DRAFT

NRHM

BROAD FRAMEWORK FOR PREPARATION OF DISTRICT HEALTH ACTION PLANS

AUGUST 2006

National Rural Health Mission
Ministry of Health & Family Welfare
Government of India

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BACKGROUND:

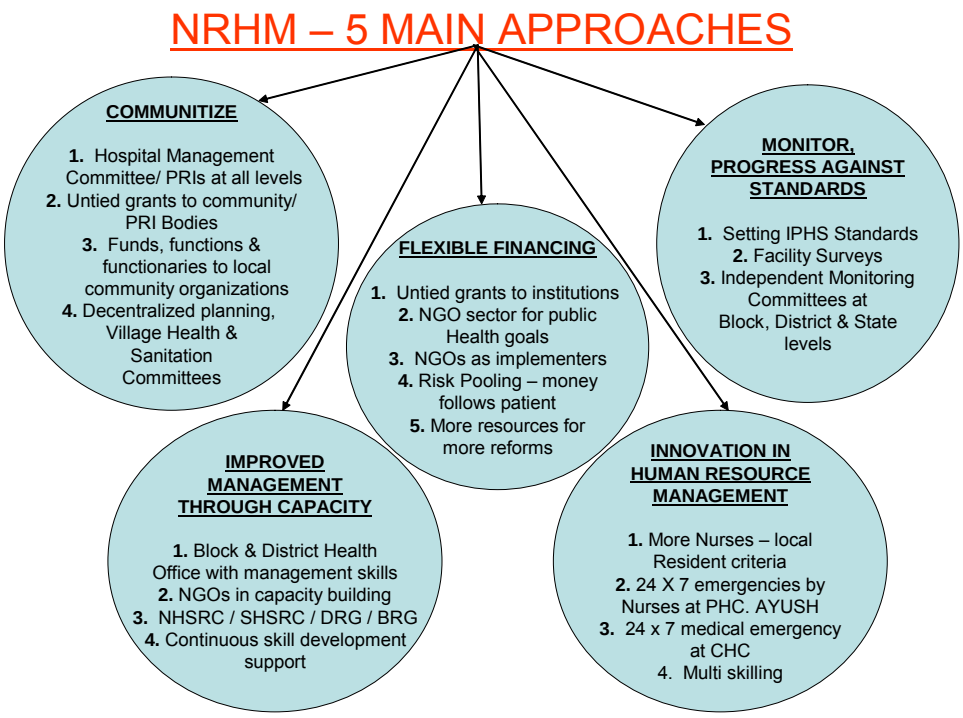
The Hon'ble Prime Minister launched the NRHM on 12th April, 2005 throughout the country with special focus on 18 States, including eight Empowered Action Group (EAG) States, the North-Eastern States, Jammu & Kashmir and Himachal Pradesh.

The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It also seeks to reduce the Maternal Mortality Rate (MMR) in the country from 407 to 100 per 1,00,000 live births, Infant Mortality Rate (IMR) from 60 to 30 per 1000 live births and the Total Fertility Rate (TFR) from 3.0 to 2.1 within the 7 year period of the Mission.

IMPLEMENTATION FRAMEWORK & PLAN OF ACTION FOR NRHM

The key features in order to achieve the goals of the Mission include making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring & evaluation against standards, convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indicators.

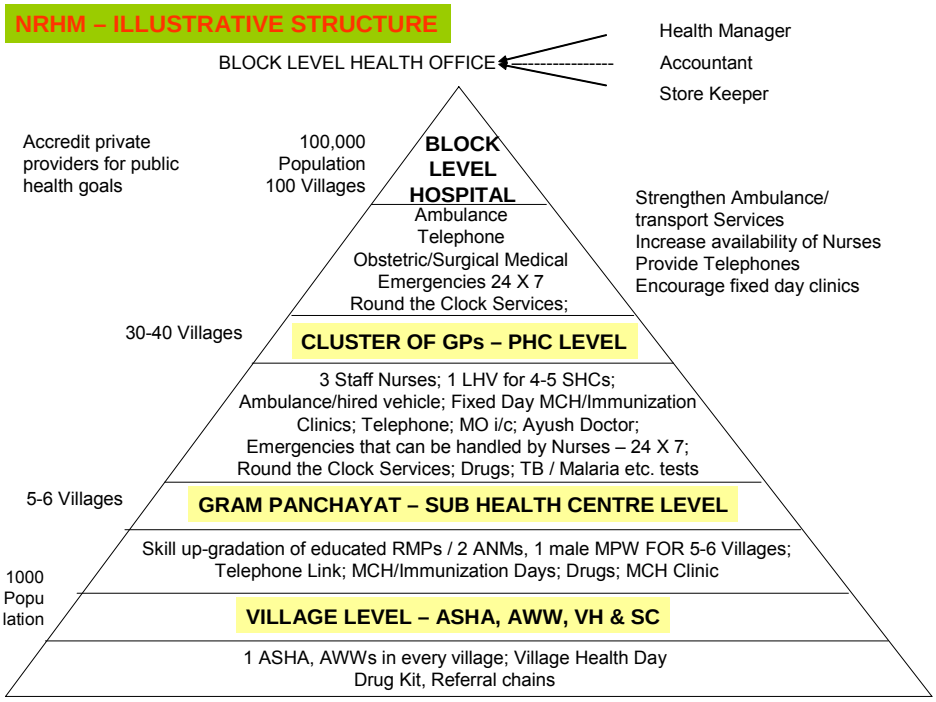
The Diagrammatic Representation of the 5 Main approaches of NRHM is illustrated below:



IMPROVING THE PUBLIC HEALTH DELIVERY SYSTEM

Given the status of public health infrastructure in the country, particularly in the EAG and the North Eastern States, it will not be possible to provide the desired services till the infrastructure is sufficiently upgraded. The Mission seeks to establish functional health facilities in the public domain through revitalization of the existing infrastructure and fresh construction or renovation wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in manpower planning as well as infrastructure strengthening. The Mission would provide priority to both these aspects.

A generic Public Health Delivery System envisioned under NRHM from the Village to the Block Level is illustrated below:



PUBLIC HEALTH INFRASTRUCTURE

The Central Govt. has so far supported only the construction/up gradation of sub-centres. Because of their difficult financial conditions, the States have usually not provided sufficient funds for construction / up-gradation of Primary Health Centre [PHC]/Community Health Centre [CHC]/District Hospitals etc. As a result, health infrastructure is in poor condition in most of the states. NRHM allows the expenditure for construction subject to the condition that it should not be more than 33% of the total NRHM outlay in the case of high focus States, and, 25% in the case of non-high focus States. NRHM also provides for up-gradation of District Hospitals.

In the first Cabinet approval, provision had been made for setting up of Indian Public Health Standards (IPHS) only for Community Health Centres (CHCs)/PHCs. The Mission now provides for IPHS at all levels i.e., sub-centres PHC/CHC and district hospitals.

As per the original Cabinet approval, untied grants were to be made available only to sub-centres. However, the Mission now proposes provisions for untied funds at PHC/CHC/district levels. A provision for funds for taking up innovative schemes at district/State/Central level has also been made.

Having Rogi Kalyan Samitis for managing health facilities has already been approved by the Cabinet. Now funds would be released as corpus grants to these Samitis as 100% grant by GOI during 2006-07, while it would be in the ratio 2 : 2 : 6 with regard to State / Internal / GOI from 11th Plan onwards.

The Mission also seeks to ensure the availability of requisite equipments and drugs at all the public health care facilities. Procurement of equipments/ drugs would be progressively decentralized and a road map prepared.

It is proposed to improve outreach activities in un-served and underserved areas specially inhabited by vulnerable sections through provision of Mobile Medical Units [MMU] in every district under this proposal. The MMUs would also cover Anganwadi centres.

IMPROVING AVAILABILITY OF CRITICAL MANPOWER

The issue of availability of critical manpower in the rural areas is proposed to be addressed through initiatives like introduction of a trained voluntary community Health Worker (**ASHA)** in every village of the 18 high focus states, additional ANM at each sub-centre, three staff nurses at the Primary Health Centres (PHC) to make them operational round the clock and additional specialists and paramedical staff at the Community Health Centres (CHC). The condition of local residency is proposed to ensure that the staffs stay at their place of posting. In the North-east, keeping in view the difficulty in availing services of doctors and specialists, the emphasis is on recruitment, training and skill upgradation of locally recruited ANMs/nurses/midwives/ para medics. It is also proposed to supplement the availability of critical manpower across the States through contractual appointment/local level engagement of medical and paramedical manpower upgrading and multi-skilling of the existing medical personnel. Innovations in Public private participation for service provision, franchising of service providers, licensing and training of Rural Medical Practitioners (RMP), rationalization of existing manpower are few of the innovations/options being explored. Stringent monitoring at all levels, involvement of the PRIs and monitoring by the Rogi Kalyan Samitis should ensure presence of doctors & para medicals in the rural areas. Besides compulsory posting of doctors in the rural areas, better cadre management & personnel policies would also help to improve manpower availability.

CAPACITY BUILDING

In order to provide managerial support, for tracking funds and monitoring activities under the Mission, provision has been made for setting up Programme Management Units at the State/District level. Over 500 professionals have already been recruited. The successful implementation of the Mission would require health sector reforms and development of human resources. Capacity building at all levels is a huge challenge under NRHM. In order to provide technical support to the Mission for achieving this objective, it is proposed to set up National Health System Resource Centre [NHSRC] at the Central and State levels (SHSRC) with an annual corpus support of Rs. 15 crore and Rs. one Crore at the Central and State levels respectively. The NRHM also emphasizes the setting up of fully functional Block and District level Health Management systems, as under NRHM 70% of the resources would be utilized at Block and below Block levels and 20% at the district level. Given the large army of ASHAs, ANMs, Nurses and Rural Medical Practitioners continuous skill development is

needed. Strengthening nursing institutions, linking medical colleges for providing skill development support to rural health workers, involving the voluntary sector in skill development are few key interventions to be taken up.

To make the health facilities more accountable, their control would be gradually shifted to the PRIs and civil society. The Sub-centres are proposed to be placed exclusively under the control of the Panchayat. The PHCs and CHCs are also to be managed by the Panchayat Block Samitis (PBS) and Rogi Kalyan Samitis (RKS).

COMMUNITY HEALTH WORKERS

As per the approval of the Cabinet dated 4.1.2005, one female Accredited Social Health Activist (ASHA) is to be provided for every village with a population of 1000 (with provision for relaxation in the eight EAG States, Jammu and Kashmir and Assam) in each of the high focus states. She would be the link between the community and the health facility and would be the first port of call for any health related demand. Now under the Mission, it is proposed to have an ASHA in all the 18 high focus States. Besides, based on the recommendations of the Committee of Secretaries (COS) in its meeting held on 20.10.2005, it is also proposed to support ASHAs in tribal districts of all the remaining States. In case the other States would like to extend the scheme in remaining districts as well, it would be possible for them to do so under the RCH II. ASHA along with Anganwadi workers (AWW) & the Auxiliary Nurse Midwife (ANM), Self Help Groups & community based organizations, preraks of continuing education centres through their coordinated action at the village level & through combined organization of monthly Village Health, Nutrition & Sanitation day at the Anganwadi centres would be expected to bring about perceptible changes in the health status of the community.

CONVERGENT ACTION ON OTHER DETERMINANTS OF HEALTH

The PRIs and a large range of community based organizations like Self Help Groups, School, water, health Nutrition & Sanitation Committees, Mahila Samakhya Groups, Zila Saksharta Samitis provide an opportunity for seeking local levels accountability in the delivery of social sector programmes. Schools and Anganwadis would form the base of these activities. NRHM provides for School Health Check-ups and School Health Education to be worked out in consultation with the States. Convergence of programmes would be at the village and facility levels.

