NHM, Jammu and Kashmir

ROAD MAP FOR REDUCING INFANT MORTALITY RATE (IMR) TO SINGLE DIGIT (2018-22)

DRAFT

NIPI-Jhpiego

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k. Strengthening Reproductive health services.
l. Strengthening Adolescent health services.
m. Strengthening of data related to mortality of maternal and child deaths.
n. Strengthening of existing interventions.

9. **Budgetary requirements**

ABBREVIATIONS

AARR Average Annual Rate of Reduction	**LBW** Low Birth Weight
ANM Auxiliary Nurse Midwife	**LaQshya** Labour Room Quality improvement Initiative
ASHA Accredited Social Health Activist	**MNCH** Maternal Newborn Child Health
ANC Antenatal Care	**MO** Medical Officer
BEmOC Basic Emergency Obstetric Care	**NICU** Neonatal Intensive Care Unit
CEmOC Comprehensive Emergency Obstetric Care	**NHP** National Health Policy
CH Child Health	**NHM** National Health Mission
CHC Community Health Centre	**NMR** Neonatal Mortality Rate
ENMR Early Neonatal Mortality Rate	**NFHS** National Family Health Survey
ETAT Early Triage and Treatment centre	**NSSK** NavjaatShishu Suraksha Karyakram
FBNC Facility Based Newborn Care	**NRHM** National Rural Health Mission
FRU First Referral Unit	**PHC** Primary Health Centre
FPC Family Participatory Care	**PPIUCD** Postpartum Intra Uterine Contraceptive Device
HBYC Home Based Care of Young Child	**RBSK** Rashtriya Bal Swasthya Karyakram
HBNC Home Based Newborn Care	**RMNCH+A** Reproductive, Maternal, Newborn, Child and Adolescent Health
HDU High Dependency Unit	**SBA** Skilled Birth Attendant
HMIS Health Management Information System	**SBCC** Social Behaviour Change Communication
HPD High Priority District	**SN** Staff Nurse
HR Human Resource	**SNCU** Special Newborn Care Units
HRH Human Resources for Health	**SBR** Still Birth Rate
IMR Infant Mortality Rate	**SDG** Sustainable Development Goals
IUCD Intrauterine Contraceptive Device	**TFR** Total Fertility Rate
ICDF Intensified diarrhoea control fortnight	**U5MR** Under Five mortality rate
IYCF Infant and Young Child Feeding	**WASH** Water Sanitation and Hygiene
JSSK Janani Shishu Suraksha Karyakram	**NICU** Neonatal Intensive Care Unit
JSY Janani Suraksha Yojana	**NMR** Neonatal Mortality Rate
KMC Kangaroo Mother Care	

EXECUTIVE SUMMARY

Infant mortality is the death of child before his or her first birthday. Infant mortality Rate(IMR) that refers to number of infant deaths per 1000 live births is an important marker of health in the society particularly maternal and child health. IMR includes neonatal deaths (deaths within first month of life) and post neonatal (between 1month and 1 year of life). The major causes of neonatal deaths are pre-maturity/preterm (35%), neonatal infections (33%), intra-partum related complications/birth asphyxia (20%) and congenital malformations (9%). Infections particularly pneumonia and diarrhoea are major contributors of post-neonatal infant mortality. Most of the infant deaths happen in the first month of life with highest numbers happening in first week itself. As per latest data for J&K, Early Neonatal Mortality rate and Neonatal Mortality Contribute to 62% and 75% of infant deaths respectively.

Proven evidence based interventions are available for all these causes of infant mortality and still a large number of infant deaths happen due to above causes. This is primarily because we have not been able to achieve universal coverage of life saving interventions.

J&K has seen a remarkable improvement in the number of infant deaths after the start of NHM. IMR of state has decreased from 45 in 2009 to 24 in 2016, which translates to decrease by 8.96percentage points per year. This reduction translates into saving an estimated 4800 additional infants in year 2016, or 13 more infants saved each day as per the current IMR in comparison to IMR of 2009. This has been possible by improving coverage of quality antenatal care, skilled care at birth, postnatal care for mother and newborn and care of small and sick newborns. A great achievement but still a large number of preventable infant deaths are happening which reflects poorly on how as a society we are caring for our weakest section. Five states in the country (Kerala, Tamil Nadu, Delhi, Maharashtra and Punjab) have IMR less than J&K with Kerala having lowest IMR of 10.Extrapolating IMR of Kerala on J&K would mean saving additional 3200 infants per year.

Keeping the above number of additional infant deaths in mind state has set up a vision of achieving single digit IMR by 2022. This is an ambitious goal and its achievement would depend on quality of planning and translation of plans in to action. To achieve this state needs to accelerate the rate of decline from current Average Annual Rate of Reduction (AAAR) of 8.96% to AARR of 14.52%.

Accelerated decline is not possible by continuing with same interventions or with marginal increases in coverages of life saving interventions. This will require universal and timely coverage of all existing interventions and roll out of new evidence based interventions. There will also be need for finding innovative solutions with regard to program implementation. In this regard, state of J&K has drafted an action plan for accelerating rate of decline in IMR. This action plan will act as a roadmap in guiding the state for achieving vision of single digit IMR by 2022.

The J&K IMR reduction action plan has the following components

- ✓ Introduction: This section covers the importance of reducing infant mortality in achieving national health goals in addition to discussing the status of various child mortality rates and their trend in last decade.
- ✓ Situational analysis: Any intervention proposed needs to be in line with the problem or barrier, so it is imperative to have an in-depth understanding of the problem. This section has discussed the coverage of important MNCH interventions in the state and their trend as per evaluated data from SRS, NFHS4, NFHS 3 and HMIS and other state reports. The other contributory factors having impact on IMR arediscussed.
- ✓ Vision and goals of IMR action plan: The vision of this plan is to achieve single digit IMR by 2022. This would require doubling current rate of decrease.
- ✓ Key interventions to reduce IMR: The action plan enlists the community based and health facility based interventions for accelerating rate of decline. The community based interventions which need strengthening include Birth preparedness, Home Based Newborn care, MAA, IDCF, UIP, VHNDs and IMNCI, In addition Home Based Care for Young Child (HBYC) will be rolled out. Key health facility based interventions will need strengthening ofPMSMA, Skilled birth attendance (SBA), Universalization of essential newborn care, Newborn resuscitation, Early and exclusive breast feeding and strengthening

facility based newborn care(FBNC). In addition state will implement Dakshata, LaQshya, Family Participatory Care (FPC) in SNCU, Kangaroo mother care (KMC), Emergency triage and treatment (ETAT), Obstetric ICU and HDU.

NHM J&K and NIPI-Jhpiego state team jointly developed the IMR Action plan with inputs from NIPI-Jhpiego National team. The draft IMR Reduction action plan was presented in NHM Executive Committee meetingson 28 August and 17October 2018 for discussion and approval. The Executive Committee suggested certain changes and constituted a technical expert committee for reviewing and finalizing the document. The Expert Committee was chaired by Director Family Welfare, MCH & Immunization and had members from Paediatrics and Obstetrics and Gynaecology departments of GMC Srinagar and Jammu.The Expert Committee reviewed and approved the action plan on 3rd December after suggesting some changes which were incorporated in the document. Copy of the minutes placed as Annexure B.

After finalizing the action plan, the year wise and total budgetary requirements were calculated and placed as annexure A at the end of document.

INTRODUCTION

Infant mortality Rate(IMR) that refers to number of infant deaths per 1000 live births is an important marker of health in the society particularly maternal and child health. In 2015, the world began working toward a new global development agenda, which seeks to achieve new targets by 2030 in Sustainable Development Goals (SDG). Among other targets SDGs envisions to eliminate preventable deaths of newborns and children. India is a signatory to SDGs and is committed to achieve the targets set in SDGs. India has put forward an ambitious National Health Policy (NHP) in 2017, which provides the direction for achieving universal health coverage and delivering quality health care services to all. The NHP, 2017 has set ambitious goals to end preventable deaths of mothers, newborns & children and thus set the stage for acceleration of efforts for reducing maternal, newborn and child mortality, improve their health and nutrition status and intensify the programme in the states/districts that have the most vulnerable populations.

