ASHA, PRIs, CBOs, etc.	• ASHA selected, trained and functional. • Village health plans prepared with involvement of PRI and CBOs.	• No of ASHA functional • Village health plans prepared	• Department reports.
Capacity Building to upgrade knowledge and skills of staff	• Capacity building of staff across all cadres at regular intervals viz. refresher, skill upgradation, etc.	• No of capacity building sessions and staff trained	• Training reports.
Strengthening supportive supervision, monitoring and reporting mechanism to ensure accountability and optimize outputs.	• Establishment of Monitoring and Evaluation Cell. • Preparation of HMIS • Establishing Universal Filing system • Feedback and reporting mechanism at State & District level	• Monitoring and Evaluation Cell functional • Data collected & compiled as per HMIS. • UFS in place. • Sample checking of received reports	• Monitoring reports • Evaluation Reports
Introducing Audits like Referral audit, Maternal and Child death audit, Medical audit, Resource utilization audit, etc. on sample basis to validate the authenticity of services.	• Formation of Quality Assurance Team (QAT) • Establishment of Audit System	• Quality Assurance Team functional • No. of audits conducted at regular intervals.	• Audit Report
Develop a Drug Policy to increase efficiency of procurement, streamline distribution mechanism and ensure timely supply of quality drugs in the public health system.	• Drug Policy enforced. • Formation of Drug Corporation	• Drug policy in place. • Drug Corporation functional.	• Policy document • GO issued. • Procurement & Supply through the drug corporation
New initiatives like introducing Public Health Course and placement of Hospital Management professionals at Government Health Facilities.	• PH Course introduced. • Training of doctors in Hospital Administration • Hiring of HM Professional.	• No. of Batches completed. • No. of doctors trained and placed. • No. of HM professionals in place.	• No. of pass outs • Reports
Implementation of Medical Insurance Scheme	• Formulation of Medical Insurance Scheme • Implementation of Medical Insurance Scheme	• No. of person benefited under Medical Insurance Scheme	• Government and Insurance Companies Report

2. Strengthening of Health Institutions

STRATEGY	ACTIVITY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERFICATION
Equipping Health Institutions/facilities through appropriate provision of manpower (for e.g. regular & contractual staffing), fiscal (for e.g. regular and untied funds) and physical resources (e.g. repair/renovation, extension, equipments).	• Resource Mapping and Facility Survey • Ensuring 90% of the staff available across all cadres • Upgrading the institutions as per population norms and package of services to be offered. • Supply of equipments based on facility survey and services provided by Health Institutions • Upgrading Community Health Center to IPHS standards	• Survey Report • Status of Sanctioned Vs. Filled Positions • No. of Institutions established and upgraded against requirement. • List of Equipment Supplies as per norms • No. of Community Health Center upgraded	• Department reports. • Audit reports
Introduce a Logistics Management System to enhance functionality of Health Institutions	• Design LMS • Establish LMS Cell at State and District level	• Logistic Management System operationalized at State & District level.	• Report from LMS cell
Administrative & Human Resources reforms in the department e.g. Appraisal system, incentives, promotions, transfers, etc.	• HR policy revision	• Policy Document in place	• Review/Appraisal Report

3. Improving Maternal & Child health care

STRATEGY	ACTIVITY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERFICATION
Improving Maternal Health through enhancing quality of ANC & PNC and increasing institutional deliveries.	• Skill upgradation of ANM to provide quality services at community level with involvement of ASHA and at SHC level. • Special schemes for referral transportation and cash incentives for all categories with pro poor focus. • Availability of Emergency Obstetric Care at health institutions within reach.	• No of Skill trainings organised. • % increase in institutional deliveries. • No of health institutions providing Emergency obstetric care.	• Training Reports • Departmental Report
Improving Child Health to reduce Mortality, Morbidity and Malnutrition	• Improving quality of Child Health Care as per New Born Care (NBC), Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and Infant and Young Child Feeding (IYCF) norms. • Skill enhancement of service providers specially ANM and ASHA. • Availability of Neonatal Care at health institutions within reach. • Establish a functional referral system for malnourished and sick children.	• Guidelines for incorporating requisite norms. • Training calendar prepared and training started as per IMNCI norms • Skill training of service providers organised • No of health institutions providing Neonatal care. • % increase in cases referred	• Published & circulated • Training reports • Training reports • Reports from health institutions
Public Private Partnership to enhance accessibility and availability of MCH services	• Scaling up the mobile clinic scheme in remote inaccessible areas. • Accredited of Private Health Clinics	• No of district with Mobile Clinic scheme. • No of Private Health Clinics accredited	• Report from Partners