DECENTRALIZATION

As the indicators of health depend as much on drinking water, nutrition, sanitation, female literacy, women's empowerment as they do on functional health facilities, NRHM seeks to adopt a convergent approach for interventions under the umbrella of the district plan which seeks to integrate all the related initiatives at the village, block and district levels. The **District Health Action Plan would be the main instrument for planning, Inter-sectoral convergence, implementation and monitoring of the activities under the Mission.** Rather than funds being allocated to the states for implementing programmes designed and approved at the GOI level, the States would be encouraged to prepare their perspective and annual plan which in turn would be based on the District Plans. Even though village is envisaged as the primary unit for planning, looking at the extensive capacity building required before it would be in a position to take up the exercise, the Mission would not insist on the village plans at least during the first two years. The District Health Mission under the Zilla Parishad would get the district plan prepared covering health as well as the other determinants of health. Household and Facility Surveys would define the baseline. Periodic surveys would thereafter be taken up on an annual basis to track the improvements in the facilities as well as in the reduction in health indicators. The District Plans would be collated into a State Plan which would be appraised and approved by the Mission at the national level. As far as the other determinants of health are

concerned, the funds for them would continue to flow through the existing channels but the District Plan would clearly bring out the convergent action being taken at the district level. NRHM recognizes that delegation of financial and administrative powers at various levels would be necessary for the successful implementation of the decentralized plans. A Framework for delegation of powers is given in Annex- VII

MAINSTREAMING OF AYUSH

Provision has been made for State specific proposals for mainstreaming AYUSH, including appointment of AYUSH doctors/paramedics on contractual basis, providing AYUSH Wings in PHCs and CHCs. As envisaged under NRHM vision and goals, efforts will be made to integrate AYUSH in primary health delivery.

FLEXIBLE FINANCING

The programmes under the erstwhile Departments of Health and Family Welfare and Department of AYUSH were not being run in an integrated manner. As a result the transfer of funds to the states under different budget heads at different points of time vertically hampered flexibility. It also led to duplication of efforts, and, thereby, wastage of scarce resources. For improved delivery, the Mission attempts to bring the schemes of the Ministry of Health & Family Welfare within the overarching umbrella of NRHM as approved earlier by the Cabinet. Therefore, under the Implementation Framework, from the Eleventh Plan onwards, it is proposed to have a single budget head for the activities under the Mission. This would provide the States much needed flexibility to direct the funds to those areas where they are needed the most. However, a minimum amount would be earmarked for various disease control programmes to ensure that the national objectives and commitments are met. The funds under the NRHM budget head would flow through the integrated health society at the State and the District levels. The norms under which the funds would be allocated by the Centre to the States and by the States to districts on the basis of Integrated State/District Health Activity Plans have been clearly spelt out in the Implementation Framework.

NORMATIVE FRAMEWORK

The District Health Action Plans would be prepared based on a normative framework. The cost norms have been derived from three sources. First, existing norms of the schemes brought under the umbrella of the NRHM. Secondly, norms developed by the NCMH. Thirdly, norms developed and approved as new interventions under NRHM.

MONITORING AND ACCOUNTABILITY FRAMEWORK

The NRHM Framework is based on a rights based approach. The Framework proposes accountability at every level through a three pronged process of community based monitoring, external surveys (SRS, DLHS household surveys by ASHA, facility surveys in the district level) and stringent internal monitoring. The process of community involvement of the health institutions itself would enhance accountability and the NRHM would facilitate this process by wide dissemination of the results. For effective monitoring a strong MIS is being put in place. The Citizen Charter would help the public to know their rights and entitlements at each facility. The setting up of IPHS at each level of health delivery system would be instrumental in provision of minimum service guarantees at those levels. Monitoring also would be in terms of service guarantees provided by each facility, utilization of such services by the community {especially weaker sections} changes in their health seeking behavior, etc. The Facilities Survey is expected to create a baseline for each health facility and assist in monitoring annual progress against the baseline in terms of services guaranteed. The

MOUs signed with the States would enable monitoring of progress under NRHM in terms of the agreed milestones. Independent evaluation would ensure midcourse corrections.

PRO-PEOPLE PARTNERSHIPS WITH THE VOLUNTARY SECTOR

Investments by voluntary Organizations are critical for the success of NRHM. The Mission provides for partnerships with the voluntary groups/ organisations for advocacy, building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services and working together with community organizations. It is proposed to provide people friendly regulatory framework that promotes ethical practice through accreditation, standard treatment protocols and training and upgradation of skills of non-government health providers. 5% of the total NRHM outlay is proposed to be the resource allocation to voluntary organizations on the basis of approved guidelines & norms.

REDUCING IMR/MMR/TFR AND THE DISEASE BURDEN

Reproductive and Child Health Programme (RCH-II) was launched in 2005 as a part of the Mission as the principal vehicle for reducing IMR, MMR and TFR as envisaged in the original Cabinet Note. Upgradation of Community Health Centres as First Referral Units (FRUs) for dealing with Emergency Obstetric Care, 24x7 delivery services at the PHCs, operationalising of Sub-Centres multi-skilling of doctors, contractual appointments of MOs and AMOs, training medical officers in Anesthetic skills, training doctors/ANMs/Nurses as Skilled Birth Attendants (SBA) permitting ANMs to administer certain drugs in emergency, partnerships with voluntary organizations, RCH camps accreditation of non profit organizations, IEC activities are the major interventions in reducing MMR. For reducing neo natal mortality programme for Integrated Management of Childhood illnesses (IMNCI) is being extended at the community and facility levels. Activities of ASHAs, Anganwadi workers and ANMs, preraks of continuing Education Centres and SHG groups at the village level with focus on both preventive and promotional aspects of health care accelerated immunization programme, advocacy on age of marriage/ against sex selection, spacing of births, institutional delivery, breast feeding, meeting unmet demands for contraception, besides providing a range of RCH services are to have impact on reducing the health indicators. Efforts are being made to integrate HIV AIDS programme with the RCH at the district and sub-district levels. Convergence of disease control programmes, integration of services, combined awareness generation, education and the advocacy at community and facility levels, taking care of preventive, promotive and curative health care are expected to bring down IMR/MMR/TFR and the disease burden as stated in the proposal.

RISK POOLING AND THE POOR

The Mission recognizes that in order to reduce the out of pocket expenditure of the rural poor, there is an imperative need for setting up effective risk pooling systems as already envisaged. State specific, community oriented innovative and flexible insurance policies need to be developed and disseminated. While the first priority of the Mission is to put the enabling public health infrastructure in place, various innovative models would be pilot tested to assess their utility.

FINANCING OF NRHM

The National Commission on Macroeconomics and Health (NCMH) has worked out an additional requirement of non recurring expenditure of Rs. 33811/- crores per annum and additional recurring expenses of Rs. 41006 crores at current prices for delivering functional health care in the public domain. This outlay, which would be shared by the Centre and the States, would push the expenditure on Public Health care to nearly 3% of GDP. As some of the elements included in this

computation of fund requirement relate to activities which are not strictly covered under the NRHM (like setting up of medical colleges etc) and if allocations to be made on such activities are excluded, then the additional capital and recurring requirements come to Rs. 30,000 crores and Rs. 36,000 crores per annum respectively over and above the current allocations. It may, however, be mentioned that with growth in GDP, in order to maintain the same percentage level of health expenditure vis-à-vis GDP, the expenditure would have to go up in the same proportion.

Given the absorptive capacities of the States and the time it may take up to build their capacities, it is projected in the implementation framework that there would be a 30 % annual increase in the central allocation for health till 2007-08, which, thereafter is envisaged to grow at the rate of 40 %. If the projected funds become available, the public health expenditure is likely to reach 2% of the GDP from the current level of 0.9%.

In order to step up the expenditure on public health over the next 5 years, the states also have to very significantly increase the allocation for the health sector in their budgets, since they contribute almost 4/5th of the current total expenditure. The EFC has agreed that under the NRHM, 100 % grant be provided to the states during the 10th Plan which could be phased downwards to 85% in the 11th and 75% in the 12th Plan.

TIME LINES

Clear time lines have been worked out for NRHM activities as also for system of outcome monitoring that may be seen at Annex-VI.

ABOUT THE DISTRICT HEALTH MANUAL

This Manual is intended to be a user-friendly tool to assist range of stakeholders, to be engaged in the district health planning, in developing the DHAP. The intended target group for this document includes:

- Members of State and District Health Missions
- District & Block level programme managers of line departments i.e., Health and Family Welfare, AYUSH, Women and Child Development including ICDSs and water/sanitation.
- State Programme Management Unit and District Programme Management Unit Staff
- Members of PRIs and MNGOs/ FNGOs and civil society groups (in case these groups are involved in the DHAP formulation)

Besides above referred groups, this document will also be found useful by public health managers, academicians, faculty from training institutes and people engaged in programme implementation and monitoring and evaluation.

This Manual needs to be used in conjunction with many other documents. It is highly recommended that the planning team entrusted with the task of developing the plan have access to all the documents listed in the annexure as ahead of the commencement of planning process and familiarize themselves with the contents of these documents.

STRUCTURE OF THE DISTRICT HEALTH MANUAL

Information in this Manual is organized in 10 chapters along with an executive summary. Chapter 1 &2 provide the overarching NRHM context in which DHAPs are embedded and the Broad Contours of the District Planning Process.

Chapter 3 guides a reader on the financial resources, funding sources and guidelines for allocation of resources available for the programming purposes, on an annual basis. This section will guide the planning teams on the probable allocations they could make for the State level interventions and the funds that are to be programmed at the District level.

Chapter 4 provides insights for organizing activities during a preparatory phase ahead of actual plan formulation. A comprehensive situational analysis with the help of primary and secondary data sources is critical to sound planning. The planning team at district and block-level should access different data sources for district and analyse them with the help using the suggested templates.

Chapter 5 refers to the processes and activities that need to be undertaken at block level and district level. Block consultations are the first step towards engaging community in developing plans in a meaningful and participatory manner. Much will depend on how block level consultations are facilitated and skill the facilitators possess. Also these consultations will act as trendsetters for the ultimate village health planning as reflected in the NRHM implementation framework.

Chapter 6&7 explains in detail about how to set the plan objectives in light of situation analysis, problems diagnosis and needs assessment. As NRHM focuses on achieving outcomes, a results focus has to be reiterated. District planning team is guided through use of templates as how to set objectives or conducting a force field analysis for arriving at the outputs/programme results to be achieved. A programme LFA will also help in developing a results chain. Activities to achieve higher-level results should be considered after taking into cognizance solutions offered in the block level consultations.

Chapter 8 & 9 deals with development of work plans, budgets, Monitoring & Evaluation plan including Programme Management.

Chapter 10 gives a Structure of the District Health Plan

Chapter

1

National Rural Health Mission (NRHM)

The National Rural Health Mission (NRHM) aims to provide for an accessible, affordable, acceptable and accountable health care through a functional public health system.

It is designed to galvanize the various components of primary health system, like preventive, promotive and curative care, human resource management, diagnostic services, logistics management, disease management and surveillance, and data management systems etc. for improved service delivery.

This is envisioned to be achieved by putting in place an enabling institutional mechanism at various levels, community participation, decentralized planning, building capacities and linking health with its wider determinants. It also aims to expedite achievements of policy goals by facilitating enhanced access and utilization of quality health services, with an emphasis on addressing equity and gender dimension.