J&K has seen a remarkable improvement in the number of infant deaths after the start of NHM. IMR of state has decreased from 45 in 2009 to 24 in 2016. Though this is remarkable but still a large number of preventable infant deaths are happening, which necessitates need for this action plan. In line with national and global commitments J&K state is also committed to accelerate rate of reduction in child mortality rates. A very high proportion of under-five deaths happen before the first birthday and it would need proportionately higher inputs to address infant mortality.In J&K, also a high proportion of deaths happen in first year of life. In this regard, state of J&K has set out a goal to reduce Infant Mortality rate (IMR) to single digits by 2022. To ensure uniform and highest level of commitment for achieving the above goal, state has developed this IMR reduction action plan.

The purpose of the action plan is to have an understanding of current situation of key indicators which determine infant mortality and their trend in last decade. The report has also listed key interventions along with the budgets required to accelerate rate of decline in infant mortality.

The action plan is intended to act as a policy roadmap document for use by state and district program managers. It will guide the state for coming four years regarding interventions which state needs to implement or strengthen for achieving the goals set in action plan

J&K IMR REDUCTION ACTION PLAN DEVELOPMENT PROCESS

- **Finalization of draft template**
  NHM J&K and NIPI-Jhpiego state and National team developed a template jointly to specify the contents for IMR Action plan.
- **Data collection, collation and analysis**
  Data analysis of NFHS, HMIS and from supportive supervision visits to districts. Coverage of Key MNCH interventions across different blocks was assessed.
- **Identification of problem areas in relation to IMR**
  The initial step involved identification of areas in which coverage is less than satisfactory and indicators, which have not shown any improvement in last decade.
- **Suggested interventions/strategies and budget to achieve desired goals.**
  Key intervention to be implemented were shortlisted after in depth discussions and incorporated in action plan. The objectives, vision and goals of action plan were finalized. Budgetary support required for achieving the target by 2022 was also finalized.
- **Presentation of draft IMR reduction action plan on 28th August 2018.**
  NHM Executive committee members reviewed the action plan and suggested changes in the content and budgeting for human resources in the action plan.
- **Presentation of Updated IMR reduction action plan in NHM Executive committee meeting on 17th October 2018.**
  NHM Executive committee meeting on 17 October 2018 discussed the IMR action plan and constituted a technical expert committee for reviewing and finalizing the action plan. The executive committee meeting included concerned HODs from GMC Jammu and GMC Srinagar in the technical expert committee headed by Director Family Welfare, MCH and Immunization J&K.
- **Review of Action plan by Technical Expert committee on 3 December 2018.**
  The Technical expert committee reviewed the interventions for feasibility and impact it can have on IMR of the state. The experts provided valuable inputs that were incorporated in the action plan. Copy of minutes of expert committee annexed as annexure “B”
- **Final draft IMR Reduction action plan after incorporating inputs of Technical Expert committee.**
  Incorporation of changes in IMR Reduction action plan as per technical expert committee.
- **Next steps**
  Dissemination of final action plan with state and district level stakeholders.

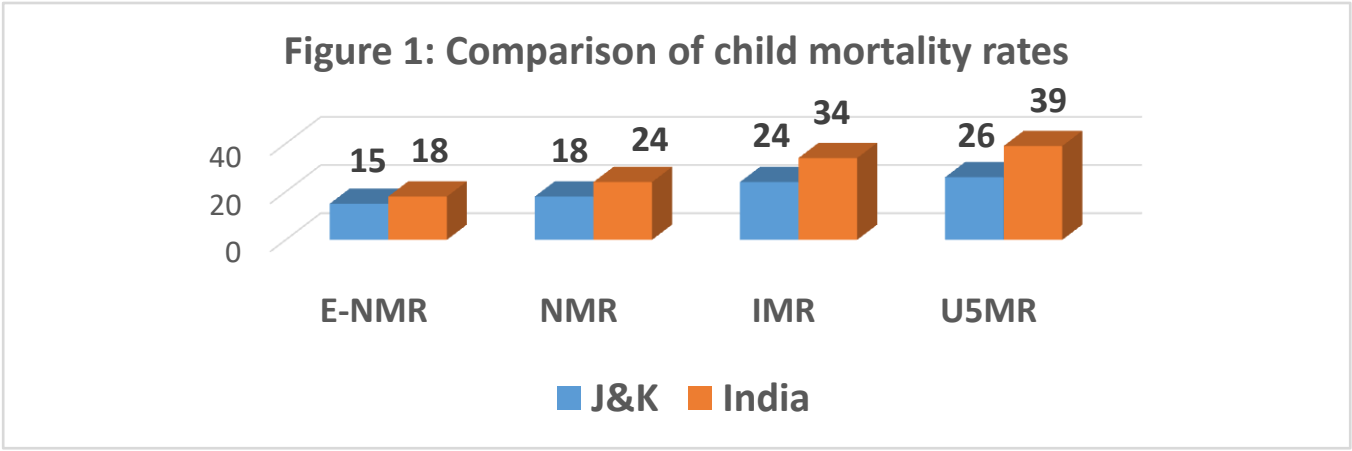
Regular review of progress on interventions in the action plan.

SITUATIONAL ANALYSIS

CURRENT CHILD HEALTH SCENARIO AND TREND IN JAMMU AND KASHMIR

Maternal, newborn and child health remain critical drivers of social development and key marker of performance of health system. With prioritized investment in maternal and child health services during the two phases of National Health Mission (2005-2017), there has been significant decline in MMR and U5MR in this period. Implementation of the RMNCH+A strategy (in 2013) has led to accelerated progress in the second phase of NHM (2013-2017).

The mortality rates for J&K are well below the national average particularly for under five-mortality rate (U5MR) which is 26 for state in comparison to national average of 39. Figure 1 is depicting the status of various child mortality indicators in comparison to national values.

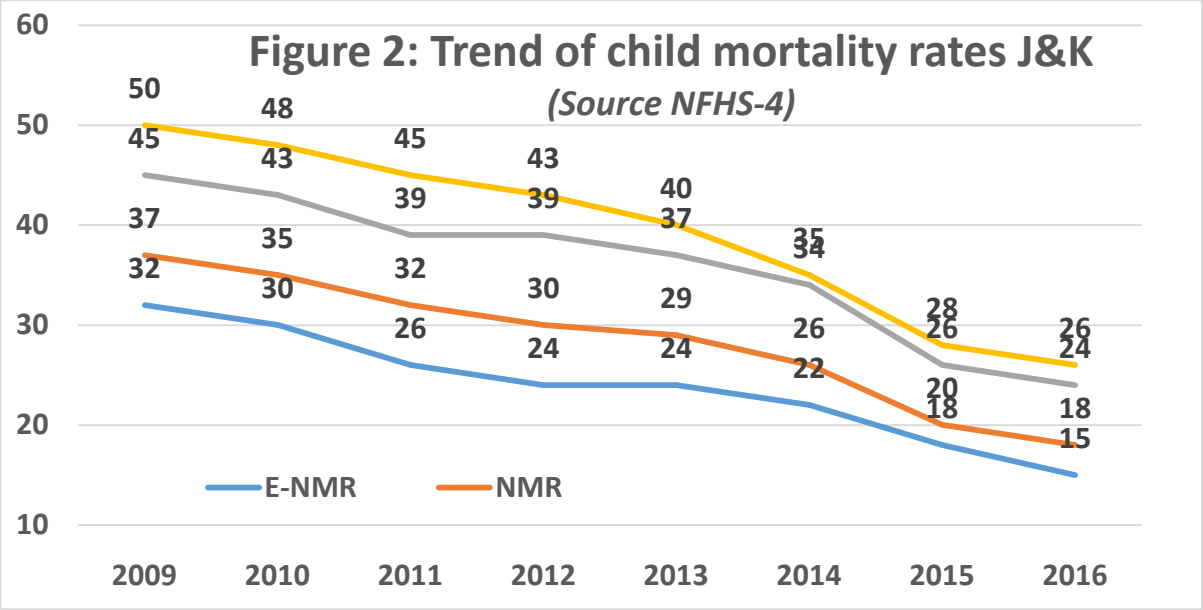


TRENDS IN DECLINE IN NEWBORN, INFANT AND CHILD MORTALITY IN JAMMU AND KASHMIR

While steady progress is being made in addressing childhood illnesses, newborn health remains a critical challenge. Although there has been a significant reduction in child mortality rates but still an unacceptable level of preventable child mortality is happening in the state. If we take example of IMR, there are four states (Kerala, Tamil Nadu, Punjab and Delhi) in India whose IMR is lower than J&K. Kerala has an IMR of 10 as per SRS 2016. So achieving a single digit IMR is possible, if evidence based public health approach is adopted.

The same vision is shared by government of Jammu and Kashmir which wants to reduce the mortality and morbidity among the vulnerable sections of society particularly mothers and children. In this regard, state is committed to achieve single

digit IMR in the state in addition to decreasing preventable maternal deathsand stillbirths.



TIMING OF CHILD DEATHS:

Early child deaths contribute most to deaths happening in children under five years.

- 92% of U5 deaths happen in 1st year of life.
- **75% and 62.5%** of IMR being contributed by **NMR and E-NMR** respectively

INEQUITIES IN RISK FOR DEATH

Difference in U5MR as per gender and region			
	Male	Female	Total
Urban	23	23	23
Rural	**25**	**30**	**27**
Total	25	28	26

Other mortality indicators			
	Rural	Urban	Total
SBR	1	4	2
E NMR	**17**	11	15
P NMR	**18**	15	17
NMR	**19**	15	18

Social determinants are an important contributing factor. Rural children are at higher risk of death and rural females are at highest risk of death in J&K before their 5th birthday.

The social determinants play a part in other mortality rates, as all rates are much higher in rural areas. All interventions need to ensure to break the barrier and reach all mothers and newborns equitably

CURRENT STATUS &CHANGE IN KEY MNCH INDICATORS OVER THE LAST DECADE

The coverage and quality of care determines its effectiveness. Recently released survey data from NFHS 4 (2015-16) provides an insight into the current state of implementation of MNCH services in J&K that impact infant survival.

In the last decade, state of J&K has been able to achieve replacement level of TFR in addition to reduction in adolescent pregnancies. This progress will have a lasting impact in reducing infant mortality rate. Unmet need of spacing has not decreased in the last decade and this should be a priority area in the thematic area of reproductive health for the state in coming years. Additional thrust is also needed to achieve FP2020 targets.

The coverage of antenatal care has increased and is around 80% for J&K now. This has not translated into proportional increase in coverage of key interventions particularly uptake of IFA supplementation during pregnancy. Only 1/4th of pregnant women have had full ANC in J&K. This represents a huge lost opportunity as ANC period is a starting point to ensure a health pregnancy, delivery and post delivery period for both mother and child.

The use of health facilities has showed an impressive increase in 2015-16 compared to the last survey (NFHS 2005-2006). The institutional births in public health facilities increased from 50.2% to 85.7%, which presented a tremendous opportunity for improving care around birth. Health provider has assessed more than 70% mothers, which can help in early identification of complications that are major causes of maternal and newborn mortality during and after childbirth, could be prevented and managed. There is also significant gap in proportion of mothers and newborns who received health checkup within two days of delivery. Proportion of newborns examined after delivery by health workers is very low (20%).The current use of IUCD/PPIUCD remains the same (2.7% to 2.8%) despite a decade of investment and shows that the opportunity presented by the institutional deliveries has not been leveraged.

Quality of emergency obstetric care reflected by the number of caesarian sections (CS) performed shows that overall rate is well above recommended population norms at 33%. (Accepted norm is between 5%-15%). For births in private sector, it is 75.5%, which is an increase by more than 100% of NFHS 3 figures.

The fully immunization rates are above the national average and have increased in the last 10 years but the rate of 75% is still well below the recommended rate for vaccine coverage. These rates suggest the state needs to strengthen the microplanning and vaccine delivery systems.

Sick children with diarrhea and fever or ARI symptoms are taken to health facilities in around 3/4th of cases, which is encouraging, but only 40% children with diarrhea receive zinc. Good care seeking behavior makes a case for strengthening facility based child health interventions.

In spite of the fact that 86% of deliveries are happening at health facilities only in 46% cases breast-feeding was initiated with one hour of birth. Also exclusively breast feeding rates are less at 65.4%. All this reflects that the practices related to infant and young child feeding need huge improvement. Though the rates for underweight have decreased in the last decade, still 1/4th of children are stunted. State can build on the platform of mothers absolute affection programme to improve child-feeding practices, which will translate into better nutritional status in children. 43% under five children and 38% of pregnant women are still anemic though the rate have seen an improvement in last decade.

In addition, the state aggregates often mask the differentials within the state. The key therefore is to focus on the HPDs and aspirational districts for accelerated and concerted action, as they require special consideration in terms of planning and implementation of MCH initiatives.

Table below is depicting the coverage as per NFHS-4 and change in comparison to values in NFHS-3.

Table: CURRENT STATUS &CHANGE IN KEY MNCH INDICATORS OVER THE LAST DECADE

Indicators	**India**	**J&K**	**J&K**
	NFHS-4 (2015-16)		**NFHS-3 (2005-06)**
Fertility			
Total fertility rate (children per woman)	2.2	2.0	2.4
Women age 15-19 years who were already mothers or pregnant at the time of the survey (%)	7.9	2.9	4.2
Current use of IUD/PPIUD (in currently married women age 15–49 years) (%)	1.5	2.8	2.7
Male Sterilization (%)	0.3	0.4	2.6
Unmet need for spacing (%)	5.7	5.8	5.7

Indicators	India	J&K	J&K
	NFHS-4 (2015-16)		NFHS-3 (2005-06)
Maternity Care (for last birth in the 5 years before the survey)			
Mothers who had at least 4 antenatal care visits (%)	51.2	81.4	60.4
Mothers who had full antenatal care (%)	21.0	26.8	12.7
Registered pregnancies for which the mother received Mother and Child Protection card (%)	89.3	88.8	NA
Mothers who received postnatal care from a doctor/nurse/ LHV/ANM/ midwife/other health personnel within 2 days of delivery (%)	62.4	74.9	44.5
Children who received a health check after birth from a doctor /nurse/ LHV/ANM/ midwife/other health personnel within 2 days of birth (%)	24.3	20.3	NA
Delivery Care (for births in the 5 years before the survey)			
Institutional births (%)	78.9	85.7	50.2
Institutional births in public facility (%)	52.1	78.1	41.1
Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	81.4	87.6	56.5
Child Immunizations			
Children age 12-23 months fully immunized (BCG, measles, 3 doses each of polio and DPT) (%)	62.0	75.1	66.7
Treatment of Childhood Diseases (children under age 5 years)			
Children with diarrhoea in the last 2 weeks who received oral rehydration salts (ORS) (%)	50.6	69.1	40.6
Children with diarrhoea in the last 2 weeks who received zinc (%)	20.3	39.1	NA
Children with diarrhoea in the last 2 weeks taken to a health facility (%)	67.9	74.2	67
Children with fever or symptoms of ARI in the last 2 weeks preceding the survey taken to a health facility (%)	73.2	78.5	75.2
Child Feeding Practices and Nutritional Status of Children			
Children under age 3 years breastfed within one hour of birth (%)	41	46.0	31.9

Indicators	India	J&K	J&K
	NFHS-4 (2015-16)		NFHS-3 (2005-06)
	.6		
Children under age 6 months exclusively breastfed (%)	54.9	65.4	42.3
Children age 6-8 months receiving solid or semi-solid food and breast milk (%)	42.7	50.0	52.7
Total children age 6-23 months receiving an adequate diet (%)	9.6	23.5	NA
Children under 5 years who are severely wasted (weight-for-height) (%)	7.5	5.6	4.4
Children under 5 years who are underweight (weight-for-age) (%)	35.7	16.6	25.6
Anaemia among Children and Adults			
Children age 6-59 months who are anaemic (<11.0 g/dl) (%)	58.5	43.3	58.5
Pregnant women age 15-49 years who are anaemic (<11.0 g/dl) (%)	50.3	38.1	55.7

OBJECTIVES

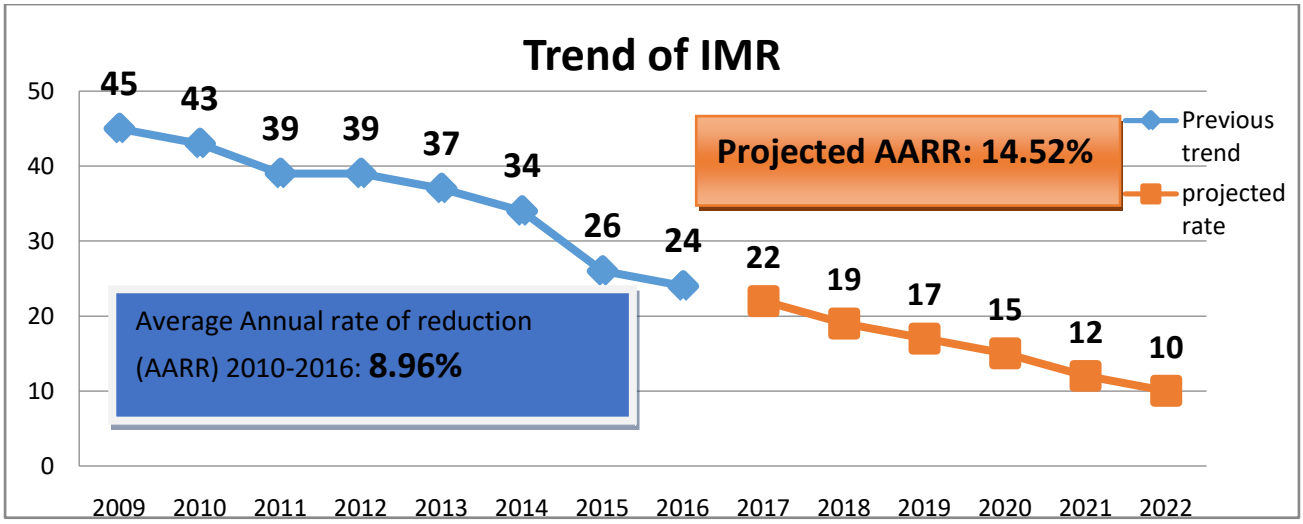
The action plan has been developed to achieve the following objectives

- Strengthening and investing in care during labour, child birth and the first day and week of life- will lead to a triple return of preventing maternal deaths, still births and newborn deaths
- Reaching every women and newborn to address inequities.
- Ensure each infant is counted- measurement, tracking and accountability
- Eliminating preventable infant deaths due to pneumonia, diarrhea & congenital diseases by improving quality and coverage of evidence based child health interventions.

VISION AND GOALS

This action plan envisions a health system that eliminates preventable deaths of children and stillbirths, where mothers and children survive, thrive and reach full potential.

The specific goal of this action plan is to achieve single digit IMR by year 2022. To achieve single digit IMR by year 2022 the state needs to accelerate the rate of decline in IMR

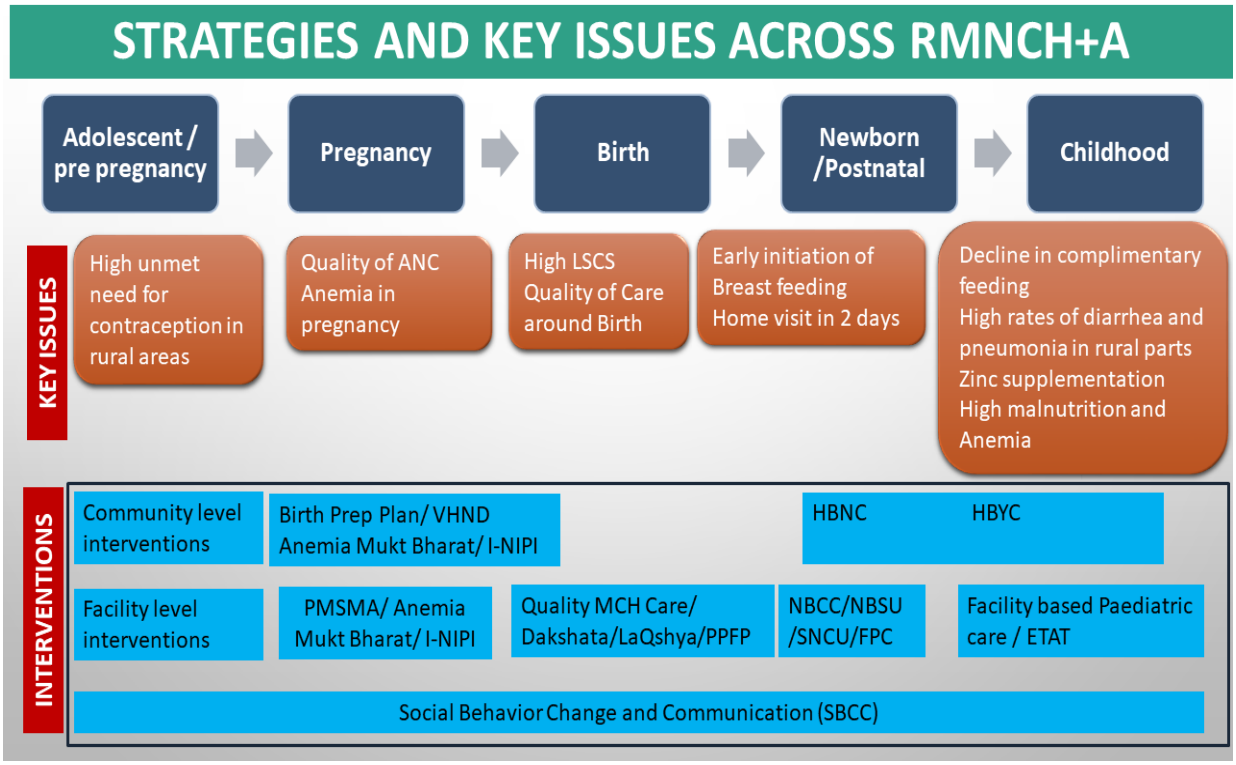


Accelerated efforts will be required to improve care provided to prospective mothers right before conception, during delivery and after delivery. In addition to strengthening of existing activities, new strategies will be put in place for accelerating the growth.

STRATEGIC AREAS OF INTERVENTION TO IMPROVE NEWBORN SURVIVAL

Analysis of secondary data from the NFHS rounds, SRS and the HMIS/SNCU online provides clear strategic directions for further accelerating progress towards sustaining the required annual rate of reduction in NMR and IMR.

Key issues& recommendations emerging from the secondary data analysisare summarized in the figure below:



LIST OF INTERVENTIONS:

The action plan is expected to serve as a roadmap that redefines and focusses state, district and sub district strategies and actions until 2022. State is already implementing a large number of interventions to decrease child mortality. This action plan will lay a roadmap for strengthening of existing intervention. In additions newer evidence based interventions will be started to accelerate the rate of decline in mortality rates.

	Strengthening Existing interventions	New interventions
Facility based	- Facility based Newborn care through SNCU, NBSU and NBCC - PMSMA - Skilled birth attendance - JSY / JSSK implementation - Essential Newborn care to all - Newborn resuscitation. - Vitamin K1 - Early and exclusive breast feeding - Ante-natal corticosteroids in preterm - Strengthening advanced care by NICU at regional level	- Dakshata & LaQshya - Family participatory care (FPC) - Kangaroo mother care (KMC) - Emergency triage and treatment (ETAT) - Obstetric ICU and HDU. - PPFP (PPIUCD) - Newer contraceptives
Community based	- Home based Newborn care (HBNC) - Mothers absolute affection (MAA) - Intensified diarrhoea control fortnight (IDCF) - Universal immunization programme - Full ANC - IMNCI - Pre-referral dose of antibiotics by	- Home based care for young child (HBYC) - Anaemia Mukt Bharat (I-NIPI)

KEY STRATEGIES TO BE UNDERTAKEN

A. Strengthening of Facility based newborn care and care during referral by strengthening of existing NICUs/SNCUs, NBSUs, NBCCs and operationalization of new SNCUs, NICUs/ SNCUs and NBSUs in addition to improving care during referral of sick neonates and infants.

The table below mentions the current availability of health facilities in relation to facility bases newborn care. Access to quality facility based newborn care has improved markedly in the last decade by operationalization of NBCCs, NBSUs, SNCUs and NICUs.

No of delivery points	**176**	**No. of functional NBCCs (Inclusive of NBCCs at OTs**	**281**
No of facilities with > 3000 deliveries annually (2017-18)	**9**	**No. of SNCUs Approved**	**32**
Number of approved FRUs	**76 + 23 DHs**	**No. of SNCUs operational**	**24**
Number of Functional FRUs	**55**	**No of NBSUs**	**76**
		No of NICUs (NICUs are at medical colleges)	**3**

32 SNCUs have been approved for the State out of which, **24 SNCUs** have been established and made functional in addition to **Three Neonatal Intensive Care Units (NICUs)** at Govt. Medical Colleges, which provide tertiary care management of sick neonates referred from districts.Each SNCU is provided with one-time establishment cost and operational cost is being provided on yearly basis as per the workload. For maintenance of existing SNCUs, operational cost is being provided for 08 SNCUs/ NICUs @ Rest 10 lakhs/year having admissions of more than 50 per month and @ Rest. 5 lakhs/year for the SNCUs which have admissions of less than 50 per month. In addition to this, an operational cost of Rs.2.5 lakhs is being provided for Type II SNCUs which have been sanctioned under 13th Finance Commission Award

Following key activities will be strengthened at multiple levels to improve access and quality of care being provided to infants admitted in public health facilities.

- Improving access to Facility Based Newborn Care by operationalization of additional SNCUs, NBSUs and NBCC as per need and demand.
- Ensuring service providers handling newborns and infants are trained in relevant training packages and ensuring their posting in relevant sections of health facilities.
- Operationalization of NICU at SKIMS Medical College, Bemina, Govt. Gandhi Nagar Hospital, Jammu and strengthening of Neonatal Intensive Care Unit (NICU) at SMGS hospital Jammu.

- Upgradation of selected existing SNCUs by providing ventilators/CPAPs based on delivery load, referral rate and geographical location.
- Annual maintenance contract of equipment in SNCUs, NBSUs and NBCCs for maintaining the equipment and decreasing downtime and disruption of services.
- Equipping ambulances with transport incubators and emergency medical technicians for preventing death of sick infants during transportation to higher facilities.
- Roll out of Family Participatory Care (FPC) & Kangaroo Mother Care (KMC) in the NICUs/SNCUS of the state and ensuring high coverage of these interventions.

Action Plan for operationalization of Under Establishment SNCUs			
S. No.	**Name of District**	**Name of Facility**	**Target**
1	Kupwara (Type 1)	CHC Kupwara	2018-19
2	Kulgam (Type II)	District Hospital Kulgam	2018-19
3	Doda (Type II)	CHC Bhaderwah	2018-19
4	Doda (Type II)	CHC Gandoh	2018-19
5	Rajouri (Type II)	CHC Thanamandi	2018-19
6	Baramulla (Type 1)	CHC Uri	2019-20
7	Jammu (Type 1)	Govt. Hospital, Sarwal	2019-20
8	Reasi (Type II)	District Hospital Reasi	2019-20

Type II SNCUs that have been established under the award of 13th Finance Commission Award were provided two MOs & 2 SNs/ANMs. During the current FY 2018-19 type II SNCUs located in District Hospitals shall be provided with Four Medical Officers and subsequently during the FY 2019 all the remaining SNCUs shall be provided full manpower as mandated under Facility Based Newborn Care Guidelines of MoHFW GoI and shall also be further strengthened in terms of equipment & infrastructure.

Operationalization of new NICUs to cater the increased demand for tertiary facility based newborn care in the state at SKIMS Bemina and Govt. Gandhi Nagar Hospital, Jammu. Strengthening of Neonatal &Paediatric intensive care unit at SMGS hospital Jammu as it the only tertiary paediatric care facility in Jammu.

Procurement of ventilators for selected SNCUs based on admission, referral rate along with their location in difficult geographical areas. These SNCUs refer a large number of neonates to tertiary care die to lack of ventilators/CPAP. Capacity of each SNCU in terms of human resources and infrastructure will be accessed before provision of ventilators. 14 Ventilators/CPAP @ 12 Lakh per ventilator to be procured for 7 SNCUs at DH Doda, DH Udhampur, DH Ramban, DH Poonch, DH Anantnag, DH Baramulla & DH Handwara.

To improve provision of care to sick newborns during transport, 108 ambulances will be equipped with incubator facility. This will prevent hypothermia during referral and ensure continuity of a minimum recommended care during referral.
Annual maintenance contract of equipment in SNCU. NBSU and NBCC to decrease frequency of equipment malfunction and to decrease duration of downtime. The activity will involve selection of areputed agency and rates for each SNCU, NBSU and NBCC for provision of ANC services.

	2018-19	2019-20	2020-21	2021-22
Operationalization of NICU at SKIMS Bemina and Govt. Gandhi Nagar Hospital, Jammu Budgetary requirement are for infrastructure upgradation and procurement of equipment		4 Cr	0	0
Strengthening of Neonatal Intensive Care Unit at SMGS hospital Jammu		1.83 Cr	0	0
Procurement of ventilators/CPAPs for selected SNCUs based on delivery load, admissions and referral rate and geographical location.		1.68 Cr	0	0
Annual maintenance contract of equipment in SNCU. NBSU and NBCC		50 Lakh	50 Lakh	50 Lakh
Equipping ambulances with transport incubators and Emergency Medical Technicians for preventing neonatal deaths during transport to higher facilities		1 Cr	0	0

Capacity Building:

National Collaborative Centre is conducting the training of the staff of SNCUs / NICUs for FBNC at Kalawati Saran Children Hospital, New Delhi in Facility Based Newborn Care.70 doctors and 88 nurses posted in SNCUs and NICUs have been trained. After undergoing 4 days training at GMC Srinagar/ Jammu, 91 participants were sent for two weeks' observer ship training at Kalawati Saran Children Hospital, New Delhi.

All the manpower working in SNCUs shall be trained in phased manner as per details given in the table below and refresher trainings shall be conducted for the already trained manpower to brush up their skills at the level of Medical College Jammu & Srinagar:

Action Plan for FBNC Trainings							
				2018-19	2019-20	2020-21	2021-22
Batches to be conducted including refresher batches (24 participants per batch)				2	3	3	3
No. of participants as per batches				48	72	72	72
Participants	**Sanction**	**In position**	**Trained**				
MO	110	77	70	20	30	30	30
SN	141	114	88	28	42	42	42
Total Staff to be trained per year				48	72	72	72

Capacity building for implementation of SNCU Online Portal: For improving the monitoring& the service utilization of SNCUs an online reporting and monitoring software tool developed by MoHFW, GoI in collaboration with the UNICEF is utilized. Presently 16 SNCUs are reporting on the portal and Staff of remaining SNCUs shall be trained so that by the end of 2018-19 all SNCUs shall be in a position to report on the online portal. This will improve the service delivery and accountability of the SNCU staff for further reducing the infant mortality.

B. Operationalization of Newborn Stabilization Units (NBSUs) & Newborn Care Corners (NBCCs) for providing essential newborn care.

NBSU is a facility within or in close proximity of maternity ward for the care of sick and low birth weight newborns. 76 NBSUs have been established in the State till date; however most of the newborn stabilization units established is not fully functional due to the fact that no dedicated trained manpower was available for these units. Realizing the situation MoHFW, GoI has developed a comprehensive training package for capacity building of the Staff managing the NBSUs.

Out of 76 established NBSUs, operational cost shall be provided for 67 Newborn Stabilization Units @ Rest 1,00,000 per unit per year for maintenance of the unit and consumables. In addition, Nine NBSUs have been upgraded to Special Newborn Care Units (SNCUs) at following Health Institutions.

S No.	District	Health Institution	S No.	District	Health Institution
1	Bandipora	District Hospital Bandipora	6	Ganderbal	DH Ganderbal
2	Bandipora	CHC Gurez (Dawar)	7	Poonch	CHC Mendhar
3	Samba	District Hospital Samba	8	Rajouri	CHC Sunderbani
4	Shopian	District Hospital Shopian	9	Ramban	DH Ramban
5	Kulgam	DH Kulgam			

Two ANMs have been provided for each of the NBSUs under NHM; however, there is need of dedicated Medical Officer (MBBS) to make the unit fully functional, as ANMs alone are not able to manage the unit independently in spite of FIMNCI trainings. State shall project the requirement of Medical Officer (MBBS) for each of the NBSU in SPIP of NHM for the FY 2019-20 so that the units can be operationalized.

State is planning to conduct refresher trainings to the staff working in NBSUs during FY 2018-19 & 2019-20 in eight batches in order to improves utilization and service quality of NBSUs at peripheral healthcare units and decrease unnecessary referrals to higher centers.

Action Plan for FIMNCI/ NBSU Training Package						
				2018-19	**2019-20**	**2021 – 22**
Batches to be conducted including refresher batches				**2**	**2**	**2**
No. of participants per batch				**16**	**16**	**16**
Participants	**Sanction under NHM**	**In position**	**Trained**			
MO	-	-		16	16	16
ANM	156	121	120	16	16	16
Total Staff to be trained per year				**32**	**32**	**32**

Newborn Care Corner (NBCC) is a space within the Delivery room & OT for providing essential care to newborns at birth. State has operationalized 281 Newborn Care Corners. For strengthening of NBCC Operational cost @ Rest 20,000/ per NBCC unit is provided for NBCCs in 51 PHC's working as functional delivery points.

3369 MOs/ SNs/ANMs have been trained till date under Navjaat Shishu Suraksha Karyakram (NSSK). State is planning to conduct refresher trainings to the staff working at all the Delivery Points in FY 2018-19 to 2021-22 in Eighty-Eight batches

Action Plan for NSSK Trainings					
		2018-19	**2019-20**	**2020-21**	**2021-22**
Batches to be conducted including refresher batches		**22**	**22**	**22**	**22**
No. of participants as per batches		**32**	**32**	**32**	**32**
Participants	**Trained**				
MO	1466	352	352	352	352
SN	1903	352	352	352	352
Total Staff to be trained per year		**704**	**704**	**704**	**704**

Refresher training course for newborn resuscitation & the operationalization of the radiant warmers at delivery points shall be conducted by the end of FY 2018-19 so that all the delivery points are saturated with NSSK trained staff in order to improve the outcome of deliveries and decrease the early neonatal deaths, which constitute about 2/3rd of the IMR.

C. <u>Improvement in intrapartum care by strengthening of labour rooms in terms of infrastructure & capacity building of staff for providing SBA delivery through implementation of DAKSHTA/ LaQshya.</u>

Strengthening of Labor Rooms & Maternity OTs under LaQshya:

Approximately 46% maternal deaths, over 40% stillbirths and 40% newborn deaths take place on the day of the delivery. As such, a transformational change in the processes related to the care during the birth, which essentially relates to intra-partum and immediate postpartum care, is required to achieve tangible results within short period. In order to address this challenge, MoHFW, GoI has launched a new programme called LaQshya. LaQshya programme is intended for achieving improvements in the intra-partum and immediate post-partum care, which take place in the labour room and maternity operation theatre.

LaQshya initiative addresses structural issues like infrastructure, Human resource, Layout of Labour room and Maternity OT, equipment's, drugs, consumables and other issues that affect processes of care.

In J&K, it has been proposed to implement LaQshya programme in eleven districts of the State in first phase which include District Kathua/ Rajouri/ Poonch/ Reasi/ Ramban/ Doda & Kishtwar from Jammu Division and District Anantnag/ Pulwama/ Baramulla & Kupwara from Kashmir Division. In addition, two Medical college hospitals viz. SMGS Hospital Jammu & LD Hospital Srinagar shall be also strengthened under LaQshya programme. In the first phase, District hospital & one high Caseload CHC from each identified district shall be taken up for the said intervention. LaQshya/Dakshata will be scaled up in rest of the districts from 2020. The state is planning to have one DH and 2 high case load CHC certified from each district until 2022.

Under the LaQshya programme, there will be continuous process of gap analysis and action planning to plug the gaps identified in labour rooms and OTs through NQAS checklist developed by NHSRC until the facilities attain sufficient score for quality certification.

Interventions	2018-19	2019-20	2020-21	2021-22
No. of DHs where LR & OT shall be upgraded after gap analysis as per LaQshya standards.	11	6	5	
No. of CHCs where LR & OT shall be upgraded after gap analysis as per LaQshya standards	10	17	15	
No. of facilities where LR & OT to be ready for NQAS certification under LaQshya.	5	23	15	
Having a birth companion for all deliveries, Budget will be required for ensuring privacy of other PW in labour room and provision of PPE to birth companion.	For all deliveries			
Hiring of additional specialist for operationalization of non-operational FRUs in the state. Gap analysis of all FRUs to be done at the beginning of each FY and the same to be projected in PIP of each year.	As per Gap Analysis.			
Procurement of CTG machines for all high case load facilities for monitoring progress of labour	0	35	15	15

Establishment of High Dependency Units (HDUs) & Obstetric ICUs: Establishment of High Dependency Units (HDUs) at high case load facilities is need of the hour to further bring down the maternal & early neonatal mortality in the state. High Dependency Unit (HDU) is an area in the vicinity of Labour Room for management of high risk pregnancies requiring vigilant monitoring and interventions by specially trained teams. For managing high risk pregnancies, Obstetric High Dependency Units are being established at eight (8) District Hospitals of the State in first phase namely DH Kulgam/ DH Pulwama/ DH Shopian/ DH Handwara (Kupwara), DH Poonch, DH Kishtwar, DH Rajouri & DH Kathua.In addition to HDUs at District Hospitals, establishment of Hybrid Obstetric ICU & HDU at SMGS Hospital Jammu & LD Hospital Srinagar are also being established.

From 2020 HDU will be established in the remaining districts and obstetric ICU will be established in 5 new medical colleges hospitals.

Indicator	2018-19	2019-20	2020-21	2021-22
Number of HDU to be established	8	7	7	0
Number of Obstetric ICU to be established	2	3	2	
Obstetric ICU will be established in new medical college hospitals as well by 2022				

Implementation of Dakshata for empowering service providers for improved MNH Care during Institutional Deliveries.

Dakshata is a strategic initiative for empowering the health workers in providing high-quality of care during childbirth. Major components of this programme include skill building of health workers in life-saving practices during childbirth, ensuring availability of supplies essential for life-saving practices, improving adherence of health workers to learned skills, and improved use of data for decision-making.

In first phase Dakshata will be implemented in 11 Districts of the State namely District Rajouri, Poonch, Ramban, Doda, Kishtwar, Reasi & Kathua from Jammu Division and District Anantnag, Pulwama, Baramulla & Kupwara from Kashmir Division. In the next phase rest of the districts will be covered.

Under the said programme, 5 days ToT for District trainers was conducted at RIHFW Dhobiwan, Kashmir from 9th-13th April 2018 and second batch of training was conducted at Govt. Hospital Gandhi Nagar, Jammu from 18th-22nd April 2018. The District trainers shall also act as Dakshata Mentors who shall conduct onsite mentoring and supportive supervision visits for handholding facility staff for translation of the learned skills into practice.

The district level training is undergoing. Health workers from two highest case load facilities are being prioritized in first trainings at district.

Indicator	2018-19	2019-20	2020-21	2021-22
No of Dakshata ToTs to be trained at State level (each batch of 20 Participants comprising of 10 MOs & 10 SNs from identified districts)	2 Batches	2 Batches	2 Batches	2 Batches
No. of district level Dakshata trainings (each batch of 15 participants comprising of 5 MOs & 10 SNs from identified facilities)	11 (1 batch per district)	22 (2 batches per district)	22 (2 batches per district)	22 (2 batches per district)
Note: Till 2020, the high case load facilities from the identified districts in first phase shall be saturated with trained staff and then 2020 onwards, the programme will be scaled up in remaining districts.				

D. <u>Expanding package of services during antenatal care and implementation of Pradhan Mantri Surakshit Matritiva Abhiyaan (PMSMA).</u>

Program managers, medical officers and Frontline workers providing ANC services will be trained on expanded list of services to be provided to women availing ANC services. The objectives include strengthening existing screening protocol and additionally screening for Gestational diabetes mellitus, Hypothyroidism in high-risk cases&Syphilis. State will implement it in phased manner with eight district prioritized for first year. Rest of the districts to be completed in next two years.

Indicator	2018-19	2019-20	2020-21	2021-22
No. of districts were training on expanded ANC is to be done	8	8	6	

E. <u>Improving the survival rates of Low Birth Weight (LBW) & Pre term babies, by rolling out of Family Participatory Care (FPC) & Kangaroo Mother Care (KMC) services in tertiary care units & SNCUs of district hospitals.</u>

Family Participatory Care (FPC) cum **Kangaroo Mother Care** (KMC) centres shall be established in the phased manner in high caseload facilities of the State. Budget stands approved & released for establishment of four FPC/ KMC Centers at GMC Srinagar, GMC Jammu, DH Poonch& DH Baramulla in the month of January 2018. State level training of trainers has been conducted with technical support from NIPI-Jhpiego.

In the subsequent years FPC cum KMC Centers shall be scaled up in other districts of the State.

Activity	2018-19	2019-20	2020-21	2021-22
Setting up of FPC cum KMC Centers	4	6	6	6
Training of medical officers and staff nurses (No of batches)	4	6	6	6

F. <u>Strengthening facility based paediatric care in district hospitals of the state</u>

Access to quality facility based neonatal care has seen a great improvement with the operationalization of SNCUs at district hospitals. However, the district hospitals are not equipped to deal with paediatric emergencies and there is need to upgrade paediatric inpatient care by strengthening paediatric wards. Paediatric OPDs also require upgradation.

Plan of action: A baseline assessment will be conducted as per national guidelines at all district hospitals and gaps identified in facility based paediatric care. Facility in charge, Program managers and district and state level will framean action plan for strengthening as per guidelines. Each facility will developed a detailed project report.

The facilities will be provided funds as per the guidelines for strengthening in terms of Emergency treatment and triage for newborns (ETAT), paediatric OPD and paediatric wards (particularly for managing diarrhoea and pneumonia in children.)

Activity	2018-19	2019-20	2020-21	2021-22
Baseline assessments of district hospitals	6	4	6	6
Strengtheningof Emergency treatment and triage for newborns (ETAT), paediatric OPD and paediatric wards	6	4	6	6
Training of medical officers and staff nurses (No of batches)	6	4	6	6

G. **Home Based New-born Care (HBNC)**

The state has 12 State Trainers, 220 District Resource Persons (DRPs). 802 ASHA Facilitators (ANMs) have been trained in HBNC Module 6&7 Round I, II &III to enhance their knowledge and skills. 11718 out of 11853 ASHAs have been trained in HBNC module. 11730 are trained in HBNC Module 6& 7 Round II, 11484 are trained in HBNC Module 6&7 Round III and 10130 ASHAs are Trained in HBNC Module 6&7 Round IV for providing better Home Based Newborn Care. During the Financial Year 2017-18 One lakh Sixteen Thousand Eight Hundred Fifty Six (116856) Newborns were visited under HBNC.

PROGRESS OF ASHA TRAININGS ON MODULE 6 &7				
Sl.	Phases	Target number of ASHAs	ASHAs trained	%
1.	1st Phase	12000	11718	97.65
2.	2nd Phase	12000	11718	97.65
3.	3rd Phase	12000	11552	96.27
4.	4th Phase	12000	11166	93.05

In order to further decrease IMR, HBYC will be introduced and scaled up to decrease the infant mortality in post-neonatal and under five children by improving compliance to exclusive breast feeding, complimentary feeding, immunization and growth monitoring. Under HBYC program five additional home visits will be be conducted by ASHA on 3rd, 6th, 9th, 12th & 15th month after child birth and she shall be entitled for 50 rupees per visit

All the ASHAs of the State need to be trained under this initiative, however during the FY 2018-19 ASHAs of aspirational districts & districts covered under POSHAN Abhiyan viz Kargil, Rajouri, Doda, Ramban, Kathua, Kupwara, Kishtwar &Baramulla shall be trained. In subsequent years, the intervention shall be scaled up to other districts of the State.

Activity	2018-19	2019-20	2020-21	2021-22
District level training of trainers training (No of Batches)	8	4	5	5
Training of ASHA workers in HBYC by cascade method (30 participants per batch)	All ASHA workers of the district			

H. <u>Reducing prevalence of Anaemia to levels where it ceases to be a major public health problem.</u>

Anaemia remains a significant public health problem with high prevalence across the country irrespective of gender, age and geography. Moderate preconception anaemia significantly increases the risk of foetal growth restriction and increases risk for low birth weight. Problem of this magnitude require concerted efforts and in this regard, "Anaemia Mukt Bharat" strategy has been launched. Prevalence of anaemia is high in all age groups in the state and in this regard state will focus on implementation of all interventions in the Anaemia Mukt Bharat strategy. State will target reduction in prevalence of anaemia by 3 percentage points per year among all age groups. The priority actions for state include

- Prophylactic iron folic acid supplementation as per revised guidelines.
- Deworming
- Intensified year-round behavior change communication campaign including ensuring delayed cord clamping
- Testing of anaemia using digital methods and point of care treatment
- Mandatory provision of iron folic acid fortified foods in public health programmes.
- Addressing non-nutritional causes of anaemia in endemic pockets, with focus on malaria.

Interventions	2018-19	2019-20	2020-21	2021-22
State level launch/orientation of Anaemia Mukt Bharat and state TOT		1		
District TOTs in a phased manner for roll out of the intervention		6	6	10
Intensified year-round behavior change communication campaign		22	22	22
Having a robust supply chain mechanism in place for providing prophylactic and therapeutic IFA and parenteral iron as per guidelines		22	22	22
Procurement of digital Haemoglobin meters and to be provided in a phased manner after handholding		1000	1000	1000

of staff. 30% blocks in each district to be prioritized for first year based on prevalence of anaemia and will be scaled up to all blocks in subsequent years.				
Having a robust supply chain for consumables related to Haemoglobin estimation		6	6	10
Provision of fortified foods in public health programmes		6	6	10

I. <u>Improving survival and quality of life for infants with birth defects & disabilities.</u>

The increase in institutional deliveries in our State provides us a unique opportunity to screen the newborn at delivery points. This window of opportunity, if missed, could be either fatal for the child or lead to a permanent disability.Screening of newborns at delivery points is a crucial component of this strategy for which the healthcare personnel at delivery points including Doctors, Staff Nurses and ANMs need to be thoroughly oriented and trained enabling them to identify, record and refer the cases to appropriate centres. In addition, strengthening of RBSK will ensure identification of disabilities, which were not picked up at birth, and disabilities with onset after birth.

Training of Medical Officers/ Staff Nurses &ANMs from functional delivery points in Comprehensive Newborn Screening is underway in the State.

J. <u>Implementation of Mothers Absolute Affection (MAA)</u>

MAA - "Mother's Absolute Affection" is a country wide intensified breastfeeding promotion campaign targeting all pregnant & lactating mothers, ASHAs, Sub-centres, and Birthing Facilities/Delivery Points. The goal of the 'MAA' Programme is to revitalize efforts towards promotion, protection and support of breastfeeding practices through health systems to achieve higher breastfeeding rates.

State has already completed one-day state level orientation for relevant stakeholders. Training of ToTs (Medical Officers) in seven days Mothers Absolute Affection Programme/ Infant Young Child Feeding training has been completed in the State during 2017-18. The state is planning to train the Medical Officers & Staff Nurses from the delivery points in 4 days MAA training in phased manner as per the details given as under:

4 days IYCF/ MAA training for staffs posted at Delivery points		
No of Batches	22	22
(No of Medical Officers/ Staff Nurses to be trained)	528	528

K. <u>Strengthening reproductive health services particularly Post-partum family planning services and preventing adolescent pregnancies, in addition to increasing male involvement in family planning.</u>

Age at which women have their children and interval between pregnancies also determines infant mortality rate. State will focus on Improving access and coverage of reproductive health services. The priority actions for state include

- Prioritize actions for delaying age at 1st pregnancy in convergence with stakeholders and other departments with special focus on teenage pregnancy.
- Train an adequate number of service providers for Family Planning Services and ensure availability of commodities, as per FP 2020.
- State will focus on ensuring availability of entire basket of contraceptives
- Saturate high caseload facilities to provide PPIUCD

L. <u>Strengthening adolescent health services.</u>

It is said that investing in adolescent health brings a triple dividend by improving the adolescents for now, for their future lives and by improving the next generation. Improving nutritional status of adolescents and avoiding teenage pregnancy will have a long lasting impact on infant mortality rate. Data from J&K NFHS-4 estimates prevalence of any anaemia in adolescence at 40% and 22% percent for girls and boys respectively. 2.9 percent pregnancies were adolescent pregnancies. The priority actions related to adolescent health include:

- Scale up nutritional interventions for adolescents through VHNDs, and iron folic acid supplementation (I-NIPI/WIFS) through schools and AWCs.
- Strengthening of Adolescent friendly health clinics (AFHCs) in the state.
- Utilizing peer educator platform for improving coverage and utilisation of interventions directed to adolescents.

M. **<u>Strengthening of data related to mortality of maternal and child deaths in addition to strengthening of maternal and child death review mechanisms.</u>**

It would involve development of software based maternal and child death reporting software as is being implemented by states like Maharashtra and Haryana. The data will be used to identify gaps and delays which contributed to maternal and child deaths. It will also provide district wise burden of deaths. It would involve identifying and hiring an agency for development of software and website maintenance. After that orientation meetings will be held to orient all health workers on the modalities of functioning and specific responsibilities for ensuring that the objectives of death review mechanisms are met.

N. <u>Strengthening of existing interventions to ensure that they reach maximum beneficiaries and improving the quality of interventions.</u>

The other existing strategies like Immunization, entitlements under JSSK and JSY scheme, strengthening of monitoring system through supportive supervision visits,

internal program monitoring by improving uploading of quality data on various portals of MOHFW i-e HMIS, RCH, SNCU, PFMS portal etc. shall be strengthened for achieving the desired goal of single digit IMR in coming years. Areas with poor coverage in the existing interventions will be identified and strategies developed to improve implementation of existing interventions.

Annexure A: Budget requirements for interventions to achieve reduction in IMR to 10 by 2022*(Rupees in Lakhs)*

	Strategy	Source of Funds		2018-19	2019-20	2020-21	2021-22
A	**Strengthening of Facility based newborn care by strengthening of existing SNCU's, operationalization of new SNCUs, NICUs, PICUs in addition to strengthening of care being provided during transport of sick infants during referral**						
A1	Operational Cost for FBNC Units (SNCUs/ NBSUs/ NBCCs) including maintenance cost (3 NICUs/ 32 SNCUs, 67 NBSU & NBCCs)	NHM	Target	108	108	108	108
			Amount	252.2	273.2	273.2	273.2
A2	Facility Based Newborn Care (FBNC) training	NHM	Target	2	3	3	3
			Amount	10.34	15.51	15.51	15.51
A3	Operationalization of NICU at SKIMS Bemina and Govt. Gandhi Nagar Hospital, budgetary requirement for infrastructure upgradation and procurement of equipment	NHM	Target		2		
			Amount		400		
A4	Strengthening of Neonatal Intensive Care Unit at SMGS hospital Jammu	NHM	Target		1		
			Amount		183		
A5	Procurement of ventilators/CPAPs for selected SNCUs based on delivery load, admissions, referral rate and geographical location.	NHM	Target		12	14	
			Amount		144	168	
A7	Equipping ambulances with transport incubators for prevention of neonatal deaths during transport to higher facilities	NHM	Target		50	50	
			Amount		100	100	
	Budget Subtotal			**262.54**	**1115.71**	**556.71**	**288.71**
B	**Operationalization of Newborn Stabilization Units (NBSUs) & Newborn Care Corners (NBCCs) for providing essential newborn care.**						
B1	Refresher Training for FIMNCI/NBSU Package	NHM	Target	2	2	2	
			Amount	4.56	4.56	4.56	
B2	Provision of Medical Officers for NBSUs	NHM	Target		67	67	67
			Amount		241.2	241.2	241.2
B3	NSSK Trainings	NHM	Target		22	22	22
			Amount		14.17	14.17	14.17
	Budget Subtotal			**4.56**	**259.93**	**259.93**	**255.37**
C	**Rolling out of Family Participatory Care (FPC) & Kangaroo Mother Care (KMC) Centre**						

	Strategy	Source of Funds		2018-19	2019-20	2020-21	2021-22
C1	Setting up of FPC cum KMC Centers	NHM	Target	4	6	6	6
			Amount	20.88	31.32	31.32	31.32
C2	Training of MOs/ SNs in FPC	NHM	Target	3	6	6	6
			Amount	2.37	4.74	4.74	4.74
	Budget Subtotal			**23.25**	**36.06**	**36.06**	**36.06**
D	**Roll out and Emergency Pediatric Care and Emergency Triage Assessment and Treatment (ETAT) for improving emergency pediatric care at district level**						
D1	Setting up of Emergency Pediatric Care Units and ETAT centers in all District Hospitals in phased manner	NHM / State	Target	6	4	6	6
			Amount	120.6	84	126	126
D2	Capacity building of MOs and nursing staff involved in emergency pediatric Care	NHM / State	Target	4	6	6	6
			Amount	2	3	3	3
	Budget Subtotal			**122.6**	**87**	**129**	**129**
E	**Home Based Newborn Care (HBNC) and Home Based Care for Young child (HBYC) and MAA**						
E1	Implementation of Home Based Newborn Care (HBNC) in all the districts of the state ((ASHA Incentive, Trainings & IEC)	NHM	Target	4			
			Amount	151.56			
E2	Implementation of Home Based Young Care (HBYC) in all the Districts of the State (Trainings & IEC). Additional incentive to supervisors and ASHA workers and monitoring cost for first year, estimated at 100 Lakhs per district	NHM	Target		6	6	6
			Amount		414.15	600	600
E3	Recurring cost from 2nd year of Launch of HBYC. Budget for additional incentive to be provided to ASHAs for additional visits and supervisors.	NHM	Target		5	10	16
			Amount			300	480
E4	4 days Trainings on IYCF/ MAA for MOs, SNs, ANMs of all DPs and SCs	NHM	Target	22	22	22	
			Amount	31.46	50	50	
	Budget Subtotal			**183.02**	**464.15**	**950**	**1080**
F	**Roll out of Aneamia Mukt Bharat Stategy in the state**						
F1	State level launch/orientation of Anaemia Mukt Bharat and state TOT	NHM	Target		1	0	0
			Amount		10	0	0
F2	District Trainings in a phased manner for roll out of the intervention	NHM	Target		6	6	10

	Strategy	Source of Funds		2018-19	2019-20	2020-21	2021-22
			Amount		6	6	10
F3	Procurement of IFA supplements, Folic Acid tablets and Albendazole for children, adolescents, WRA and pregnant and lactating women (Recurring)	NHM	Target		6	6	10
			Amount		566.62	600	600
F4	Cost of testing and therapeutic management (Recurring)	NHM	Target			6	10
			Amount			756	1260
F5	ASHA incentive for mobilizing children 6-59 months, WRA (initially for newly wed women covered under Mission Parivar Vikas) and post partum lactating women (Estimated 1,000 ASHA/district x Rs. 300 per quarter)	NHM	Target		6	6	10
			Amount		149.68	150	150
	Budget Subtotal			**0**	**732.3**	**1512**	**2020**
G	**Strengthening of DHs & CHCs under LaQshya**						
G1	Civil Works for Labour Rooms at identified hospitals (DHs) Upgradation of existing Structure	State/ NHM	Target		3	6	5
			Amount	0	32.89	240	200
G2	Civil Works for Labour Rooms at identified hospitals (CHCs) - Upgradation of existing Structure	State/ NHM	Target			17	15
			Amount	0		510	450
G3	Equipment for Labour Room Strengthening under LaQshya	NHM	Target		21	23	20
			Amount	0	1477.77	230	200
G4	Infrastructure for Obstetric ICUs/ HDUs under LaQshya	State/ NHM	Target	10	4	6	7
			Amount	340	100	220	270
G5	Equipment for Obstetric ICUs/ HDUs under LaQshya	NHM	Target	10	4	6	7
			Amount	600	200	400	500
G6	Hiring of additional specialists as per Gap. The facilities selected for LaQshya has shortage of 7 OBGY Specialists, 4 Pediatricians and 21 Anesthetists. Calculated at 1 Lack per month.	NHM	Target		32	50	50
			Amount		32	50	50
G7	Procurement of CTG machines for all high case load facilities for monitoring progress of labour, Approved for district hospitals in this year PIP, Calculated at 1 Lakh per CTG Machine	NHM	Target			15	15
			Amount			15	15
	Budget Subtotal			**940**	**1842.66**	**1665**	**1685**
H	**Improving Skills of LR Staff through Dakshata/ LaQshya**						

	Strategy	Source of Funds		2018-19	2019-20	2020-21	2021-22
H1	TOT for Dakshata (State Level)	NHM	Target	2	2	2	2
			Amount	4.65	4.65	4.65	4.65
H2	Dakshata training (District Level)	NHM	Target	12	22	22	22
			Amount	9.18	13.46	13.46	13.46
H3	Procurement of Mannequins for Dakshata	NHM	Target	24	25	-	-
			Amount	36	35		
H4	LaQshya trainings/workshops (Divisional Level)	NHM	Target	2	1	-	-
			Amount	1.59	4.3		
H5	Orientation workshop of MOs/SNs (District level)	NHM	Target	22	7	-	-
			Amount	8.21	7.12		
H6	Onsite mentoring at Delivery Points	NHM	Target	22	22	22	22
			Amount	31.68	15.84	95.04	95.04
	Budget Subtotal			**91.31**	**80.37**	**113.15**	**113.15**
Yearly Budget Requirements (INR in Lakhs)				**1627.28**	**4618.18**	**5221.85**	**5607.29**
Total Budget Requirement (INR in Lakhs)				**17074.60**			
Total Budget Requirement from 2019 to 2022 (INR in Lakhs)					**15447.32**		