4. Population Stabilization

STRATEGY	ACTIVITY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERFICATION
Enhancing the awareness, choice, acceptance and quality of family planning services	• BCC activities (IEC & IPC) for socio-economic issues and utilization of family welfare services. • Skill training of ANMs for IUD insertion and medical officers & staff nurse for injectable contraceptives o pilot basis • Social marketing of contraceptives. • Establishing beneficiaries oriented sterilization ward cum counseling centers at health institutions.	• BCC activity framework. • No. of skill training of health functionaries. • No. of social marketing franchise established. • No. of wards/centers established.	• District Plans • District reports
Strengthening the Adolescent Reproductive and Sexual Health (ARSH) services	• Incorporating the health components recommendations as per National Youth Policy 2003 on pilot basis. • BCC activities for issues such as child marriage, age at marriage, RTI/STI, etc. • Establishing multipurpose youth friendly centers (YFC) at district level health institutions. • Incorporating ARSH component in school through involvement of teachers, parents and students.	• No of pilot projects initiated. • BCC activities framework. • No. of YFC established. • No. of districts introducing ARSH education in schools.	• Reports and Survey

5. Major disease control programmes

STRATEGY	ACTIVITY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERFICATION
Increase the involvement of community in awareness of IDSP.	• Establish and Operate a Central-level Disease Surveillance Unit. • Strengthen disease surveillance at the state, district & sub district levels. • Improve Laboratory Support. • Training for Disease Surveillance	• Central-level Disease Surveillance Unit is functional • Epidemic Response protocol established. • No. of blood slide collected • No. of training conducted	• Reports
Increase the management capacity of NGOs involved with HIV/AIDS and Blindness Control programme.	• Effective implementation of the awareness programme in identified high risk areas. • Strengthening counselling centres in District Hospitals. • Monitoring of NGOs activities	• No. of cases identified. • No. of counselling cases identified. • Random Sampling.	• Reports
The malaria control program needs to be reassessed in terms of its priorities, the data collection process and effectiveness.	• Identification of hotspot areas. • Specific plans as local needs. • Effective sample collection, testing and treatment • Social Marketing of mosquito nets. • Strengthening of data collection	• No. of hotspots areas identified. • Plan developed. • No. of cases identified and cured. • Random cross verification of data collected.	• Reports
The TB control programme to be strengthened and effective implementation at community level through DOTS	• Effective IEC of DOTS for :- o Community involvement o Early detection and timely treatment	• No. of DOTS providers. • No. of case identified and cured.	• Reports
Improve the data collection strategy to enable accurate assessment of coverage of immunizations	• Development of immunization monitoring system • Assessment of coverage of immunization. • Regular supply of vaccine • IEC for community mobilization	• MIS system in place. • Random sampling • Vaccine is available • No of fully immunized children	• MIS reports • Field visit reports • Reports

6.Reducing out of pocket expenditure

STRATEGY	ACTIVITY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERFICATION
A Public expenditure review to capture expenditure against various heads classified as fixed, semi-variable, variable; by target group (Poor/SC/ST) and by urban and rural. Health institutions to be opened according to the census population norms in the State.	• Identification and reallocation of funds available under different head. • Identification of areas for opening new centres with GIS.	• Reallocation done • GIS in place and list prepared	• State budget • Report and finalization list
Organizing regular Health Melas in out reach areas.	• Calendar prepared and activity started.	• No. of Health Melas conducted	• Monthly report
Extending the existing pro-poor scheme like the Dindayal Antyoday Upachar Yojana (DDAUY), Janani Suraksha Yojana(JSY), Prasav Hetu Parvahn Avam Upachar (PHPAU)	• Effective implementation of pro poor schemes. • Monitoring & Feedback mechanism to be strengthened	• No. of beneficiaries. • Random sample of reported cases	• Reports
New schemes for Health check up, Maternal & Child Health, Adolescent reproductive and sexual health and Family Welfare programmes for poor, urban slums and other areas.	• Existing schemes to be reviewed and improved. • Develop new schemes as per need.	• Revised schemes in place. • No. of new schemes developed	• GO • State budget allocated.
Mobile units to be established between rural areas and referral centers.	• Strengthen present system • Out reach areas Identification. • PPP for effective implementation of Mobile units	• No. of fully functional mobile units. • No. of outreach areas covered. • No. of NGO involved	• Reports • Sample test & report