Vision

- To provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- To increase public spending on health from 0.9% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling.
- To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.
- To revitalize local health traditions and mainstream AYUSH into the public health system.
- Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.
- Addresses inter State and inter district disparities.
- Time bound goals and report publicly on progress.
- To improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.

Objectives of NRHM

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrate comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.

Approaches of NRHM

- Communitize: this will entail transfer of funds, functions and functionaries to PRIs and also greater engagement of RKS, Hospital development committees or user groups etc
- Improved management through capacity: Right from the national level, NRHM visualizes a sustained process of capacity development of management of the programme through, NHSRC, SHRCs. Besides these institutional arrangements district and block level health management systems are being suggested, so that programme is more responsive to local management needs and challenges
- Flexible financing: Programme aims for making available untied funds at different levels of health care delivery system so that service guarantees as spelled out in the IPHS can be made available
- Monitor progress against standards: Facility surveys will setup the benchmarks for the purpose of monitoring achievements of standards. Also additionally preparation of the annual reports by independent agencies will help in publishing these reports.
- Innovation in human resource management One of the major challenge in making health services effectively available to the rural poor involves innovations in human resources management. NRHM proposes, ensuring availability of locally resident health workers, contractual positions, multi-skilling, integration with AYUSH etc so as to optimally use human resources

Core Strategies of the Mission

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through better human resource development, clear quality standards, better community support and an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing (PHCs) through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.

- Provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard. (IPHS defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels)
- Preparation and implementation of an inter sector District Health Plan prepared by the District Health Mission, including drinking water, sanitation, hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, District and Block levels.
- Technical support to National, State and District Health Mission, for public health management
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of human resource for health.
- Developing capacities for preventive health care at all levels for promoting healthy life style, reduction in consumption of tobacco and alcohol, etc.
- Promoting non-profit sector particularly in underserved areas.

Role of the District Health Mission

- Responsible for planning, implementing, monitoring and evaluating progress of Mission.
- Preparation of Annual and Perspective Plans for the district.
- Suggesting district specific interventions.
- Carrying out survey of non-governmental providers to see what contribution they can make.
- Partnerships with NGOs, Panchayats for effective action.
- Strengthening training institutions for ANMs/Nurses, etc.
- Provide leadership to village, Gram Panchayat, Cluster & Block level teams.
- Establish Resource Group for Professionals also can facilitate implementation of core strategies of the Mission.
- Experiment with risk pooling for hospitalization.
- Ensure referral chain and timely disbursement of all claims.
- Arrange for technical support to the blocks teams and for itself.
- Arrange for epidemiological studies and operational research to guide district level planning.
- Nurture community processes.
- Transparent systems of procurement and accountability.
- Activate women's groups, adolescent girls' fora to ensure gender sensitive approach
- Provide _data analysis and compilation facility in order to meet regular MIS needs.
- Carry out Health Facility Surveys and supervision of household surveys.
- District Health Mission to ensure that district annual action plan as per RNTCP requirement would continue to be submitted by the district to the state TB cell.

Chapter

2

DISTRICT HEALTH ACTION PLAN

Broad Contours

In order to make NRHM fully accountable the District Health Plan will be the principle instrument for planning, implementation and monitoring. , formulated through a participatory and bottom up planning process. District Health Mission has been constituted in the districts as per guidelines.

As a next step each district has to formulate/design District Health Action Plan (DHAP). To facilitate this process, a DHAP manual is being put together. The DHAP will contain situational analysis of the district, objectives and interventions, work plan and budgets and an M&E plan.

The DHAP document will be appraised and approved at State level and will be guiding document for implementation, monitoring & evaluation of NRHM activities in the district. It is envisaged that decentralized programme management is likely to be more responsive to the health care needs of local community and will be a step towards ultimate communitisation - a hallmark of NRHM.

The District Health Mission has been entrusted with the responsibility of steering formulation and ensuring implementation of the plans. In preparations for development for the DHAPs, the Health Mission may constitute a Planning Team in which they may like to co-opt other members such as MNGOs to be part of the planning team.

What a District Plan ought to have

i) Background
ii) Planning Process
iii) Priorities as per the background and planning process
iv) Annual Plan for each of the Health Institutions
v) Community Action Plan
vi) Financing of Health Care
vii) Management Structure to deliver the programme
viii) Partnerships for convergent action
ix) Capacity Building Plan
x) Human Resource Plan
xi) Procurement and Logistics Plan
xii) Non-governmental Partnerships
xiii) Community Monitoring Framework
xiv) Action Plan for Demand generation
xv) Sector specific plan for maternal health, child health, adolescent health, disease control, disease surveillance, family welfare etc.

The intention is to develop a fully accountable public health system through intensive monitoring and performance standard.

District Health Plan reflects the convergence with wider determinants of health like drinking water, sanitation, women empowerment, child development, adolescent school education, female literacy etc.

The Planning Process under NRHM

The District Health Plan should as far as practicable be an aggregation and consolidation of the **Village and the Block Health Plan.**

This requires setting up of planning teams and committees at various levels – Habitation/Village, Gram Panchayat (SHC), PHC (Cluster level), CHC/Block level and District level. At Village, PHC and Block levels, broadly representative committees would perform both planning and ongoing monitoring functions. A similar committee at District level would be involved in reviewing plans, based on drafting by the specialized district planning team.

Besides large scale consultations, planning teams have to conduct household surveys, help select ASHAs, and organize training for community groups and health functionaries. NGOs have a role in the entire planning process.

Orientation of planning team and contractual engagement of professionals as per need has to be the starting point for the planning process.

Village Health Plans are likely to take time and therefore District, Block and Cluster level consultation may have to form the basis for initial District Plans. The initial plans could be ad-hoc and for a year. The perspective plans must be on the basis of Village Health Plan. Even then, Block will be the key level for development of decentralized plans.

Levels of planning and the key functionaries

Village level Health and Sanitation Committee would be responsible for the Village Health Plans. ASHA, the Aanganwadi the Panchayat representative, the SHG leader, the PTA/MTA Secretary and local CBO representative would be key persons responsible for the household survey, the Village Health Register and the Village Health Plan**.**

The **Gram Panchayat Level Health Plans,** comprising a group of villages in many states and a single village in a few, will be worked on at the Sub Health Centre Level. The Gram Panchayat Pradhan, the ANM, the MPW, a few Village Health & Sanitation Committee representatives will be responsible for the Gram Panchayat Health Plan. They will also be responsible for over view and support for the household survey, preparation of Village Health Registers and preparation of Village Health Plans- the Gram Panchayat /SHC level would also organize activities like health camps to facilitate **the planning** process.

The **Cluster level will be led by the PHC/Additional PHC**. Ordinarily there will be 1-4 Clusters in a Block. The PHC Health monitoring and planning committee will facilitate planning inputs of Panchayat representatives, along with other inputs from the community to formulate a broad plan. In this context the Medical Officer in charge of PHC will work in close coordination with the Pradhan/s of the Gram Panchayat/s covered in that Cluster. The Cluster level would be responsible for over viewing the work of Gram Panchyat/s and for organizing surveys and activities through the SHCs**.**

The **Block/CHC level monitoring and planning committee** will review the Block Health Plan. The Adhyakisha of the Block Panchayat Samiti, the Block Medical Officer, the Block Development Officer, NGO/CBO representative, head of the CHC level Rogi Kalyan Samiti will be key members of this team. Additional social mobilization professionals and planning resource persons will also be contracted at the Block level to develop a good Resource team at that level. The Block level Health Mission Team will finalize the Block Health Plans. The Block Health Teams would also supervise household and health facility surveys. They would also organize public hearings and health camps in order to make the planning process activity intensive.

The **District Level Health Mission** will have a Health monitoring and planning committee responsible of providing overall guidance and support to the planning process. A **draft plan will be formulated by the District Health Team,** and presented for discussion to the broader committee. After relevant discussion and modifications in the committee, the district plan will be finally streamlined by the District health team, which, besides a few existing government functionaries, the District Health Teams will also have NGO representatives and a few professionals specially recruited to meet planning and implementation needs. The District Planning team will be responsible for household Surveys and Health facility surveys. They would also facilitate organization of health camps and public hearings in order to make the planning process activity intensive. The Zila Parishad Adhyaksha, the District Medical Officer, the District Magistrate would be key functionaries of the District Team. Every district health society would be assisted by a technical support agency, which they can choose from a number of options.

Strategy for Technical Assistance for District Planning

The State should harness all technical resources in the State for preparation of District Health Plans including development partners, department of community medicine in medical colleges, NGOs with expertise in this area etc.

The State may also constitute a 10-15 member District Plan Appraisal Team under the SHRC for appraisal of the Draft District Plan for checking Quality, Standards, normative criterions etc before it receives the formal approval of the District Health Mission and is sent to the State for approval.

The **State Resource Center** would also finalize survey formats and formats for preparation of plans at various **levels.** It would also finalize with guidance and directives from the ministry, the criteria for prioritization and indication of resources likely to be available for each Block and convey these to the district these details as also help develop the financial norms in conformity with these guidelines and on the basis of inputs from Blocks and Districts.

The Basis -Annual Work Plans and Perspective Plans

The NRHM has a seven year time frame (20065-2012). The Perspective Plan would be a 7 year plan outlining the year wise resource and activity needs of the district. The Annual Plan will be based on resource availability and a prioritization exercise.

As far as possible, States should let districts know by October of the resources likely to be available in the coming financial year.

The District should disaggregate likely budget availability on the basis of needs at village/cluster/block levels by November. The Village, Gram Panchayat, Cluster & Block Plans should come to district based on a prioritization exercise.

The District Health Mission Society will recommend the Annual Work Plan and Budgets and the Perspective Plan to the State level Health Mission under the Chief Minister.

Essential requirements for preparation for Village, Block, and District Health Plans

- Constitution of planning team and committees with clearly demarcated responsibility at each level.
- Engagement of professionals on contract at State, District and Block level urgently to meet planning needs.
- Broad norms for planning activities. Some idea on what is to be taken up and the space for diversity and innovations.
- Preparation of training modules for planning teams, and finalization of survey format for household survey, Family Health Cards, Village Health Register, mapping of non-governmental providers, and Health facility surveys.
- Survey of non-governmental health providers to assess their possible role in the District Health Plan.
- Organization of large scale activities like health camps, Public hearings to make the planning process activity intensive.
- Involvement of Women's groups and Community based organizations in planning activity.
- Release of untied grants to SHCs/ Gram Panchayats to facilitate activities.
- Recruitment and relevant training of ASHAs/ANMs.
- Orientation of existing health department functionaries on new ways of working.
- Convergent local action along with other departments.

Framework for District Action Plan

The following framework for assessing the present situation is proposed:

Resources – Including Health humanpower, logistics and supplies; Community resources and financial resources, Voluntary sector health resources

Access to services – including public and private services and informal health care services; also look at levels of integration of services within Public health system

Utilisation of services – including outcomes, continuity of care; factors responsible for possible low utilization of public health system

Quality of Care – including technical competence, interpersonal communication, client satisfaction, client participation in management, accountability and redressal mechanisms

Community needs, perceptions and economic capacities, PRI involvement in health, existing community organizations and modes of involvement in health

Socio-epidemiological situation: Local morbidity profile, major communicable diseases and transmission patterns, health needs of special social groups (e.g. adivasis, migrants, very remote hamlets)

Critical areas for concerted action

The following problem matrix table may be useful in prioritizing the critical areas of concerted action. These have been dealt in detail in the following chapters.

Sl. No	Priorities	Constraints	Action to overcome constraints
1	Functional facilities - Establishing fully functional Sub Health Centres / PHCs/ CHCs/Sub Divisional/District Hospitals.	• Dilapidated or absent physical infrastructure • Non-availability of doctors/paramedics • Drugs/ vaccines shortages • Dysfunctional equipments • Untimely procurements • Chocked fund flows • Lack of accountability framework • Inflexible financial resources. • No minimum mandatory service provision standards for every facility in place which makes full use of available human and physical resources and no road map to how desirable levels can be achieved	• Infrastructure/equipments • Management support • Streamlined fund flows • Contractual appointment and support for capacity development • Pooling of staff/optimal utilization • Improved MIS • Streamlined procurement • Local level flexibility • Community /PRI/RKS for accountability / M&E • Adopt standard treatment guidelines for each facility and different levels of staffing, and develop road maps to reach desirable levels in a five to seven year period.
2	Increasing and improving human resources in rural areas	• Non-availability of doctors • Non-availability of paramedics • Shortage of ANMs/MPWs. • Large jurisdiction and poor monitoring. • No accountability	• Local preference • Contractual appointment to a facility for filling short term gaps. • Management of facilities including personnel by PRI Committees.

		• Lack of any plan for career advancement or for systematic skill upgradation. • No system of appraisal with incentives/disincentives for good/poor performance and governance related problems.	• Train and develop local residents of remote areas with appropriate cadre structure and incentives. • Multi-skilling of doctors / paramedics and continuous skill upgradation • Convergence with AYUSH • Involvement of RMPs. • Partnership with non-State Stakeholders.
3	Accountable health delivery	• Panchayati Raj Institutions / user groups have little say in health system • No village / hamlet level unit of delivery • No resources for flexible community action	• Referral chain from hamlet to hospital • Control and management of Health facilities by PRIs • Budget to be managed by the PRI/User Group • PRI/User Group mandate for action • Untied funds and Household surveys
4	Empowerment for effective decentralization and Flexibility for local action	• Only tied funds • Local initiatives have no role • Centralized management and schematic inflexibility • Lack of mandated functions of PRIs / User Groups • Lack of financial and human resources for local action • Lack of indicators and local health status assessments that can contribute to local planning. • Poor capability to design and plan programmes.	• Untied funds at all levels including local levels with flexibility for innovation. • Increasing Autonomy to SHC/PHC/CHC/Taluk/ District Hospital along with well monitored quality controls and matched fund flows. • Hospital Management Committees • Evolving diverse appropriate PRI / User framework • PRI/User group action at Village / GP / Block and District level
5	Reducing maternal and child deaths and population stabilization	• Lack of 24X7 facilities for safe deliveries. • Lack of facilities with for emergency obstetric care. • Unsatisfactory access and utilization of skilled assistance at birth • Lack of equity/sensitivity in family welfare services/ counseling. • Non-availability of Specialists for anesthesia, obstetric care, pediatric care, etc.	• Functional public health system including CHCs as FRUs, PHC-24X7, SHCs, Taluk/District Hospital • Trained ANM locally recruited • Institutional delivery • Quality services at facility • Expanding facilities capable of providing contraception including quality sterilization services on a regular basis so as to meet existing demand and unmet needs.

		• No system of new born care with adequate referral support. • Lack of referral transport systems. • Need for universalization of ICDS services and universal access to good quality ante-natal care. • Need for linkage with parallel improvement efforts in social and gender equity dimensions. • Lack of linkages with other dimensions of women's health and women friendliness of public health facilities.	• Thrust on Skilled Birth Attendants/local appointment and training • Training of ASHA • New born care for reducing neo natal mortality; • Active Village Health and Sanitation Committee; • Training of Panchayat members. • Expanding the ANM work force especially in remote areas and in larger village and semi-urban areas. • Planned synergy of ANM, AWW, ASHA work force and where available with local SHGs and women's committees. • Linkage of all above to the Panchayat committee on health.
6	Action for preventive and promotive health	• Poor emphasis on locally and culturally appropriate health communication efforts. • No community action & household surveys • No action on promoting healthy lifestyles whether it be fighting alcoholism or promoting tobacco control or promoting positive actions like sports/yoga etc. • Weak school health programmes • Absence of Health counseling/early detection. • Compartmentalized IEC of every scheme	• Untied funds for local action • Convergence with other departments/institutions • IEC Training and capability building • Working together with ICDS/TSC/CRSP/SSA/ MDM • Improved School Health Programmes • Common approach to IEC for health • Involvement of PRIs in health. • Oral hygiene movement. • National Oral Health Care Programme • Oral health awareness can be taken to the rural level. • School Eye Screening Programme.
7	Disease Surveillance	• Vertical programmes for communicable diseases • No integrated / coordinated action for disease surveillance at various levels in place yet. • No periodic data collection and analysis and no district and block specific epidemiological data available	• Horizontal integration of programmes through VH&SC, SHC, PHC, CHC. • Initiation and Integration of IDSP at all levels. • Building district / Sub-district level epidemiological capabilities.

8	Forging hamlet to hospital linkage for curative services	• Entitlements of households not defined • No community worker • No well defined functional referral/transport/communicatio n system. • No institutionalized feedback mechanism to referring ASHA/peripheral health facility in place	• ASHA/AWW/ANM • Household /facility surveys/survey of non – governmental providers for entitlements. • Linkages with SHC / PHC / CHC for referral services
9.	Health Information System.	• Absence of a Health Information System facilitating smooth flow of information. • Not possible to make informed choices	• A fully functional two way communication system leading to effective decision making. • Publication of State and District Public Reports on Health.
10.	Planning and monitoring with community ownership	No local planning, no household surveys, no Village Health Registers. Lack of involvement of local community, PRI, RKS, NGOs in monitoring of public health institutions like SHC/PHC/CHC/Taluk/District Hospitals.	Habitation/village based household surveys and Facility Surveys as the basis for local action. Untied resources for planning and monitoring. Management of health facilities by the PRIs. Thrust on community monitoring, NGO involvement, PRI action, etc. Ensure Equity & Health. Promote education of women SC/ST & other vulnerable groups.
11	Work towards women's empowerment and securing entitlements of SCs /STs /OBCs /Minorities	Standard package of interventions under current schemes. Coverage and quality of services to women, SCs/STs/OBCs/ Minorities not tracked health institution wise. No analysis of access to services and its quality.	Facility and household services to generate useful data for disaggregated monitoring of services to special categories. NGO and research institution involvement in Facility surveys to ensure focus on quality services for the poor. Visits by ASHAs. Outreach services by Mobile Clinics.
12.	Convergence of programme for combating/preventing HIV/AIDS, chronic diseases, malnutrition, providing safe drinking water etc. with community support.	• Vertical implementation of programme. • Only curative care. • Inadequate service delivery. • Non-involvement of community.	• Convergence of programmes. • Preventive care. • Health & Education • Empowering Communities. • Providing functional health facility [SHC], PHC [CHC] for effective intervention.

13.	Chronic disease burden.	• Double disease burden. • Lack of stress on preventive health. • Lack of integration of programmes with main health programmes. • No IEC/advocacy. • Inadequate Policy interventions.	• Village to National level integration. • Stress on preventive Health • IEC/Advocacy • Help of NGOs • Policy measures.
14	Social security to poor to cover for ill health linked impoverishment and bankruptcy.	Large out of pocket expenditures even while attending free public health facilities- food transport, escort livelihood loss etc. Economically catastrophic illness events like accidents, surgeries need coverage for everyone especially the poor,	• Innovations for risk pooling mechanisms that either cross subsidize the poor or are forms of more efficient demand side financing so that the economic burden of disease on the poor decreases. • Guaranteeing hospitalization at functional facilities

Broad Outline of the Planning Process

District health planning is viewed as an iterative and two-way process, where District planning teams provide overall planning framework and financial parameters, along with arranging training inputs for the Block and Village planning teams. The Village teams would need to develop draft plans to be collated and approved at the Block level. Similarly Block plans would be collated and approved at the District level.

It is desirable as the ongoing model of planning, for such a process to build upwards as Village health plans → Block health plans → District health plan. However, this would not be possible in a full fledged manner in the first year, since formation and orientation of planning capable bodies at Village and Block levels will take time.

Hence, during the first year, the District planning team will have to arrange five types of activities:

- Preparation of broad framework of planning based on assessment of current situation, resources, NRHM priorities; drafting outline of block health plans; disseminating these to Block health authorities, PRIs and block level NGOs

- Consultative process involving discussion of draft block plans with Block health authorities, PRI representatives and block level NGOs

- Consultative process, involving discussion of key block planning issues with a few groups of selected village stakeholders such as Panchayat heads, ANMs and CBO representatives in each block, to get community level feedback about major local priorities and issues

- Consolidation of block and district health plans based on a, b and c;

- Technical appraisal of the Draft District Plan by District Plan Appraisal Team of the State Government for checking quality, standards, norms etc and taking corrective actions by the District Planning Committee

- Presentation of the proposed District health plan to the District health society and Zilla Parishad for final approval

- Facilitating formation and capacity building of Village and Block planning teams throughout the district

Components of the District Health Plan

It is envisaged that this plan would be a holistic plan but to facilitate fund release and for monitoring, the Plan may be divided into the following components:

a. New interventions under NRHM
b. RCH II
c. Strengthening of Immunisation
d. Disease Control / Surveillance Programmes such as NVBDCP , RNTCP, NPCB, IDD ,NLEP and IDSP
e. Intersectoral convergence activities including Nutrition, Safe Drinking Water etc

A. New interventions under NRHM:

The following is an illustrative list of activities which can be taken up under NRHM at various levels.

NRHM ACTIVITIES AND NORMS

Activity	Possible processes and illustrative norms
1. Visioning workshops for National, State, District and Block level Mission Teams	Need for setting up teams at each level comprising existing government functionaries and a few contractual personnel with new skills at all levels, as per need. Orientation on the details of the plan of action is critical for the system owning the challenge of NRHM. Involvement of NGOs/non governmental institutions as a team of resource persons under the framework of NIHFW/SIHFW. It should not be a routine orientation. ***Costs as per approved workshop and training norms.***
2. Constitution and orientation of all community leaders on village, SHC, PHC, CHC Committees	Effective institutionalization of community ownership requires concerted efforts for appropriate selection and training of community representatives on committees. Broadly, the effort should be to have at least 50 percent women on every committee with at least 30 percent from non governmental sectors. Reservation for SC/ST/OBCs may be considered at various levels as per State norms. The effort has to be for a functional system. Orientation should involve NGOs and resource persons from outside the government system as well. Thrust on surveys, management of accounts, functionality of facilities, etc. ***Cost as per approved workshop and training norms***.
3. Untied grants to Village Health and Sanitation Committees	***Every village with a population of upto 1500 to get an annual untied grant of up to Rs. 10,000, after constitution and orientation of Village Health and Sanitation Committees.*** The untied grant to be used for household surveys, health camps, sanitation drives, revolving fund etc.
4. Selection and training of Community Health Workers (ASHAs, AWWs) etc.	***Total support of up to Rs. 10,000 per ASHA for initial training, monthly orientation, drug kit, support materials, travel expenses, etc.***
5. Performance related incentives for ASHAs, AWWs.	While performance related incentives would come under various programmes, the total resources should be kept aside at the Gram Panchayat Committee at SHC level for disbursement to ASHAs. Every Gram Panchayat Committee can seek replenishment of performance based funds after disbursement to ASHAs. ***Rs. 5000 permanent advance may be made available to every Gram Panchayat as a permanent advance for this purpose. Disbursement as per performance norms.***
6. Selection and training of non–governmental providers of health care RMPs/TBAs	Based on a survey of non-governmental providers (RMPs/TBAs) and their likely potential to become as qualified as a government provider, ***special training programmes to enlarge the pool of skilled health workers in rural areas should be made. This will help in promoting common treatment protocols and in promoting current practices and priorities. NGOs ought to be involved in such efforts. Cost as per standard training norms.***

7. Physical infrastructure for village level health activity.	ASHA to work from the Aanganwadi Centre. Since Aanganwadis have the responsibility for under 6 children, pregnant women and adolescent girls, there is a need for additional space for the ICDS centre that may be used as a health care room. Resources can come from existing rural development programmes under which ICDS centres are being constructed and provided for.
8. Selection, remuneration and training of ANMs.	More than 2 lakh ANMs will be required to be added to the system. Currently only 13,000 ANMs are completing their training each year. Innovative systems involving NGOs to introduce vocational training at High School and Ashramshalas in tribal areas to work with the educated local girls to develop them into ANMs, ought to be undertaken. In service training to develop existing ANMs into skilled attendants at birth is required. Duration to be worked out as per need. Involvement of distance education systems with large local contact hours in hospitals needs to be explored in partnership with NGOs. Blocks need to develop their plans for filling up ANM vacancies, identification of selection teams, training packages, remuneration, etc. Improvement of mobility of ANMs with a provision for interest free loans for two wheelers could be explored. ***Cost norms to be developed in consultation with States as per standard cost norms for training, remuneration and orientation. All appointments will be contractual and based on local selection criteria.***
9. Selection, training and remuneration of PHNs at PHC level	There is a need to strengthen the monitoring and supervision role of the Lady Health Visitor, who may be called the Public health Nurse. She should be equipped to improve skills of ANMs, supervise their work, assign specific tasks to them, etc. ***Cost norms to be developed in consultation with States as per standard cost norms for training, remuneration and orientation. All appointments will be contractual and based on local selection criteria.***
10. Selection, training and remuneration of Staff Nurses and other paramedics (including AYUSH stream) at PHC/ CHC level.	The Nursing Schools put together are not producing as many qualified nurses as needed. Given the huge demand for good Nurses overseas, there is also a large drain of such services to overseas demands. A thorough review of Nursing Schools, ways of augmenting capacities as per needs, has to be worked out in each State. Innovative training and orientation system with the help of NGOs has to be developed to provide for effective monitoring, etc. Existing norms to apply. ***Cost norms to be developed in consultation with States as per standard cost norms for training, remuneration and orientation. All appointments will be contractual and based on local selection criteria.***

11. Selection, training and remuneration of Medical Officers at PHCs (including AYUSH stream)	Medical Officers at PHCs have to be multi skilled and special programmes for their orientation has to be developed in State specific contexts. The issue of absenteeism has to be tackled by carefully looking at the system of incentives and career progression. Opportunities for need based orientation have to be evolved. ***Cost norms to be developed in consultation with States as per standard cost norms for training, remuneration and orientation. All appointments will be contractual and based on local selection criteria.***
12. Selection, training and remuneration of Specialists at CHC level.	It is a problem to get the services of Specialists at CHC level. Flexible systems of recruitment have to be developed along side improvement of facilities and opportunities for hospital like services at these institutions. ***Cost norms to be developed in consultation with States as per standard cost norms for training, remuneration and orientation. All appointments will be contractual and based on local selection criteria.***
13. Construction and maintenance of physical infrastructure of SHCs	The Gram Panchayat SHC Committee has the mandate to undertake construction and maintenance of the facilities. ***An annual maintenance grant of Rupees 10,000 will be available to every SHC. Specific proposal for major repairs will have to be developed if such works are required. Provision for water, toilets, their use and their maintenance, etc, has to be priorities.***
14. Construction and maintenance of physical infrastructure of PHCs	PHC level Panchayat Committee/Rogi Kalyan Samiti will have the mandate to undertake and supervise improvement and maintenance of physical infrastructure. ***Annual maintenance grant of Rs. 50,000 to be available to each PHC. Provision for water, toilets, their use and their maintenance, etc, has to be priorities.***
15. Construction and maintenance of physical infrastructure of CHCs.	CHC level Rogi Kalyan Samiti/ Block Panchayat Samiti to undertake construction and maintenance of CHCs. ***Annual maintenance grant of Rs. 1 lakh to every CHC, to ensure quality services through functional physical infrastructure.***
16. Procurement and distribution of quality equipments and drugs in the health system.	***Develop capacities in States like the Tamil Nadu Health Systems Corporation to procure quality drugs and develop logistic arrangements for their timely utilization. Central government procurements as an interim measure till capacities are developed at State/ district/Block levels for quality and timely procurement. Emphasis on timeliness, transparency, and quality of procurements.***
17. Support to BPL families for institutional deliveries under the Janani Suraksha Yojana.	***Accreditation of government and non governmental institutions for institutional deliveries with systems for timely availability of financial resources to the BPL families. States may propose enhancement of norms in line with NCMH unit costs.***

18. Untied grants to SHCs, PHCs and CHCs	***Every SHC to get Rs.10,000/-, every PHC to get Rs. 25,000 and every CHC Rupees 50,000 as untied grants for local health action. The resources could be used for any local health activity for which there is a demand.***
19. Support to Mobile Medical Units/ Health Camps	With the objective to take health care to the door step of the public in the rural areas, especially in under-served areas, Mobile Medical Units are proposed to be provided, one per district under NRHM. The states are, however, expected to address the diversity and ensure the adoption of most suitable and sustainable model for the MMU to suit their local requirements. They are also required to plan for long term sustainability of the intervention. Two kinds of MMUs are envisaged, one with diagnostic facilities for the states other than North-Easter States, Himachal Pradesh and J&K. In addition, for the North-East, Himachal Pradesh and J&K, specialized facilities and services such as X-ray, ECG and ultra-sound are proposed to be provided due to their difficult hilly terrain, non-approachability by public transport, long distances to be covered etc. The states are needed to involve District Health Society / Rogi Kalyan Samiti / NGOs in deciding the appropriate modality for Operationalization of the MMU. The provision of staff will be considered only for the states who will run the vehicles with support of NGOs/RKS and in case of states outsourcing the vehicles. The unit cost for mobile van for staff is Rs.7.00 lakhs, mobile unit with essential accessories costs Rs.18.25 lakhs per district and a mobile unit with diagnostic facilities has a unit cost of Rs.23.75 lakhs per district. The total capital expenditure for 595 districts in the country is estimated to be Rs.175 crores. The recurring expenditure for North-Eastern states, J&K and Himachal Pradesh with provision of a radiologist and an additional driver for diagnostic van is Rs.23.71 lakhs per district per annum. For other states, the unit recurring cost is Rs.19.87 lakhs per district per annum. The total recurring expenditure for 595 districts in the country is Rs.122.21 crores. The total capital expenditure is estimated to be Rs.175 crores with total recurring expenditure of Rs.122.21 crores for the whole country. States to work out need and numbers for mobile dispensaries. Health Camps as a means of mobilizing local communities for health action and for creating demand. Unit costs to be developed in consultation with States. Mobile Medical Unit for each State.

20. Support for School Health Programmes / Adolescent Health Programmes	Innovative School Health Programmes could be taken up for a range of issues in public health. Funding as per specific proposals from schools/ Blocks/ districts. Screening of school children for detection of refractive errors and provide free spectacles to poor children. School Health Programme should include: ▪ Oral Health awareness programme for the children ▪ Should also have oral/dental screening programme for early identification and prevention.
21. Support for IEC activities	A variety of activities involving communities and also the media. **Allocations at national, state and district levels. Up to Rupees ten per capita which should be equally spent at the three levels (1/3, 1/3, 1/3).**
22. Nutrition and Health Education Programmes for women's groups.	As a means to strengthen ICDS activities and to improve cultural practices with regard to child care. As per local proposals for strengthening the component.
23. Resources for surveys, camps, public hearings.	As per local needs and as articulated in the Block, District and State level Annual and Perspective Plans.
24. Grants in aid to NGOs at district, state and national levels.	Up to 5 percent of the total NRHM Budget could be used as Grants in aid to NGOs at various levels. This will improve outreach of services and efficiency of delivery. It will include public private partnership as well.
25. Innovation funds at all levels.	For local action that emerge as priorities in the Block/District Action Plans. States to appraise need for innovation and suggest costs as per need and existing State norms.
26. Monitoring and Evaluation Costs.	Up to Rs. 5 per capita will generate an annual corpus of Rs. 150 crores. Of this resource 25 % may be used at the national level, 25% at the State level and the rest at district level and below.
27. Management Costs/ Contingencies.	Up to 6 % of the total Annual Work Plan for that year, calculated o the basis of the total State level NRHM Plan (including the District Plans). Resources for contractual engagement of personnel with new skills, travel costs, etc. to be met from this. State component and district component to be earmarked.
28. State level Resource Centre	To be set up with an annual corpus of Rs. One crore in large States and Rupees Fifty lakhs in smaller States/UTs. To be used for operationalizing new ideas and for strengthening service delivery. Resources to be used for hiring resource persons and for field based operational activities.

29. National level Resource Centre	To be set up with an annual corpus of Rupees 15 crores. To be used for raising new ideas and for operationalizing them to improve effectiveness of service delivery and efficiency of resources.
30. Support to district and Block level Resource Groups.	For development of capacities and for field based supervision of services.
31. Research Studies	Up to Rs. 5 per capita will generate an annual corpus of Rs. 150 crores. Of this resource 25 % may be used at the national level, 25% at the State level and the rest at district level and below.
32. Support for Planning activities.	As per specific need expressed by Districts/Blocks.
33. Capacity building needs at all levels	To be a priority at all levels. To be designed as per local needs. Non-negotiability of quality and standards. NGOs to be involved as resource teams and institutions at all levels for capacity building.
34. Costs of core, basic and secondary health care	As per National Commission on Macro Economics and Health assessment. The cost in the non-governmental sector is likely to be 30-50 percent higher. State Health Missions to assess costs based on detailed district specific exercise. Mission Steering Group at State level can approve costs up to 25 percent more than provided by NCMH. Any further increase has to be formally approved by the National Level Mission Steering Group.
35. Resources for risk pooling.	To be used as per specific state/region/district models that may evolve, to support premium for Below Poverty Line Families. Ceiling on premium as per UHIS – Rs. 300 for a family of five.
36. Strengthening Nursing Schools.	As per need and specific proposals. This will also include improvement of physical infrastructure of ANM training centres and other nursing institutions.
37. Improving physical infrastructure of SHC/PHC/ CHC/Taluk/District Hospital	Upto 1/3rd of total annual allocation under NRHM in special focus states and upto 1/4th in low focus states.
38. Ambulances for all PHCs/CHCs/District Hospitals.	As per case load and need. To be under the supervision of the RKS/ User group.
39. Telephones for SHCs/PHCs/CHCs/District Hospitals.	As per need.

40. Rogi Kalyan Samitis / Hospital Management Committees	NRHM strategies to upgrade the CHCs to Indian Public Health Standards (IPHS) with a purpose to provide sustainable quality care with accountability and people's participation along with total transparency. To ensure a degree of permanency and sustainability, a management structure called Rogi Kalyan Samiti (RKS) (Patient Welfare Committee)/Hospital Management Committee (HMC) has been evolved. RKSs are proposed to be established in 585 rural hospitals, 3222 Community Health Centres, and 23109 Primary Health Centres in the country. The initiative would bring in the community ownership in running of rural hospitals and health centres, which will in turn make them accountable and responsible. To motivate the states to set up RKSs, a support of Rs.5.0 lakhs per rural hospital, Rs.1.00 lakh per CHC and Rs.1.00 per PHC per annum would be given to these societies through states. The societies would be eligible for these grants only where they are authorized by the States to retain the user charges at the institution level. An amount of Rs.29.25 crore as a seed money for Operationalization of RKSs in rural hospitals, Rs.32.22 crores for CHCs and Rs.231.09 crores for RKS in PHCs has been estimated.
41. Ceiling on Civil works	Up to a maximum of 33% of Annual Plan in Special Focus States and 25% of Annual Plan in other States.
42. Preparation of District Health Action Plans	Up to Rupees twenty lakhs per district for surveys, workshops, studies, consultations, orientation in the process of preparation of District Health Action Plans.
43. Preparation of District and State level public reports on health annually by independent agencies.	Up to Rupees Fifty Thousand per year for the preparation of District Public Reports and up to Rupees two lakhs per year for the preparation of State Public report on Health, based on analysis of published reports, studies, surveys, etc.
44. Special needs of North Eastern States	As mentioned at para 109, North Eastern States may require relaxation of norms. It shall be taken in the appraisal process.

RCH-II

The second phase of National RCH 2 programme was launched in April 2005. The programme aims to achieve national population policy goals with reference to IMR, U5MR, MMR and TFR (since subsumed - in NRHM goals) National/State/District RCH PIPs reflect on a set of technical strategies and activities to achieve these goals. It is advisable to the district planning team members (members of district health missions and other co opted members) to familiarize themselves with the state PIP with special reference to RCH goals and strategies. This document will also be useful in guiding the district teams in terms of how state proposes to hire additional human resources, capacity building plans and BCC activities etc. While district plans are independent self-standing plans, nevertheless some activities will be undertaken at the state level to support district level implementation.

C. Strengthening of Immunization

Each district is preparing immunization service delivery plans to provide efficient and safe immunization services to all infants and PW as per National Immunisation schedule. These plans respond to intra district specific needs with reference to ensuring availability of immunization agents on designated sites on session days, cold chain maintenance, monitoring adverse events following immunization and surveillance of VIPs etc. It should be noted that ASHAs are supposed to mobilize clients (women & children) for immunization session. The plans should include activities for cold chain equipments, support for vaccine delivery, and support for ASHAs and requirements for AD syringes in the district. The communication activities for improving immunization coverage and for mobilizing clients on the designated NIDs have to be reflected separately.

D. National Disease Control Programmes

i. *Revised National Tuberculosis Control Programme (RNTCP)*

RNTCP incorporates elements of internationally recommended elements of Directly Observed Treatment (DOTS) short course strategy. The district level of objectives of RNTCP in conformity with national programme includes annual case detection rate of 70 per cent, treatment success rate of 85 per cent. The programme aims at improved treatment seeking behaviour of TB suspects, quality assured sputum microscopy, ensuring proper categorization of TB patients and improving treatment compliance by ensuring directly observed treatment and uninterrupted supply of quality assured drugs.

ii. *National Vector Borne Diseases Control Programme (NVBDCP)*

The NVBDCP was initiated in the year 2003-2004. It is an umbrella programme for prevention and control of vector borne diseases including Malaria, Failaria, Kalzar, JEJE and Dengue. Under the programme comprehensive and multi sectoral public health activities are implemented. Districts teams should review incidence and prevalence data available for these diseases in the district through surveillance activities and plan as per national strategy adapted to address local needs.

Vector borne diseases like Malaria, Dengue and Japanese encephalitis are outbreak prone diseases and therefore during formulation of the district health plan, epidemic response mechanism should also be outlined.

iii. *National Leprosy Eradication Programme*

The programme was initiated as a central programme in the year 1955 and Multi Drug Therapy (MDT) was introduced for treatment of leprosy in 1982. Since then the programme has achieved tremendous success in bringing down leprosy burden and leprosy has been eliminated as a public health problem (PR<1/10,000 population) at National level in December 2005. The programme now aims at providing quality leprosy services through General Health Care System, to eliminate leprosy at remaining state, district and block level and to enhance disability prevention and medical rehabilitation services for deformed leprosy patients.

iv. *National Blindness Control programme*

The National programme for control of blindness was launched in year 1976 with a goal for reduction in prevalence of blindness from 1.4 percent to 0.3 percent. The four-pronged strategy refers to strengthening service delivery, developing human resources for eye care, outreach activities and developing institutional capacities.

All school children in the age group of 10-14 years should be screened for refractive errors. Percentage of children detected with refractive errors should be 5-7%.

v. *Integrated Disease Surveillance Programme*

Integrated Disease Surveillance Project is a decentralized state based surveillance programme for the common communicable and non-communicable diseases. It is intended to provide essential data to monitor progress of on going disease control programme and also to detect early warning signals of impending outbreaks and help institutions to develop an effective response in a timely manner. The project has been phased out as per the following plan:

- **Phase 1** states, which will implement IDSP beginning in FY 2004-05 are Andhra Pradesh, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, Mizoram and Kerala.

- **Phase 2** states/UTs, which will implement the IDSP beginning in FY2005-06 are Chhattisgarh, Goa, Gujarat, Haryana, Rajasthan, Uttaranchal, West Bengal, Manipur, Meghalaya, Tripura, Chandigarh, Pondicherry, and Delhi.

- **Phase 3** states/UTs, which will implement IDSP beginning in FY2006-07 are Uttar Pradesh, Bihar, Jammu and Kashmir, Jharkhand, Punjab, Arunachal Pradesh, Assam, Nagaland, Sikkim, A & Nicobar, D& N Haveli, Daman and Diu, and Lakshadweep.

The diseases under surveillance are as follows:

Regular Surveillance:

Classification of Disease	Name of the disease
Vector borne disease	Malaria
Water borne disease	Acute diarrhea
	Typhoid
Respiratory disease	Tuberculosis
Vaccine Preventable disease	Measles, Diphtheria, Pertussis, NNT
Disease under eradication	Polio
Other conditions	Road traffic accidents
Other international commitments	Plague, Yellow fever
Usual Clinical syndromes (causing death/hospitalization)	Meningo encephalitis, hemorrhagic fevers, other undiagnosed conditions.
Skin disease	Leprosy

Sentinel Surveillance:

- Sexually transmitted diseases / Blood borne: HIV/HBV/HCV
- Other conditions: Water quality, outdoors air quality.
- Regular Periodic Surveys: NCD Risk factors

vi. National Iodine Deficiency Disorder Control Programme

The NIDDCP aims to control iodine deficiency through:

1. *IDD Survey/resurvey*
2. *Supply of iodated salt*
3. *Establishment of IDD Control Cell*
4. *Establishment f IDD Monitoring Lab*
5. *Health Education and Publicity*

E: INTERSECTORAL CONVERGENCE ACTIVITIES

As the indicators of health depend as much on drinking water, nutrition, sanitation, female literacy, women's empowerment as they do on functional health facilities, NRHM seeks to adopt a convergent approach for interventions under the umbrella of the district plan which seeks to integrate all the related initiatives at the village, block and district levels. While substantial spending in each of these sectors would be from the concerned departments, the Village Health Plan /District Plan would provide for some catalytic resources through Untied Grants for convergent action.

Also, as reflected in the HIV/AIDS and RCH convergence document, sub-district activities for prevention of HIV/AIDS are also to be planned as an integral component of the DHAPs. Possible demand generation activities for utilizing services offered such as PPTCT, VCT and ART, should be explored.

There may be variations across the states in integrating DHAPs with Safe water supply and rural sanitation in the initial years. However eventually district health missions should aim to integrate these programmes also to achieve desired synergy in activities leading to comprehensive response for health determinants.

School Health Check up Programme in Gujarat

Background

- The first school health programme in the country was started by Sir Sayajirao Gaikwad, King of Baroda, in 1909.
- The Bhore Committee (1946) reported that School Health Services were practically non existent in India and where they existed were in an underdeveloped stage.
- The Secondary Education Committee (1953) emphasized the need for medical examination of students and a school feeding programme.

Government of India

GoI launched a Special School Health Check up Programme in 1996 which was implemented in co-ordination between DoHFW and DWCD with the following objectives:

- Early detection of health related problems that are commonly occurring amongst primary school children.
- Building of health awareness in the community through primary school, children.
- Screening of children for major illnesses for appropriate and timely referral
- Follow up arrangements for detailed check up and treatment of referral cases at Government Health facilities so as to provide specialist treatment and care to needy students.

The Multi Purpose Workers (MPWs) did the primary screening and referral services were provided at primary Health Centres (PHCs). The programme was however discontinued.

Government of Gujarat

- Since 1997, the single largest health programme operating in the state.
- Organisation: State level Steering Committee chaired by the State Health Minister, with Chief Secretary, Additional Secretary (Health), Additional Secretary (Education), Additional Secretary (Finance) and Members of Legislative Assembly as members.
- Implementation: Microplans are prepared at PHC level which include details the schools and anganwadis to be visited for health check ups and list the other activities to be carried out. All these plans are collected, collated and analyzed by the state level Health Education Bureau to provide the State Plan for School Health Scheme.
- Services provided: Of a total of 8,692,436 children, 8,324,661 were examined in the year 2005-06. Children with minor ailments like anaemia, worm infestation, ear discharge, scabies, boils are treated on the spot while those requiring the services of specialists are sent to related referral centers. Children with refractory errors are provided spectacles free of cost. Children suffering from heart, kidney and cancer diseases are provided treatment at apex tertiary care hospitals. Not only is the cost of treatment borne by the state government, referral transport is also provided. If needed, specialist treatment outside the state is also provided. The scheme is currently being evaluated.
- Budget: of Rs 500 lacs under the plan budget.
- New initiative: “Health Promoting School” has been started with assistance from WHO in four districts and one urban area. The programme will take care of Quality of Water and Sanitation in schools and augument capacity building of teachers so as to achieve holistic and sustained promotion of health in schools.

Health Sector Reforms -Rogi Kalyan Samiti /Hospital Management Society

Rogi Kalyan Samiti (RKS) / Hospital Management Society (HMS) with the structure of the General Body responsible for policy formulation and decision making and the Executive Body for implementing the decisions started to reduce infant, child and maternal mortality in the State of Madhya Pradesh revolutionized the way of running hospitals in the State. The exemplary task done in Indore under the RKS got international recognition through the Global Development Network Award, 2000 as the most innovative development project. It proved that people essentially want to help themselves and good governance is about showing them the way and not interfering. RKS is the way of finding scope to upgrade infrastructure and facilities in public hospitals, which is otherwise difficult to do through government budgetary support. Other than this the charter of RKS includes in its responsibilities other roles such as creation of a better atmosphere, management training, orientation and incentives for staff and the management of resources, equipment and waste etc. This is made possible by utilizing the additional resources created through cost recovery schemes, using hospital property and land and also by freely applying for user charges. It also reflects communities capacity to pay for hospital services and could be considered as an indicator in terms of the movement towards increased hospital autonomy. Good hospital management is crucial in relation to the risk of death due to complications in pregnancy and childbirth, infancy and early childhood. Additionally, hospitals provided indispensable support for the primary health care services needed for preventive functions. The underlying theme of decentralization in the concept of RKS to increase income through non-budgetary resources has also been accepted by Andhra Pradesh and Gujarat with different objectives such as for increasing financial reliance and for delegating powers to Regional Directors in these States. In the hospitals, the heads of department are responsible for decisions taken in their wards, including the use of additional funds generated, and decision relating to staff. This active involvement of physicians is considered to be one of the success factors of the RKS. Still, a number of issues are needed to be addressed before RKS could serve as a model for total hospital autonomy such as unequal distribution of the non- budgetary resources as small hospitals has limited capacity to generate resources; pattern of utilization inclined towards improving physical infrastructure than more complex managerial issues; dual management and administrative system at the hospital level which could be rectified through channeling of government budgetary allocations though the RKS and giving additional freedom and autonomy to the hospital staff for local level decision making, missing in the quasi-government controlled RKS and also ill defined relationship between the RKS and the State government. Nonetheless, RKS seems to be the only way to reform the public health care delivery system in general and public hospitals in particular

Chapter

3

Resource Allocation and Financial Norms

The NRHM integrates all related, inter linked and stand alone schemes in the health sector including RCH, National Disease Control Programs (NDCP), Integrated Disease Surveillance as well as new initiatives proposed under NRHM and National Commission on Macro Economics and Health. A common and flexible fiscal pool has been designed to cover all NRHM activities and various financial resources including external aid have been rationalized and compressed into four categories. These include:: (i) operational support to states (released through treasury route); (ii) operational cost of institution supported by MOHFW; (iii) activities centrally implemented; and (iv) activities in the State programme Implementation Plan (released through Integrated Health & Family Welfare Societies). Support for the District Health Action Plans falls under the category of support to activities in the State PIP.
The Financial norms under NRHM integrate and harmonize existing norms for all schemes subsumed under the NRHM including NDCP, RCH and Integrated Disease Surveillance Programme. The district health mission will have total flexibility to include activities that are relevant to needs of the district keeping in view of the implementation guidelines of the various disease control programme. However, all district plans need to include some components such as Jannani Suraksha Yojana, ASHA in high focus states, Mobile Medical Units, Untied Grants to Facilities and VH&SC, Funds to Rogi Kalyan Samitis, camps and sterilization compensation mandated by the Centre from time to time in national interest.

Approaches for Equity based Resource Allocation:

The MOHFW has used an equity-based approach to allocate RCH/NRHM Flexible pool to various states. While the overall allocation is done on the basis of population, an additional weight has been assigned to the NRHM priority states to ensure allocation of higher resources to more needy states... The Eight EAG states have been assigned weight of 1.3, North Eastern States have been assigned weight of 3.2 and Other Non-EAG / NE states have been assigned weight of 1. This approach ensured more resources to the states that are critical for achieving outcomes envisaged in NRHM.

Suggested options that the states may choose to allocate funds to the districts

a) *Equal Distribution of resources for all districts:* In this approach out of the total resources allocated to the state by MOHFW 10% will be earmarked for utilization at the state level. The balance 90% is distributed equally among the districts by dividing this amount by the number of districts in the state. The average resource available to the Districts may go up by 25% to 35% depending upon the utilization and reporting by the districts. While the main advantage of this approach is simplicity, it fails to address specific needs of districts located in backward regions of the state and hence not equitable. Also, this approach assumes that all districts are of equal size, which in reality is not the case in most states.

b) *Equity based distribution based on socio-demographic characteristics*: Using socio demographic variables as criteria for allocating resources to districts is probably a more equitable method... These criteria could be rural/urban distribution, proportion of SC/ST and vulnerable groups or districts with adverse health indicators. Either a single or a combination of such criteria can be used to rank the districts and allocate resources accordingly. It should also be based on District profile Template-1 as shown in page 17 of this document. A simple example is shown below

Socio-demographic criterion	Current level	Score
% of Urban population	>75%	1
	50-75%	2
	25-50%	3
	<25%	4
% SC & ST population	>25%	3
	10-25%	2
	<10%	1
% deliveries by skilled attendant	>50%	1
	25-50%	2
	<25%	3
HIGHEST ATTAINABLE SCORE		**10**

Although the socio-demographic criteria mentioned in the document would be applicable incase of most of the communicable diseases, the endemicity of the diseases particularly malaria should also be considered as a criterion for more equitable resource allocation.

The highest possible score for a district in the example shown in the table will be 10 (4+3+3). The districts can be distributed in to 3 broad groups: (a) most vulnerable (with score of 7 and above); (b) vulnerable (scores of 4-7); and (c) least vulnerable (<4). For each group a vulnerability weight can be added as done by MOHFW. For example, 30% for most vulnerable, and 15% for vulnerable districts. For applying this formula, the average resource per district provided in Annex I can be multiplied with 1.3 and 1.1 respectively to arrive at estimated allocations for most vulnerable and vulnerable districts respectively. The remaining balance can be equally distributed among the least vulnerable districts by just dividing it by the number of such districts.

c) *Need based approach:* A need-based allocation is another option, which will be responding to specific health needs of a district.

Administrative Expenses:

The administrative expenses including consultants for program management support units and travel expenses (as per the State Govt. norms) should not exceed 6% of the total NRHM outlay for the state for the financial year. It is important to ensure that any other administrative expense reflected in the specific programme/scheme guidelines also should be within this overall ceiling of six percent.

Vector Borne Disease Control Programme requires more intensive supervision and monitoring at field level particularly in reference to spraying for vector control and surveillance activities. Hence, travel expenses should be provided as per the need of the districts indicated in their district health plans.

RNTCP has provided support to the states for intensive monitoring for quality microscopy and to ensure DOT is being implemented as per the national programme guidelines .In view of this the programme has provision for contractual staff and their mobility at the district level. The programme therefore, has laid down norms and guidelines for expenditure of the same at the district level. Para as given below may be appended.

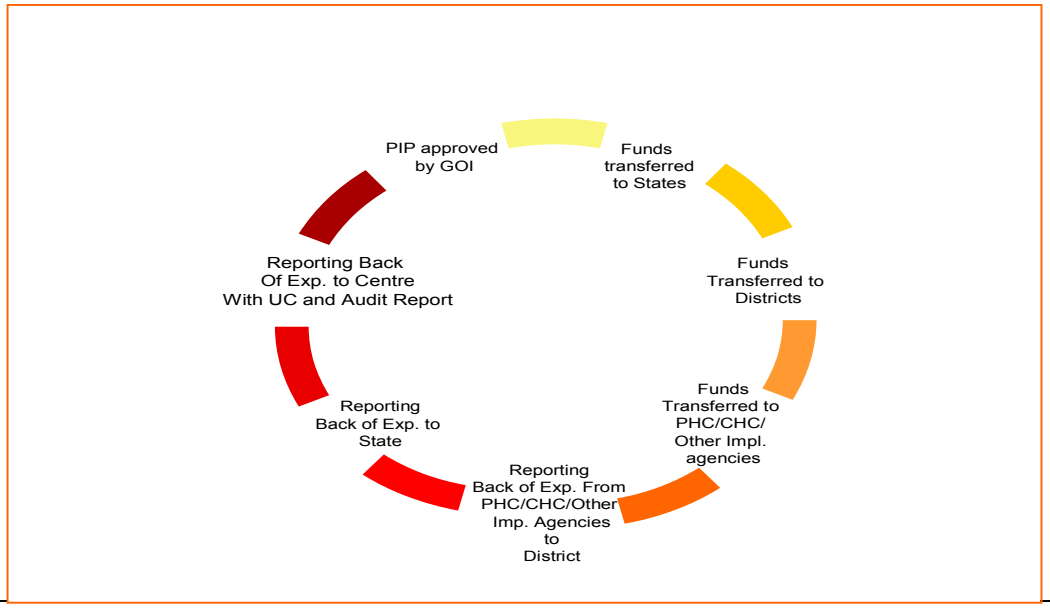
“RNTCP requires supervision and monitoring as per guidelines of the programme so that quality sputum microscopy is being performed at Designated Microscopy Centers and DOT is being administered to the patients regularly as required .It also needs to upgrade the records and provision of TB numbers to the registered patients. Hence, travel and other expenses should be as per programme guidelines”.

Fund Flow & Reporting:

- In the First year, after approval of the State PIP, funds are transferred to States in 2-3 trenches.
- States will transfer these funds to Districts as per the approved DHAP
- Districts will in turn transfer these funds to Hospitals/CHC/PHC/Sub Centres/ Other implementing agencies.
- The PHC/CHC/Sub-Centres/other implementing agencies will report back the expenditure incurred to the District
- Within the District Health Society there should be a separate RNTCP account with DTO as one of the signatory for flow of funds.
- For the smooth release of funds to the state and subsequently to the districts, timely submission of following financial reports is critical.

    - District compiles the data and sends the expenditure report to the State once every month
    - State compiles the data and sends the SOE (FMR) to Centre once every quarter
    - Districts will submit Utilization certificates to the states as soon as possible.

    The districts should closely monitor the use of advances made to various implementing agencies (govts and non govts) and ensure that they are settled within defined time frame. Delay in the submission of UCs and non-settlement of outstanding advances could result in restricting timely fund flow to the states and the districts.



Delegation of Financial Powers:

A model delegation of Financial & Administrative Powers for smooth and efficient working of the District Health/FW/RCH Societies in the following table. This may be adapted or modified depending on the local requirements.

Type of expenditure	Authority	Extent of power
A: Release of funds to Hospitals/ hospital societies, block Medical Officers and other implementing agencies as per State Government approved norms and/or proposals approved by State Government.	Executive Secretary / Member-Secretary of the concerned Programme Committee	Full powers
B: Release of funds for implementation of plans / allocations approved by Governing Body / Executive Committee.		
C: Expenditure proposals not covered under categories A and/or B		
C-1: Procurement of goods C-2: Repairs and minor civil works C-3: Procurement of services for specific tasks including outsourcing of support services.	Chair-person, Governing Body	More than Rs 2.00 lakhs and upto Rs. 5.00 lakhs per case.
	Chair-person, Executive Committee	Upto Rs. 2.00 lakhs per case.
C-4: Miscellaneous items not mentioned above such as hiring of taxis, hiring of auditors, meetings and workshops, training, purchase of training material/ books and magazines, payment of TA/DA allowances for contractual staff and/or non-official invitees to DHS meetings and/or officials deputed to meetings outside the district.	Chair-person, Governing Body	Upto Rs. 1.00 lakh at a time subject to a maximum of Rs. 10 lakhs per annum.
	Chair-person, Executive Committee	Upto Rs 50,000 at a time, subject to a maximum of Rs. 5.00 lakhs per annum.
	Member-Secretaries of the Programme Committees	Upto Rs 5,000/- at a time subject to a maximum of Rs. 1.00 lakh per annum.

Note:

1. During the Financial year, no authority can exercise the powers beyond the amount provided against that item in the annual work plan and budget for that financial year approved by the GOI.
2. A higher authority in the District Health & Family Welfare Society may exercise the power delegated to the authority subordinate to it.
3. No appointment in District Health & Family Welfare Society will be made by any authority except on the recommendation of the selection committee duly constituted by Chairperson.
4. Two functionaries of District Health & Family Welfare Society will sign every cheque.
5. Purchases under C-1 will be made through a duly constituted purchase committee with the approval of Chairperson of the Governing Body of the District Health/Family Welfare Society.

Delegation of Administrative and Financial Powers

Annexure VII provides an overview of the approved Delegation of Administrative and Financial Powers under the Mission against key NRHM activities.

Chapter

4

Conducting Situational Analysis

3.1 Preparatory Phase

Data Collection

As a preparatory exercise for the formulation of DHAPs, each district team will undertake a detailed situational analysis. This will entail conducting **facility survey, household survey and access to secondary data sources, compiled service statistics and also any published studies** Many times these datasets can be accessed through the state Monitoring and Evaluation cells. Availability of information will enable in providing with a snap shot of where the district stands with respect to key programme indicators. This apart, the exercise will provide with an overview of availability of other resources (human and financial) and gives options for pooling and optimum utilization of resources.

Facility Survey

In order to set up benchmarks for service quality and utilization, and identify input needs, facility surveys will have to be conducted. These surveys will provide critical information in terms of infrastructure and human resources gaps those needs to be addressed through planning process. Facility survey will also help in monitoring service quality standards by RKS. Thus facility survey for each facility will be critical database for input planning and assessing service quality from clients and providers perspectives Self administered tools for facility survey can be used for gathering information through Medical officers and ANMs

Household Survey

HH surveys are to be conducted at the village level by a team of ASHA, AWW and Trained TBAs. The main purpose of this exercise is to understand the health care needs of the rural population, resource mapping and also to assess as how other determinants of health influence health of HHs such as drinking water, sanitary latrine, employment and access to other requirements. To ensure community participation in planning and monitoring, household survey through village health teams specifically, ASHA and Anganwadi workers have been strongly advocated. Data collected from household survey will be used in preparing village health registers that will serve as an input tool for developing village health plan. The village health plan, thus formulated will be used at the local level and activities monitored accordingly. However this might take some time to start in the districts as concept of village health planning will take some time to sink in

These surveys would be used as planning and monitoring instruments and not for any national reporting system. The intention is to assess the needs of the District through **household and facility surveys** that track the baseline information of the institutions and households. These surveys along with **secondary data available** would form the basis for planning annually for the improvement of indicators and facilities. The base line through the facility survey will provide every institution an opportunity to assess its present performance, plan it's human and financial needs for the forthcoming years and indicate the service guarantees that the institution will provide with the additional flexible finances and human resources.

The Facility and the Household Survey would also be public documents kept in the facilities and the Anganwadis respectively for public scrutiny.

The formats for household and facility surveys are at Annex- I-IV

3.2 Situational Analysis

In this section, the profile of the district in terms of its background characteristics, health facilities (both public and private), functionality of health facilities, logistics, coverage of ICDS programmes, availability of elected representatives of Panchayat Raj institutions and presence of NGO's, CBO's in the area will have to be captured. Profile of the district helps to understand the district better and also to identify the constraints particularly in terms of size of villages, access to villages etc. For instance economic classification of workers helps to understand the size of disadvantaged groups to better focus on issues of equity.

The first template is on district profile wherein general information of the district in terms of its social-demographic characteristics has to be collected. As far as possible, it is better to use information from 2001 census. In case, there is any latest information available from an authentic source or other large-scale data sets, it can be used but the source of information will have to be quoted. The template can have district-specific information on one column and state-specific on the other. This will give an idea of how the district is placed in comparison to the state.

These templates are generic in nature and more data inputs may be included. The District Plan should also address the specific requirement of the Districts. Area specific concerns like flood problem, drought problem, needs of sc/st, health problems due to industries, water shortage should be highlighted and addressed.

District Profile-Template 1 – ≤ 400,000 (urban) currently under NRHM

S.No.	Background Characteristics	District		State
		Number	% to total	Number
1	Geographic Area (in Sq. Kms)			
2	Number of blocks			
3	Size of Villages (2001 Census)			
	1-500			
	501-2000			
	2001-5000			
	5000+			
4	Number of towns			
5	Total Population (2001)			
	-Urban			
	-Rural			

6	Sex Ratio (F/M*1000) • Population Sex Ratio • Child Sex Ratio			
	Decadal growth rate			
7	Density- per sq. km.			
8	Literacy Rate (6+ Pop) -Male -Female			
9	%SC population %ST population No. of schools No. of Anganwadi Centres			
10	Length of road per 100 sq. km.			
12	% of villages having access to safe drinking water facility			
13	% of households having sanitation facility (Specify Type –sewer, septic tank)			
14	% of population below poverty line			
15	Health Status Morbidity Male Female Child			
	Mortality MMR IMR			
16	Health Resources- Facilities (Specify level of Facility like Subcentre) Personnel(Sanctioned Vacancy) Finances(Requirement and Releases)			
17.	1.Birth rate and death rate 2. Fertility rate. 3. Disease maximum Disability. 4.High Risk Groups			
18.	**B.To link with the nutritional determinants**- 1. % of Infants with low birth weight. 2.Weight for Age no. above 90%, 3. No between 60%-80%, 4. No. below 60% weight for age			
19	**No of Primary schools** **No of Primary school teachers** **No of children enrolled(Age wise)** **(All relevant data needed to Start School Health Programme)**			

Broadly, interpret the salient findings in terms of key highlights:

- Specific Urban Health Projects may be formulated based on the relevant guidelines only in respect of cities/urban areas having population of one lakh or more.
- Population-Rural/Urban Composition: For urban areas of the district with a population upto 1 lakh, consider formulation of urban health sub plan in case there is substantial urban poor population with adverse health indicators. Similarly district may consider planning for interventions to enhance access in tribal blocks.
- Distribution of Villages by population size. This will have implications on how to organize services in outreach, assignment of villages to the additional ANMs and ASHA's, addressing logistics issues for outreach services and communication activities.
- Identify blocks with higher proportion of small villages and poor road connectivity. This will have implications for designing outreach service delivery interventions
- Sex ratio: It is important to assess child sex ratio and plan interventions for effective implementation of PC-PNDT act as well as advocacy
- Distribution of Anganwadi Centres
- Literacy-male to female: Will help in designing of appropriate communication activities using more visuals than written material text
- Availability of civic amenities such as safe water supply, sanitary latrines. This information will help in planning for interventions with support from concerned line departments to increase access to safe water and sanitary latrines.
- Economic classification especially BPL distribution will help define estimations of JSY clients and also design interventions based on alternative health financing mechanisms...

3.3 Public health facilities and functionality of facilities-Templates 2, 3 & 4

Availability of health facilities and human resources are essential prerequisites to ensure health services. Firstly, it is important to know the different types of public health institutions in the district and secondly it is necessary to understand how many institutions are actually functional in terms of availability of critical staff position so that one gets a realistic picture of centres that are able to provide services. It is therefore, essential to know essential gaps of obstetricians, pediatrician, and anesthetists, staff nurses at CHC/PHC levels.

Public Health Infrastructure in the district -Template 2

Health Facility	Number	
	Government Buildings	Rented
District Hospital		
Medical College Hospital		
AYUSH Colleges and Hospitals		
Sub District		
Rural Hospitals		
UFWC		
CHC including Identified FRUs		
BPHC		
Sector PHC		
Subcentre		
Ayurvedic Dispensary		
Homeopathic Dispensary		

Note: The above list of health facilities is an illustration. Classify the type of health facilities as per the state classification

If possible a Map the facilities in the district by blocks should be included as part of the DHAP.

Human Resources in the district -Template 3

Staff	Sanctioned	In-Position	Vacant
Chief Medical Officer/AYUSH			
Deputy Chief Medical Officer/ Additional CMHOs, Additional DHOs or RCHOs/AYUSH			
Medical Superintendent-CHC			
Medical Officers including specialists (sub district facilities) / from AYUSH also			
Medical Officers/from AYUSH also			
Lady Medical Officers only if there is any separate cadre in the state)			
Lab technicians			
X-ray technicians			
Staff Nurse			
LHV			
ANMs			
Male MPWs			
District TB Officer			
Senior Treatment Supervisor (STS)			
Senior TB Laboratory Supervisor			
Staff provided under the Vector Borne Disease Control Programme like District Malaria Officer, Assistant Malaria Officer and, Malaria Inspector			
Mention any other category			

Functionality of District Hospitals ,CHCs, PHCs and Subcentres (in terms of availability of critical staff position)- Template 4

Critical Staff	No. of facilities	Names	Sanctioned	In Position	Vacancy
District Availability of staff needed for service Guarantees	**1**				
CHC Ob&Gy specialists (either qualified or trained), Pediatrician Anesthesist (either qualified or trained) at identified FRUs					
PHC Availability of a medical officer at PHC		Indicate blocks where more than 20 percent posts are vacant			
Sub Centre Availability of an ANM at sub centre (resident at sub-centre)		Indicate PHCs, with more than 10 percent posts are vacant			

***Health personnel on the contractual basis should be reflected separately**.

3.4 The analysis section:

Discuss templates 2, 3, and 4 together and draw inferences of the extent to which the public health infrastructure is geared up to provide health services and identify gaps.

- Percentage of facilities that are functional- analyze by categories
- Based on the spatial distribution of facilities and availability of staff, identify institutions that could be strengthened on a priority basis for providing services. Consideration could be made to issues such as road connectivity with such institutions and the population it caters. This will also help in identifying blocks that need additional inputs for making services available to the community or where demand side interventions such as ASHAs will be needed on priority.
- Functionality of a facility is also highly dynamic. As staff transfers are frequent and non-availability of critical staff such as specialists at FRUs or ANMs at SCs result in serious disruption in services, the analysis should identify such recurrent problems with a view to discuss the probable solutions in block meetings.

3.5 Logistics- Template 5

The existing situation of logistics management practices has to be captured. This is essential because, several studies have pointed out poor storage practices resulting in high wastage of commodities. Even though training on logistics management has been imparted, this seems to be a neglected area and the mechanism operating at present is more of a push system rather than need-based supplies. Streamlined logistics systems can help provide medicines, contraceptives, vaccines and other consumables to service providers in adequate quantity at right time and place and also help to reduce wastage.

Status of Logistics-Template 5

Logistics Elements	Description
Availability of a dedicated District warehouse for health department	
Stock outs of any vital supplies in last year	.
Indenting Systems (from peripheral facilities to districts)	
Existence of a functional system for assessing Quality of Vaccine	

In line with this several questions need to be answered and they are:

- Does the district have storage problems? Are supplies received from various National Health Programmes (NHPs), RCH and also from state resources are stored separately and separate stock registers maintained? Is there a need to reorganize the logistics function in the District to streamline storage of supplies?

- It will give some indication of how logistics system is functional in the district. These vital supplies could be immunization agents, condoms, IUDs, tubal rings, Vitamin A, ORS, Drug kits under RNTCP etc. description should highlight if there is any pattern in the stock outs i.e. in particular blocks or supplies related to specific programmes.

- An assessment of indenting systems will be very useful to understand if supplies are made on the basis of Pull or Push factors. This will also let the programme managers assess time lag in indenting and actual supplies and adequacy of supplies reaching the peripheral facilities

- District programme managers should assess the functioning of the reverse cold chain and the actions they take based on feedback reports of the vaccine quality. This could be a very sensitive indicator of the functionality of cold-chain logistics system.

3.6 Training Infrastructure-Template 6

Continuous capacity building of health personnel is one of the most important strategies envisaged in NRHM and RCH II programmes. A number of training programmes have been suggested in the different programmes so as to equip providers with knowledge and skills for delivery of services in adherence with standards of care. In order to carry out these trainings, it is imperative to have good training infrastructure competent staff members at the training institutions and necessary teaching aids. Information on training infrastructure along template 6 has to be collected by the district if there are any training institutions in the district. These institutions could be an ANM training centre, District training team or centre or even the regional training outfits in from of RFPTCs, Divisional Training centres etc. Private sector nursing training institutions should also be considered in this analysis.

If there is more than one institution, information on all the training institutions will have to be collected (For instance, the district has ANM training school and RFPTC then Template 6 will have to be used twice and information presented separately).

Status of Logistics-Template 6

Details about the training institution/s	
Name of the Institution:	**Key issues**
Physical Infrastructures Availability of lecture halls, place for training faculty, residential accommodation for trainees (men and women) , dining hall, furnitures, safe drinking water and electricity etc	
Provide details of Faculty (Sanctioned and In-position) with designation and specialization	
Availability of Teaching Aids, computers etc. Assessment of availability of common audio visual aids at the facility	
Availability of annual training plans for the last year and achievements of the plan?	
Availability of training calendar for the current year with clear cut time line for the training activities. <u>Training activities under NRHM:</u> i) Orientation / sterilization workshops on NRHM - District level officers of related departments, sub district level officers, elected PRIs, field NGOs, faculty of ANMTCs/DTCs, block panchayat and Gram panchayat ii) