



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





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GOVERNOR
JAMMU & KASHMIR



RAJ BHAVAN
SRINAGAR-190001

Over the years, the healthcare sector in J&K has witnessed significant progress in terms of improvement in infrastructure, trained manpower and healthcare delivery systems at all levels, which is now reflected in the improved healthcare indicators of the State that have become better than many other States and the national average. The current Infant Mortality Rate (IMR) has come down to 23 in the year 2017 from 45 (2009) in the State, which is lower than the national IMR of 33 (SRS 2017).

Infant Mortality Rate is a critical indicator of overall health status of a community; and in order to achieve the Sustainable Development Goal (SDGs) of IMR of 12 or less per 1000 live birth for neonates, ahead of the country, Jammu & Kashmir has prepared an ambitious roadmap for reducing the IMR to a single digit by 2022.

As the IMR of our State is mostly (78%) contributed by the Neonatal and Early Neonatal Mortality, therefore the focus of the action plan is to strengthen care around birth, post-partum and neonatal care. Accordingly, various facility and community based strategies have been proposed for implementation in the State during the next 3 years such as, strengthening of labour rooms, creation of additional Neonatal Intensive Care Units (NICUs), provision of ventilators and transport incubators in high case load Special Newborn Care Units (SNCUs), roll out of Home Based Care for Young Child, etc.

I congratulate the Health and Medical Education Department of Government of Jammu & Kashmir for taking the initiative to provide quality maternal and child health care services and improve the overall health status of the community.

I also extend my best wishes and hope that the State will achieve the ambitious goal set out in this action plan document.

8th July, 2019
Srinagar.


(Satya Pal Malik)



K. Vijay Kumar
IPS (Rtd.)

**Advisor to the Hon'ble Governor
Jammu and Kashmir
Civil Secretariat (J&K)**



D. O. No.

Dated:

I am glad to know that the Health and Medical Education Department is bringing out an IMR Action Plan for reduction of preventable infant deaths to meet the objective of single digit Infant Mortality Rate (IMR) by 2022.

The State government is committed to reduce the Infant and Maternal Mortality by providing quality health care services to all, with special focus on poor and people living in difficult areas through various initiatives, programmes and other related activities on Reproductive, Maternal, Neonatal, Child and Adolescent health.

I congratulate the Health and Medical Education Department for preparation of IMR Action Plan. I hope that the plan will be helpful in achieving our ambitious goal of single digit IMR by the desired timelines and establish Jammu and Kashmir as a model state for achieving the desired health indicators.

I extend my best wishes to the Health and Medical Education Department for successful implementation of this Action Plan.

6th June, 2019
Srinagar


(K. Vijay Kumar)



B. V. R. Subrahmanyam
IAS



Chief Secretary
Jammu & Kashmir

D. O. No:
Dated:

Message

Improving health care delivery is a priority area for Government of Jammu and Kashmir. Multipronged strategy has been adopted to strengthen tertiary, secondary and primary health care services by setting up of AIIMS institutions, new Medical Colleges, Maternal and Child Health wings, strengthening of District Hospitals, operationalization of Health and Wellness Centers and implementation of Pradhan Mantri Jan Arogya Yojana under Ayushman Bharat. All this has been done to improve the access to and quality of public health care services at all levels in the state.

As Maternal and Child health indicators are reflection of the overall health status of the population, the government of J&K is committed to take all steps for reducing preventable Maternal and Child deaths. Development of action plan for reducing Infant Mortality Rate to single digit by 2022 is a significant step towards this commitment.

I extend my best wishes and complete support to Health and Medical Education Department in achieving the goals set out in this action plan and hope that it will act as guiding document for all stakeholders in implementing the strategies and achieving the desired results.

(B.V.R. Subrahmanyam)



Atal Dulloo, IAS

Financial Commissioner
Health and Medical Education Department
Government of Jammu & Kashmir



MESSAGE

As we move from Millennium Development Goals (MDGs) era to the Sustainable Development Goals (SDGs) period, reducing preventable child mortality remains a priority area. Achievement of Global SDG targets will depend largely on whether India is able to achieve the required reduction in child mortality rates. To ensure that we do not miss the SDG targets, it is imperative that all states develop tailored strategies with ambitious and achievable targets.

The State of Jammu & Kashmir has been able to achieve significant improvement in multiple indicators related to maternal and child health. Institutional deliveries, total fertility rate and antenatal care have shown an improvement. All this has translated into reduction of Infant Mortality Rate (IMR) to 24 (2016). At the other spectrum, some indicators have shown a suboptimal improvement. These include indicators related to breast feeding rates, adequate complimentary feeding and appropriate management of diarrhea and pneumonia.

As 92% of under five deaths in J&K happen before the first birthday, it is imperative to put reduction of Infant Mortality on high priority list. Towards this, an IMR Action plan has been developed for setting a uniform direction in order to achieve single digit IMR.

This plan will guide individual districts to design specific plans for accelerating progress and work towards the long-term goal of ending preventable infant deaths.

I extend my best wishes and fervent support to this initiative and urge all the stakeholders involved to accelerate their efforts towards the achievement of single digit Infant Mortality Rate in the state by 2022.

(Atal Dulloo)



Bhupinder Kumar, IAS

Mission Director



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PREFACE

Jammu and Kashmir (J&K) has seen a remarkable improvement in the number of infant deaths since the start of NHM. The IMR of state has decreased from 45 in 2009 to 24 in 2016. 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.

Despite this achievement, a large number of preventable infant deaths are still happening. Keeping this in mind the state has set up a vision of achieving single digit IMR by 2022.

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 16.3%. This is an ambitious goal and its achievement would depend on quality of planning and translation of plans in to action. The accelerated decline is not possible by continuing with same interventions or with marginal increases in coverages of life saving interventions but 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 in consultation with all relevant stakeholders. A consultative process was followed in developing this action plan with the vision that this action plan will act as a roadmap in guiding the state for achieving vision of single digit IMR by 2022.

I would like to express that this action plan would not have been possible without constant encouragement and guidance from our Principal Secretary Health and Medical Education. I would also express my appreciation for Child Health Division, Ministry of Health & Family Welfare, experts from Medical Colleges and Directorate of Health Services and Family Welfare who gave valuable inputs in framing this guidebook.

This document has been developed with the technical support from Norway India Partnership Initiative (NIPI)- Jhpiego state and national team, who are our development partners.

I request all concerned to take sincere steps for effective implementation of this strategy in the field, to enable the State to meet its ambitious targets.

Bhupinder Kumar, IAS

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Contents

Executive summary	16
I. Introduction	18
II. J&K IMR action plan development process	19
III. Situation analysis	20-26
IV. Objective and Goal	27
V. Key interventions and focus areas	28
VI. Description of interventions	29
VII. Annexure, Budget	41-43
Abbreviations	44

EXECUTIVE SUMMARY

Jammu and Kashmir (J&K) has seen a remarkable improvement in the number of infant deaths since the start of NHM. The IMR of state has decreased from 45 in 2009 to 23 in 2017, which translates to decrease by 7.8 percentage points per year. This reduction translates into saving an estimated 4500 additional infants in year 2017, 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. Despite the great achievement, a large number of preventable infant deaths are happening.

Keeping the above number of additional infant deaths in mind, the 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 7.8% to AARR of 17%.

The accelerated decline is not possible by continuing with same interventions or with marginal increases in coverages of life saving interventions but 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.



To achieve this state needs to accelerate the rate of decline from current Average Annual Rate of Reduction (AAAR) of 7.8% to AARR of 17%.

- ➔ **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 are discussed.
- ➔ **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, Mothers' Absolute Affection (MAA) Intensified Diarrhoea Control Fortnight (IDCF), Universal Immunization Programme (UIP), Village Health and Nutrition Days (VHNDs) and Integrated Management of Neonatal and Childhood Illness (IMNCI), In addition Home Based Care for Young Child (HBYC) will be rolled out. Key health facility based interventions will need strengthening of PMSMA, 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 Intensive Care Unit (ICU) and High Dependency Unit (HDU).

NHM J&K and NIPI teams at J&K state and national level developed the IMR reduction action plan jointly. State also constituted a technical expert committee, which had members from Pediatrics and Obstetrics and Gynecology departments of GMC Srinagar and Jammu to review the action plan.

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 towards a new global development agenda, the Sustainable Development Goals (SDG), which seeks to eliminate preventable deaths of newborns and children by 2030. India is a signatory to SDGs and is committed to achieve the targets set in SDGs. India has put forward 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, 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.

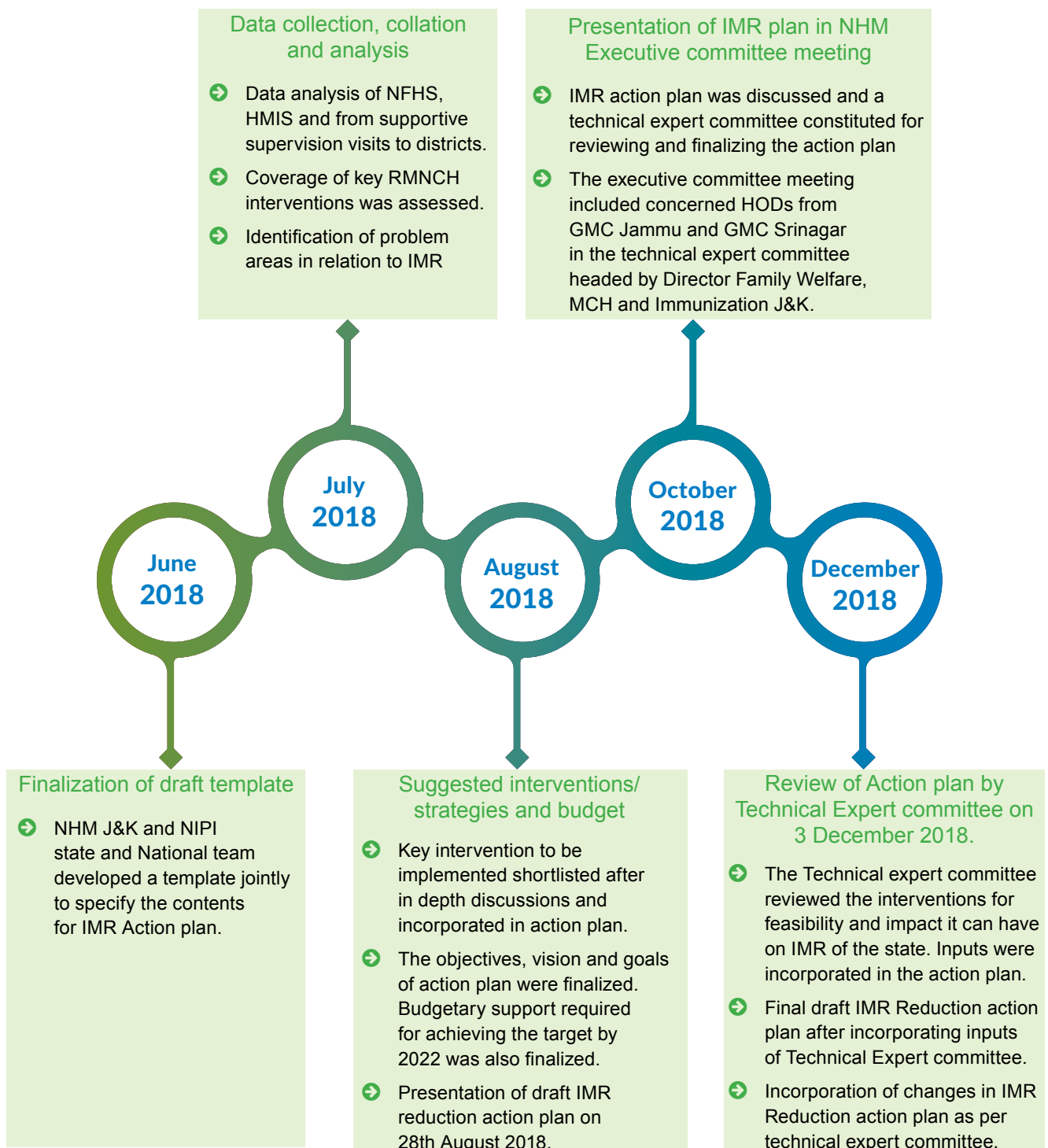
Jammu & Kashmir (J&K) has seen a remarkable improvement in reducing the number of infant deaths during the NHM period. State IMR has decreased from 45 in 2009 to 23 in 2017. This is a significant progress, yet a large number of preventable infant deaths are taking place, which necessitates an appropriate action plan. In line with national goals and policies, J&K state is committed to accelerate the rate of reduction in infant and child mortality. A very high proportion of under-five deaths occur before the first birthday and it shall require proportionate inputs to address issues around infant mortality. In this regard, state of J&K has set an ambitious goal of reducing Infant Mortality rate (IMR) to single digit by 2022. To ensure the highest level of commitment from all stakeholders and achieving the abovementioned goal, the state has developed this IMR reduction action plan.

The purpose of the action plan is to have an understanding of current situation by analysing the trend of key indicators that determine infant mortality. The report has also identified key interventions along with the budget projections 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 administration, health authorities and managers to take relevant steps for implementation of new and ongoing initiatives over the next four years (2019-2022).

II.

J&K IMR ACTION PLAN DEVELOPMENT PROCESS

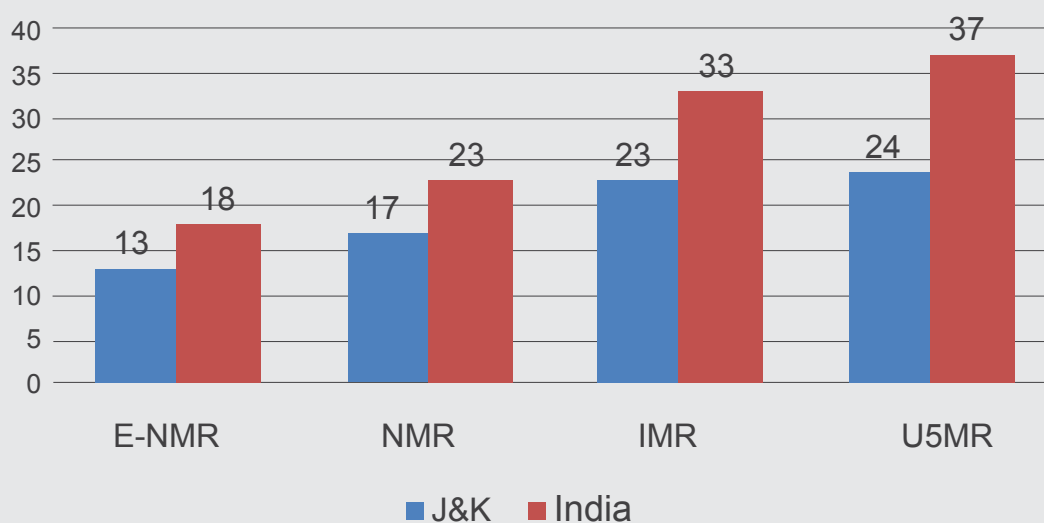


SITUATIONAL ANALYSIS

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 maternal (MMR) and child (U5MR) mortality 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 24 for the state in comparison to national average of 37. **Figure 1** depicts the status of various child mortality indicators in comparison to national average.

Figure 1: Comparison of child mortality rates





Trends in decline in newborn, infant and child mortality in Jammu and Kashmir

Figure 2 show the trends in child mortality rates in Jammu and Kashmir, which is depicting that there has been a significant decline in all child mortality rates. The decline has been a consistent one with the rate of decline being much faster from 2013 onwards.

The table below is depicting the decline in percentage points and is depicting that the greatest decline has been in early neonatal mortality rate followed by neonatal mortality rate both of which have seen reduction to less than 50% of 2009 values. Infant mortality rate has seen 49% percent reduction in the same period. In addition, the rate of decline has seen a significant acceleration in recent years as depicted by much higher rates of reduction post 2013 in the table below in comparison to rates before 2013.

Figure 2: Trend of decline in child mortality rates in J&K (Source: SRS)

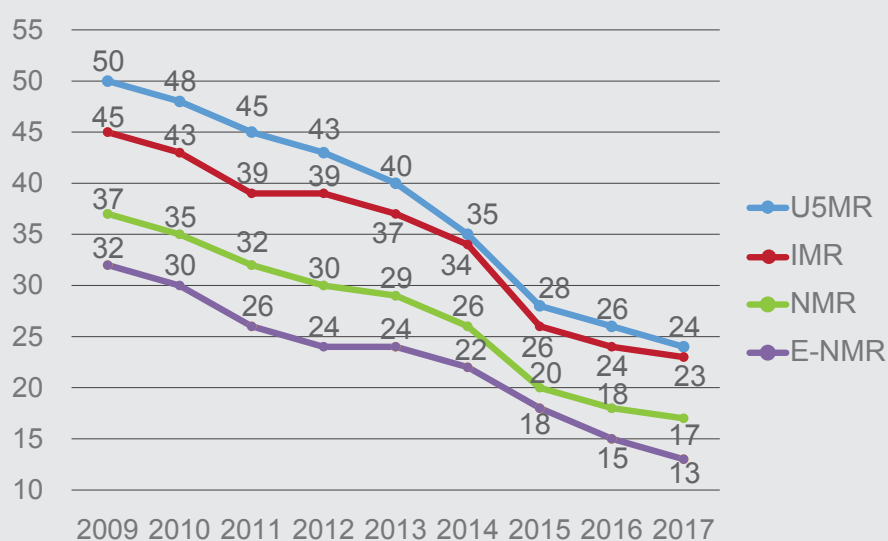


Table 1: Rates of decline in percentage points

Rates	2009	2013	2017	% Change (2009-13)	% Change (2013-17)	% Change (2009-17)
E NMR	32	24	13	25	46	59
NMR	37	29	17	22	41	54
IMR	45	37	23	18	38	49
U5MR	50	40	24	20	40	52

Timing of child deaths

Early child deaths contribute most to deaths taking place in children under five years in J&K.

96%

of **under five deaths** happen in **1st year of life.**





74% & 57%

of infant mortality (IMR) is **contributed by neonatal mortality (NMR) and E-NMR respectively**





Inequities in risk for death

Difference in U5MR as per gender and region

			Total
	17	21	19
	28	25	26
Total	25	24	24

Social determinants are an important contributing factor. Children belonging to rural areas are at higher risk of death than their urban counterparts.

Other mortality indicators

			Total
SBR	1	0	1
E NMR	14	10	13
P NMR	16	10	14
NMR	18	14	17

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



Summary of the current scenario and trends

01 → Trend analysis depicts that the greatest decline has been in early neonatal mortality rate followed by neonatal mortality rate, which points to improvement in antenatal care and care around birth.

02 → Lowest decline has been in Infant mortality rate followed by under-five mortality rate. This depicts need to ensure strengthening of existing interventions and roll out of newer ones which have an impact on infant mortality.

03 → NMR and E-NMR are the major contributors to Infant mortality in the state and infant mortality is the prime contributor for under-five deaths.

04 → Inequities in child mortality

Children born in rural areas are at higher risk of death than their urban counterparts are.

Female children in rural areas are particularly at highest risk even in comparison to rural male children.

Any action plan needs to address the inequities in coverage of evidence based maternal and child health interventions in order to have the desired impact.

05 → The rate of decline has seen a significant improvement in last few years which needs to be maintained and improved upon to achieve the goal of single digit IMR as per this action plan.



Current RMNCAH status & change in key 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.

Table: Current status & change in key RMNCH indicators over the last decade (2005-06 to 2015-16)

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
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 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 (%)	41.6	46.0	31.9
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



Key points emerging from the analysis

1. 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 intervention will have a lasting impact in reducing infant mortality rate. However, **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.
2. 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 supplements during pregnancy. **Only one fourth (26.8%) of pregnant women have received full ANC in J&K.** This represents a huge lost opportunity as ANC period is a starting point to promote a healthy pregnancy, institutional delivery and post-delivery care for both mother and child.

26.8% of pregnant women have received full ANC

3. 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.**

Institutional births in public health facilities

50.2% ↑ **85.7%**

4. Quality of Emergency Obstetric Care reflected by the number of caesarian sections (CS) performed shows **that overall rate of 33% is well above recommended population norm (between 5%-15%). For births in private sector, it is 75.5%, which is an increase by more than 100% since of NFHS 3 (2005-06).**

Caesarian sections (cs) performed

Recommended population norm

5%-15%

Overall rate

33%

Private sector

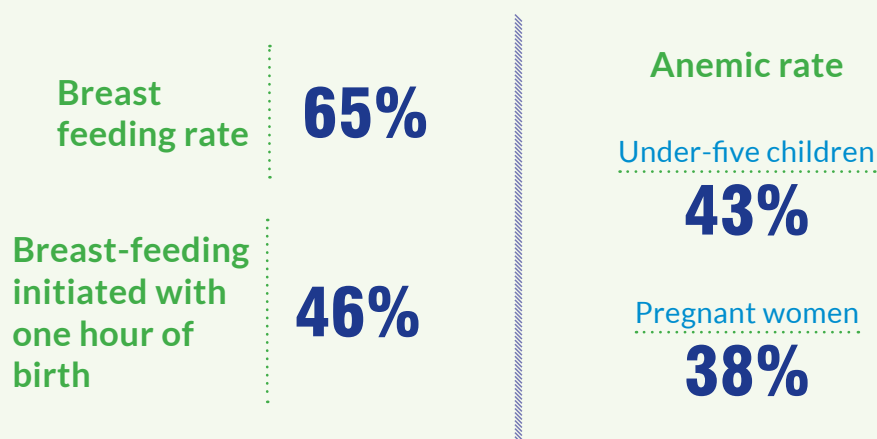
75.5%

5. Health providers reached 75% mothers within two days after birth, so that early identification of complications that lead to maternal and newborn mortality after childbirth could be prevented and managed. **However, there is significant gap in proportion of newborns who received health checkup within two days of delivery, which stands at 20% as per NFHS4.**

6. 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.
7. The full immunization rates of J & K have increased in the last 10 years and are above the national average. **Yet the coverage of 75% in the state is still well below the recommended vaccine coverage.** The data highlights the need to strengthen the microplanning and vaccine delivery systems in the state.
8. Sick children with diarrhoea and fever or ARI symptoms are taken to health facilities in three out of four cases, which is encouraging, **but only 40% children with diarrhoea received zinc.** Good care seeking behaviour makes a case for strengthening community and facility based child health services.

40% children with diarrhoea received zinc

9. While 86% of deliveries are taking place at health facilities, **only 46% of the newborns have breast-feeding initiated with one hour of birth. Exclusively breast feeding rate is 65% and can be improved further. Though the rates for underweight have decreased in the last decade, still one out of four children are stunted. 43% under-five children and 38% of pregnant women are still anemic though the rate have seen an improvement in last decade.** State can build on the platform of community health services to improve infant and young child feeding practices, which will translate into better nutritional status in children.



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

IV.

OBJECTIVES & GOALS OF THE IMR ACTION PLAN



Objectives

The action plan has been developed to achieve the following objectives:

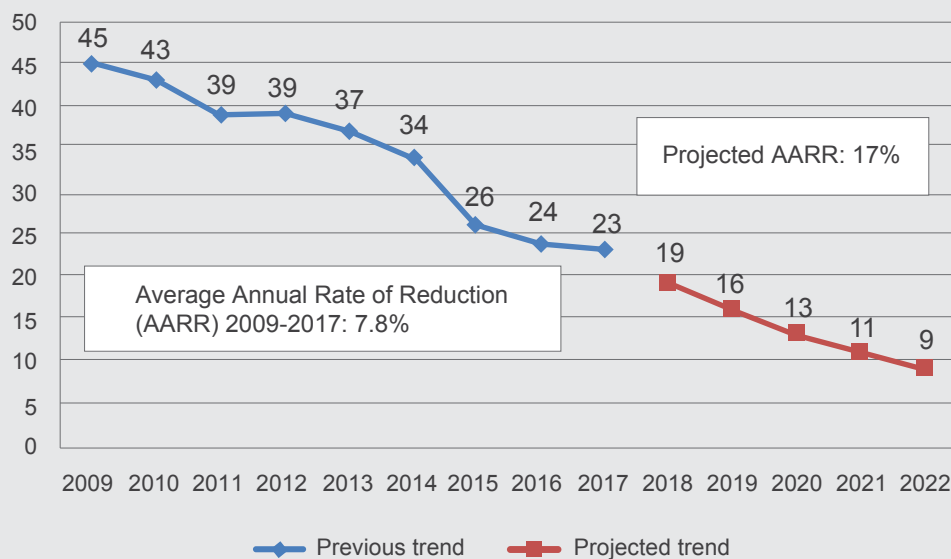
- ➔ Strengthen and invest in care during labour, child birth and the first day and week of life- will lead to a triple return of preventing maternal deaths, still births and newborn deaths
- ➔ Ensure each infant is counted- measurement, tracking and accountability
- ➔ Eliminate preventable infant deaths due to pneumonia & diarrhoea by improving quality and coverage of evidence based child health interventions



Goal

- ➔ The specific goal of this action plan is to achieve single digit IMR by year 2022

To achieve single digit IMR by 2022 the state needs to accelerate the rate of decline in IMR as projected below.



Accelerated efforts will be required to improve care provided to prospective mother's 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 rate of decline in IMR.

V.

KEY INTERVENTIONS AND ISSUES ACROSS RMNCH+A

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 analysis are summarized in the figure below:

STRATEGIES AND KEY ISSUES ACROSS RMNCH+A

	Adolescent/ pre pregnancy	Pregnancy	Birth	Newborn /Postnatal	Childhood
KEY ISSUES	High unmet need for contraception in rural areas	Quality of ANC Anemia in pregnancy	High LSCS Quality of Care around Birth	Early initiation of Breast feeding Home visit in 2 days	Decline in complimentary feeding. High rates of diarrhea and pneumonia in rural parts poor rates of Zinc supplementation High malnutrition and Anemia
INTERVENTIONS	Community level interventions	Birth Prep plan/ VHND Anemia Mukh Bharat/ I-NIPI		HBNC	HBYC
	Facility level interventions	PMSMA/ANEMIA MUKT BHARAT/ I-NIPI	Quality MCH Care/ Dakshata/LaQshya/ PPFP	NBCC/NBSU/SNCU/ FPC	Facility based Paediatric care/ETAT
Social Behavior Change and Communication (SBCC)					

VI.

DESCRIPTION OF INTERVENTIONS

This action plan shall serve as a roadmap that redefines and focusses state, district and sub district strategies and actions in the period 2019-2022. State is already implementing a large number of interventions to bring down child mortality. This action plan will lay a roadmap for strengthening of existing intervention. In addition, newer evidence based interventions will be started to accelerate the rate of decline in mortality rates.

	Strengthening existing interventions	New interventions
Facility based	<ul style="list-style-type: none"> (A) PMSMA (C) Facility based Newborn care through SNCU, NBSU and NBCC <ul style="list-style-type: none"> (C1) Strengthening SNCUs, NICUs and NBCCs (C2) Strengthening NBSUs (C3) Capacity building (J) Reproductive health services (K) Strengthening adolescent health services. 	<ul style="list-style-type: none"> (B) Dakshata & LaQshya <ul style="list-style-type: none"> (B1) LaQshya (B2) Obstetric ICU and HDU (B3) Dakshata (D) Family participatory care (FPC)/ Kangaroo mother care (KMC) (E) Strengthening facility based paediatric care in district hospitals (H) Newborn screening for congenital diseases
Community based	<ul style="list-style-type: none"> (F) Home based Newborn care (HBNC) (I) Mothers absolute affection (MAA) (L) Maternal and child death reporting system 	<ul style="list-style-type: none"> (F) Home based care for young child (HBYC) (G) Anaemia Mukht Bharat (I-NIPI)



A. Pradhan Mantri Matritva Suraksha Abhiyaan (PMSMA)

Strengthening quality of antenatal care is imperative in view of low coverage of full antenatal care in the state. State will be focusing on strengthening quality of antenatal care by implementation of PMSMA by capacity building of health workers, ensuring requisite logistics and extensive supportive supervision. The state will plan to cover eight district each year and ensure strengthening of PMSMA in all districts by 2020-21. As there have been multiple changes in provision of ANC care ranging from changes in IFA supplementation, screening for gestational diabetes mellitus etc., the state is planning to orient the staff involved in antenatal care regarding the changes. One district level training followed by trainings at block level will be conducted to orient health workers regarding the full ANC package to be provided to pregnant women.

Interventions	2018-19	2019-20	2020-21	2021-22
No. of proposed district trainings on expanded ANC	8	8	6	



B. Implementation of Dakshata and LaQshya to improve intra and immediate postpartum care

B1. Strengthening of labour rooms and maternity OTs by 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 plans to have one District Hospital and 2 high case load CHCs certified from each district by 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.



Approximately 46% maternal deaths, over 40% stillbirths and 40% newborn deaths take place on the day of the delivery

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	
Birth companion for all deliveries (budget provision for ensuring privacy and providing 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



For managing high risk pregnancies, Obstetric High Dependency Units are being established at eight (8) District Hospitals of the State in first phase

B2. Establishment of High dependency units (Obstetric HDUs) and 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 onwards, 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				

B3. Implementation of Dakshata to improve practices related to care around birth

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.



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

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 round of trainings at district level.

Indicator	2018-19	2019-20	2020-21	2021-22
No of Dakshata ToTs 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.				



C. Strengthening facility based paediatric care

C1. Strengthening 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

Access to quality facility based newborn care has improved markedly in the last decade by operationalization of NBCCs, NBSUs, SNCUs and NICUs

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 @ Rs 10 lakhs/year having admissions of more than 50 newborns per month and @ Rs 5 lakhs/year for the SNCUs which have admissions of less than 50 newborns per month. In addition to this, an operational cost of Rs.2.5 lakhs is being provided for Type II SNCUs that 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 newborns admitted in public health facilities.

- ➔ Improving access to Facility Based Newborn Care by operationalization of additional SNCUs, NBSUs and NBCC as per need and service demand.
- ➔ Ensuring service providers handling newborns and infants are trained in relevant training packages and ensuring rational posting in relevant departments of health facilities.
- ➔ Operationalization of NICU at SKIMS Medical College, Bemina, Government Gandhi Nagar Hospital, Jammu and strengthening of Neonatal Intensive Care Unit (NICU) at SMGS hospital Jammu.
- ➔ Upgradation of selected existing SNCUs by providing ventilators/CPAP facilities 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 newborns 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, especially in the low birth weight and preterm newborns.

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 established under the award of 13th Finance Commission Award were provisioned with two Medical Officers (MOs) & 2 Nurses/ANMs. During the FY 2018-19, type II SNCUs located in District Hospitals were provided with four Medical Officers. Subsequently during the FY 2019 all the remaining SNCUs shall be provided complete set of human resources as mandated under Facility Based Newborn Care Guidelines of MoHFW, GoI and the health facilities shall also be further strengthened in terms of equipment & infrastructure.

Operationalization of new NICUs will cater to the increased demand for tertiary facility based newborn care in the state at SKIMS Bemina and Government 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.

Ventilators shall be procured for selected SNCUs based on admission rate, referral rate along with their location in difficult geographical areas. These SNCUs refer a large number of neonates to tertiary care who die on the way due to lack of advanced life support. Capacity of each SNCU in terms of human resources and infrastructure will be enhanced before provisioning of ventilators. Funds for procurement of 6 ventilators @ 12 Lakh per ventilator have been approved for year 2019-20. In addition 21 Lakhs have been approved for 6 bubble CPAPs. Funds have also been approved for procurement of 15 transport incubators which will be used to equip ambulances.



During the FY 2019, all the remaining SNCUs shall be provided complete set of human resources as mandated under Facility Based Newborn Care Guidelines of MoHFW, GoI



Out of 76 established NBSUs, operational cost shall be provided for 67 Newborn Stabilization Units @ Rs. 1,00,000 per unit per year for maintenance and consumables

To improve provision of care for 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 shall be in place to decrease frequency of equipment malfunction and to decrease duration of downtime. The activity will involve selection of a reputed agency and contract rates for each SNCU, NBSU and NBCC.

	2018-19	2019-20	2020-21	2021-22
Operationalization of NICU at SKIMS Bemina and Government Gandhi Nagar Hospital, Jammu (Budget 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/CPAP machines for selected SNCUs based on delivery load, admissions, 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

C 2. Operationalization of Newborn stabilization Units (NBSUs) & Newborn Care corners.

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 until date; however, most of the newborn stabilization units established are not fully functional because no dedicated trained personnel have been designated for these units. MoHFW, Gol has now developed a comprehensive training package for capacity building of the staff managing the NBSUs and will be used to train them.

Out of 76 established NBSUs, operational cost shall be provided for 67 Newborn Stabilization Units @ Rs. 1,00,000 per unit per year for maintenance 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	Doda	CHC Gandoh
2	Bandipora	CHC Gurez (Dawar)	7	Poonch	CHC Mendhar
3	Samba	District Hospital Samba	8	Rajouri	CHC Sunderbani
4	Shopian	District Hospital Shopian	9	Rajouri	CHC Thanamandi
5	Doda	CHC Bhaderwah			

Two ANMs have been positioned for each of the NBSUs under NHM; however, there is need of dedicated Medical Officer (MBBS) to make the unit fully functional, as ANM are not trained for providing this level of care. 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 for the staff working in NBSUs during FY 2018-19 & 2019-20 in eight batches in order to improve 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	Sanctioned 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 labour room & OT for providing essential care to newborns at birth. State has operationalized 281 Newborn Care Corners. For strengthening of NBCC Operational cost @ Rs. 20,000/ per NBCC unit is provided for NBCCs in 51 PHCs 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 (NSSK) & the installation 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



3369 MOs/ SNs/ANMs have been trained till date under Navjaat Shishu Suraksha Karyakram (NSSK)

C 3. Capacity building of human resources for health for improving provision of care to children



70 doctors and 88 nurses posted in SNCUs and NICUs have been trained in Facility Based Newborn Care

National Collaborative Centre is conducting the Facility Based Newborn Care training of the staff of SNCUs / NICUs at Kalawati Saran Children Hospital, New Delhi. 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 staff 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 personnel 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	Sanctioned	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 is currently in use. Presently 16 SNCUs are reporting on the portal and Staff of remaining SNCUs shall be trained so that by the end of 2019-20 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.



D. Family participatory care and kangaroo mother care for improving survival of small and sick newborns

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 have been conducted with technical support from NIPI.

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 (Number of batches)	4	6	6	6



E. Strengthening facility based paediatric care in district hospitals

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.

A baseline assessment will be conducted as per national guidelines at all district hospitals and gaps identified in facility based paediatric care. Facility in charges, program managers at district and state level will frame an action plan for strengthening facilities as per guidelines. Each facility will develop a detailed project report. The facilities will be provided funds as per the guidelines for strengthening in terms of Emergency triage assessment and treatment for sick children (ETAT), paediatric OPD and paediatric wards (particularly for managing diarrhoea and pneumonia in children.)

Activity	2018-19	2019-20	2020-21	2021-22
Baseline assessment of district hospitals	6	4	6	6
Strengthening of Emergency triage assessment and treatment (ETAT), paediatric OPD and paediatric wards	6	4	6	6
Training of medical officers and staff nurses (Number of batches)	6	4	6	6



F. Strengthening home based newborn care and roll out of home based care for young child

The state has 12 State Trainers and 220 District Resource Persons (DRPs) for HBNC. 802 ASHA Facilitators (ANMs) have been trained in HBNC Module 6 & 7 Round I, II & III to enhance their knowledge and skills. 11,718 out of 11,853 ASHAs have been trained in HBNC module. 11,730 are trained in HBNC Module 6 & 7 Round II, 11,484 are trained in HBNC Module 6 & 7 Round III and 10,130 ASHAs are Trained in HBNC Module 6 & 7 Round IV for providing better Home Based Newborn Care. During the Financial Year 2017-18 , 116,856 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

11,718 out of 11,853 ASHAs have been trained in HBNC module

In order to further decrease IMR, Home based care for young children (HBYC) will be introduced and scaled up to decrease the infant mortality in post-neonatal period and infancy by improving compliance to exclusive breast feeding, complementary feeding, immunization and growth monitoring. Under HBYC program five additional home visits will be conducted by ASHA in the 3rd, 6th, 9th, 12th & 15th months of age and ASHA shall be provided an incentive of Rs. 250 per child for these services.

All the ASHAs 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 (Number 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			



G. Reducing prevalence and improving provision of care for anaemia

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 behaviour change communication campaign including delayed cord clamping at birth
- ➔ 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.



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

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 behaviour change communication campaign		22	22	22
Establishing 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 Haemoglobinometers in a phased manner. 30% blocks in each district to be prioritized for first year based on prevalence of anaemia and to be scaled up to all blocks in subsequent years.		1000	1000	1000
Establishing a robust supply chain for consumables related to haemoglobin estimation		6	6	10
Provision of fortified foods in public health programmes		6	6	10



H. Newborn screening for congenital diseases

The increase in institutional deliveries in J & K provides a unique opportunity to screen the newborns at delivery points. This window of opportunity, if missed, could be either fatal for the child in some cases 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, 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, nurses & ANMs from functional delivery points in Comprehensive Newborn Screening is underway in the State. The trainings will be fast tracked and the data regarding notification of congenital anomalies will be monitored. Development of requisite linkages for treatment of children identified with congenital anomalies under RBSK.



Strengthening of RBSK will ensure identification of disabilities, which were not picked up at birth, and disabilities with onset after birth



I. Implementation of mother's absolute affection (MAA)

MAA - "Mother's Absolute Affection" is a country wide intensified breastfeeding promotion campaign targeting all pregnant & lactating mothers, ASHAs, Sub-centres, and 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 & 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		
	2019-20	2020-21
Number of Batches	22	22
(Number of medical officers/ staff nurses to be trained)	528	528



J. Strengthening reproductive health services

Strengthening reproductive health services particularly post-partum family planning services and preventing adolescent pregnancies, in addition to increasing male involvement in family planning.

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

- ➔ 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;
- ➔ Ensuring availability of entire basket of contraceptives;
- ➔ Saturating high caseload facilities to provide PPIUCD



K. Strengthening adolescent health services

It is said that investing in adolescent health brings a triple dividend by improving the adolescent health for the present, for their future lives and by improving the health of 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:

- ➔ Scaling 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. Strengthening of existing interventions

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 quality of 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



L. Improving maternal and child death reporting and review system

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

VII.

ANNEXURE

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

	Strategy	Source of Funds		2018-19	2019-20	2020-21	2021-22
A	Strengthening facility based newborn care by strengthening of existing SNCUs, operationalizing new SNCUs, NICUs, PICUs & improving care being provided during referral transport of sick infants						
	Funds already released for 8 New SNCUs and work is ongoing, state will fast track operationalization of these SNCUs and make them functional by 2019.						
A1	Operational Cost for FBNC Units (SNCUs/ NBSUs/ NBCCs) including maintenance cost (32 NICUs/SNCUs, 76 NBSU & NBCCs)	NHM	Target	108	108	108	108
			Amount	252	273	273	273
A2	Facility Based Newborn Care (FBNC) training	NHM	Target	2	3	3	3
			Amount	10	16	16	16
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			263	1116	557	289
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	5	5	5	
B2	Provision of Medical Officers for NBSUs	NHM	Target		67	67	67
			Amount		241	241	241
B3	NSSK Trainings	NHM	Target		22	22	22
			Amount		14	14	14
	Budget Subtotal			5	260	260	255

	Strategy	Source of Funds		2018-19	2019-20	2020-21	2021-22
C	Rolling out of Family Participatory Care (FPC) & Kangaroo Mother Care (KMC) Centre						
C1	Setting up of FPC cum KMC Centers	NHM	Target	4	6	6	6
			Amount	21	31	31	31
C2	Training of MOs/ SNs in FPC	NHM	Target	3	6	6	6
			Amount	2	5	5	5
Budget Subtotal				23	36	36	36
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	121	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	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	152			
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	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	50	50	
Budget Subtotal				183	464	950	1080
F	Roll out of Anemia Mukh Bharat Strategy in the state						
F1	State level launch/orientation of Anaemia Mukh 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
			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		567	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		150	150	150
Budget Subtotal				0	732	1512	2020
G	Strengthening of DHs & CHCs under LaQshya						
G1	Civil Works for Labour Rooms at identified hospitals (DHs) Upgradation of existing Structure	NHM / State	Target		3	6	5
			Amount	0	33	240	200

	Strategy	Source of Funds		2018-19	2019-20	2020-21	2021-22
G2	Civil Works for Labour Rooms at identified hospitals (CHCs) - Upgradation of existing Structure	NHM / State	Target			17	15
			Amount	0		510	450
G3	Equipment for Labour Room Strengthening under LaQshya	NHM	Target		21	23	20
			Amount	0	1478	230	200
G4	Infrastructure for Obstetric ICUs/ HDUs under LaQshya	NHM / State	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	1843	1665	1685
H Improving Skills of LR Staff through Dakshata/ LaQshya							
H1	TOT for Dakshata (State Level)	NHM	Target	2	2	2	2
			Amount	5	5	5	5
H2	Dakshata training (District Level)	NHM	Target	12	22	22	22
			Amount	9	13	13	13
H3	Procurement of Mannequins for Dakshata	NHM	Target	24	25		
			Amount	36	35		
H4	LaQshya trainings/workshops (Divisional Level)	NHM	Target	2	1		
			Amount	2	4		
H5	Orientation workshop of MOs/SNs (District level)	NHM	Target	22	7		
			Amount	8	7		
H6	Onsite mentoring at Delivery Points	NHM	Target	22	22	22	22
			Amount	32	16	95	95
Budget Subtotal				91	80	113	113
Yearly Budget Requirements (INR in Lakhs)				1627	4618	5222	5607
Total Budget Requirement (INR in Lakhs)				17075			
Total Budget Requirement from 2019 to 2022 (INR in Lakhs)					15447		

ABBREVIATIONS

AARR	Average Annual Rate of Reduction
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
ANC	Antenatal Care
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CH	Child Health
CHC	Community Health Centre
ENMR	Early Neonatal Mortality Rate
ETAT	Early Triage and Treatment centre
FBNC	Facility Based Newborn Care
FRU	First Referral Unit
FPC	Family Participatory Care
HBYC	Home Based Care of Young Child
HBNC	Home Based Newborn Care
HDU	High Dependency Unit
HMIS	Health Management Information System
HPD	High Priority District
HR	Human Resource
HRH	Human Resources for Health
IMR	Infant Mortality Rate
IUCD	Intrauterine Contraceptive Device
ICDF	Intensified diarrhoea control fortnight
IYCF	Infant and Young Child Feeding
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
KMC	Kangaroo Mother Care

LBW	Low Birth Weight
LaQshay	Labour Room Quality improvement Initiative
MNCH	Maternal Newborn Child Health
MO	Medical Officer
NICU	Neonatal Intensive Care Unit
NHP	National Health Policy
NHM	National Health Mission
NMR	Neonatal Mortality Rate
NFHS	National Family Health Survey
NSSK	NavjaatShishu Suraksha Karyakram
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PPIUCD	Postpartum Intra Uterine Contraceptive Device
RBSK	Rashtriya Bal Swasthya Karyakram
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
SBA	Skilled Birth Attendant
SBCC	Social Behaviour Change Communication
SN	Staff Nurse
SNCU	Special Newborn Care Units
SBR	Still Birth Rate
SDG	Sustainable Development Goals
TFR	Total Fertility Rate
U5MR	Under Five mortality rate
WASH	Water Sanitation and Hygiene
NICU	Neonatal Intensive Care Unit
NMR	Neonatal Mortality Rate

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Promoting Health in India