7. Intersectoral Convergence for Determinants of health and related issues.

STRATEGY	ACTIVITY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERFICATION
Enhanced Intersectoral Convergence with Department of W&CD (for Nutrition, Gender & Equity Issues, Adolescent Health etc.); Department of PHE (for Environment Health), DP&SW (for involvement of PRI's) and DISM (for integrating AYUSH) etc.	• Joint planning and review meeting at State level. • Specific schemes / activities designed with related departments. • Incorporating priority issues in integrated health plan. • Implementation at grass root level through involvement of functionaries from respective departments. • Joint training of PRIs, ANM, AWW and ASHA	• No. of review meeting organized. • No of schemes/activities designed and implemented eg. Bal Shakti Yojana • Specific activities like, IEC and schemes being implemented related to Nutrition, determinates of health, Water Sanitation and ISM	• GO issued and reports received.
NGO Partnerships for Community Mobilization	• BCC (IEC / IPC) at Community Level on Environment Health, Nutrition and AYUSH issues	• No of districts with NGO Partnerships	• NGO Reports

GANTT chart for Medium Term Health Sector Strategy (2006 TO 2011)

1) Health Care Service Delivery

STRATEGY	ACTIVITIES	I	II	III	IV	V	PERSON RESPONSIBLE
Improved quality of services through appropriate Staffing, Infrastructure & Capacity building.	Ensuring 90% of the staff available across all cadres	✓	✓	✓	✓	✓	
	Upgrading the institutions as per population norms and package of services to be offered.	✓	✓	✓	✓	✓	
Promoting access to improved health care at Household and Community level through involvement of ASHA, PRIs, CBOs, etc.	ASHA selected, trained and functional.	✓	✓	✓			
	Village health plans prepared with involvement of PRI and CBOs.		✓	✓	✓	✓	
Capacity Building to upgrade knowledge and skills of staff	Capacity building of staff across all cadres at regular intervals viz. refresher, skill upgradation, etc.	✓	✓	✓	✓	✓	
Strengthening supportive supervision, monitoring and reporting mechanism to ensure accountability and optimize outputs.	Establishment of Monitoring and Evaluation Cell.	✓					
	Preparation of HMIS	✓					
	Feedback & reporting mechanism at State & District level	✓	✓	✓	✓	✓	
Introducing Audits like Referral audit, Maternal and Child death audit, Medical audit, Resource utilization audit, etc. on sample basis to validate the authenticity of services.	Formation of Quality Assurance Team (QAT)	✓					
	Establishment of Audit System	✓					
Develop a Drug Policy to increase efficiency of procurement, streamline distribution mechanism and ensure timely supply of quality drugs in the public health system.	Drug Policy enforced	✓					
	Formation of Drug Corporation	✓	✓				
New initiatives like introducing Public Health Course and placement of Hospital Management professionals at Government Health Facilities.	PH Course introduced.	✓					
	Training of doctors in Hospital Administration	✓	✓	✓	✓	✓	
	Hiring of HM Professional.		✓				
Medical Insurance	Formulation of Medical Insurance Scheme	✓					
	Implementation of Medical Insurance Scheme	✓	✓				

2. Strengthening of Health Institutions

STRATEGY	ACTIVITIES	I	II	III	IV	V	PERSON RESPONSIBLE
Equipping Health Institutions/facilities through appropriate provision of manpower (for e.g. regular & contractual staffing), fiscal (for e.g. regular and untied funds) and physical resources (e.g. repair/renovation, extension, equipments).	Resource Mapping and Facility Survey	✓		✓			
	Ensuring 90% of the staff available across all cadres	✓	✓	✓	✓	✓	
	Upgrading the institutions as per population norms and package of services to be offered.	✓	✓	✓	✓	✓	
	Supply of equipments based on facility survey and services provided by Health Institutions	✓	✓				
Introduce a Logistics Management System to enhance functionality of Health Institutions	Design LMS	✓					
	Establish LMS Cell at State and District level	✓	✓				
Administrative & Human Resources reforms in the department e.g. Appraisal system, incentives, promotions, transfers, etc.	HR policy revision	✓					

3. Improving Maternal & Child health care

STRATEGY	ACTIVITIES	I	II	III	IV	V	PERSON RESPONSIBLE
Improving Maternal Health through enhancing quality of ANC & PNC and increasing institutional deliveries.	Skill upgradation of ANM to provide quality services at community level with involvement of ASHA and at SHC level.	✓	✓	✓	✓	✓	
	Special schemes for referral transportation and cash incentives for all categories with pro poor focus.	✓	✓	✓	✓	✓	
	Availability of Emergency Obstetric Care at health institutions within reach.	✓	✓				
Improving Child Health to reduce Mortality, Morbidity and Malnutrition	Improving quality of Child Health Care as per New Born Care (NBC), Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and Infant and Young Child Feeding (IYCF) norms.	✓					
	Skill enhancement of service providers specially ANM and ASHA.	✓	✓	✓	✓	✓	
	Availability of Neonatal Care at health institutions within reach.	✓	✓				
	Establish a functional referral system for malnourished and sick children.	✓	✓				
Public Private Partnership to enhance accessibility and availability of MCH services	Scaling up the mobile clinic scheme in remote inaccessible areas.	✓	✓				

4. Population Stabilization

STRATEGY	ACTIVITIES	I	II	III	IV	V	PERSON RESPONSIBLE
Enhancing the awareness, choice, acceptance and quality of family planning services	BCC activities (IEC & IPC) for socio-economic issues and utilisation of family welfare services.	✓	✓	✓	✓	✓	
	Skill training of ANMs for IUD insertion and medical officers & staff nurse for injectable contraceptives	✓	✓	✓	✓	✓	
	Social marketing of contraceptives.	✓	✓	✓	✓	✓	
	Establishing beneficiaries oriented sterilisation ward cum counselling centres at health institutions.	✓	✓	✓	✓	✓	
Strengthening the Adolescent Reproductive and Sexual Health (ARSH) services	Incorporating the health components recommendations as per National Youth Policy 2003 on pilot basis.	✓	✓				
	BCC activities for issues such as child marriage, age at marriage, RTI/STI, etc.	✓	✓	✓	✓	✓	
	Establishing multipurpose youth friendly centres (YFC) at district level health institutions.	✓	✓				
	Incorporating ARSH component in school through involvement of teachers, parents and students.	✓	✓	✓	✓	✓	

5. Major disease control programmes

STRATEGY	ACTIVITIES	I	II	III	IV	V	PERSON RESPONSIBLE
Increase the involvement of community in awareness of IDSP.	Establish and Operate a Central-level Disease Surveillance Unit.	✓					
	Integrate and strengthen disease surveillance at the state and district levels.	✓	✓				
	Improve Laboratory Support.	✓					
	Training for Disease Surveillance and Action	✓	✓	✓	✓	✓	
Increase the management capacity of NGOs involved with HIV/AIDS and Blindness Control programme.	Effective implementation of the awareness programme in identified high risk areas.	✓					
	Strengthening counselling centres in District Hospitals.	✓					
	Monitoring of NGOs activities	✓	✓	✓	✓	✓	
The malaria control program needs to be reassessed in terms of its priorities, the data collection process and effectiveness.	Identification of hotspot areas.	✓					
	Specific plans as local needs.	✓	✓	✓	✓	✓	
	Effective sample collection, testing and treatment	✓	✓	✓	✓	✓	
	Social Marketing of mosquito nets	✓	✓	✓	✓	✓	
	Strengthening of data collection	✓	✓	✓	✓	✓	
The TB control programme to be strengthened and effective implementation at community level through DOTS	Effective IEC of DOTS for :- Community involvement Early detection and timely treatment	✓	✓	✓	✓	✓	
Improve the data collection strategy to enable accurate assessment of coverage of immunizations	Development of immunization monitoring system	✓	✓				
	Assessment of coverage of immunization.	✓	✓	✓	✓	✓	
	Regular supply of vaccine	✓	✓	✓	✓	✓	
	IEC for community mobilization	✓	✓	✓	✓	✓	

6. Reducing out of pocket expenditure

STRATEGY	ACTIVITIES	I	II	III	IV	V	PERSON RESPONSIBLE
A Public expenditure review to capture expenditure against various heads classified as fixed, semi-variable, variable; by target group (Poor/SC/ST) and by urban and rural. Health institutions to be opened according to the 2001 census population norms in the State.	Identification and reallocation of funds available under different head.	✓	✓				
	Identification of areas for opening new centres with GIS.	✓	✓				
Organizing regular Health Melas in out reach areas.	Calendar prepared and activity started.	✓					
Extending the existing pro-poor scheme like the Dindayal Antyoday Upachar Yojana (DDAUY), Janani Suraksha Yojana(JSY), Prasav Hetu Parvahn Avam Upachar (PHPAU) and starting new scheme like Health Insurance.	Effective implementation of pro poor schemes.	✓	✓				
	Monitoring & Feedback mechanism to be strengthened	✓	✓				
New schemes for Health check up, Maternal & Child Health, Adolescent reproductive and sexual health and Family Welfare programmes for poor, urban slums and other areas.	Existing schemes to be reviewed and improved.	✓					
	Develop new schemes as per need.	✓	✓				
Mobile units to be established between rural areas and referral centers.	Strengthen present system	✓					
	Out reach areas Identification.	✓					
	PPP for effective implementation of Mobile units	✓	✓				

7. Intersectoral Convergence for Determinants of health and related issues.

STRATEGY	ACTIVITIES	I	II	III	IV	V	PERSON RESPONSIBLE
Enhanced Intersectoral Convergence with Department of W&CD (for Nutrition, Gender & Equity Issues, Adolescent Health etc.); Department of PHE (for Environment Health), DP&SW (for involvement of PRI's) and DISM (for integrating AYUSH) etc.	Joint planning and review meeting at State level.	✓	✓	✓	✓	✓	
	Specific schemes / activities designed with related departments.	✓	✓	✓			
	Incorporating priority issues in integrated health plan.	✓	✓	✓	✓	✓	
	Implementation at grass root level through involvement of functionaries from respective departments.	✓	✓	✓	✓	✓	
	Joint training of PRIs, ANM, AWW and ASHA	✓	✓	✓	✓	✓	
NGO Partnerships for Community Mobilization	BCC (IEC / IPC) at Community Level on Environment Health, Nutrition and AYUSH issues	✓	✓	✓	✓	✓	

Key data sources/references relevant to this section are:

- National Family Health Survey II 1998-99 MP, (NATIONAL FAMILY HEALTH SURVEY II) for data on mortality, morbidity and indicators depicting impact of interventions on health outcomes, etc.
- Special Studies Report (IIHMR 2001), for data on medically certified deaths.
- Study of dynamics and structure of private healthcare in MP (TARU Leading Edge, 2001) for data on mortality and morbidity from NCAER 1995, etc.
- Bulletin on Rural Health Statistics in India by Ministry of Health and Family Welfare, GoI for state wise comparison.
- State of Health in MP 1998 by Alok Ranjan Chaurasia.
- Draft Tenth Five Year Plan, SDHFW, GoMP for comparison on mortality indicators across states.
- Improving Women's Health in India - Development in Practice, (World Bank, 1996) for country data on MMR and related factors.
- Reducing Child Mortality in India: Keeping Up the Pace (World Bank, 1999) for country data.
- Changing the Indian Health System: Current Issues, Future Directions (ICRIER, August 2001) for state wise data on morbidity.
- Community based health management systems - perspectives of primary stakeholders (Samarthan report) 2001
- National Population policy 2000
- NRHM,
- Background papers of Sector
- National Human Index

Organogram: Department of Public Health & Family Welfare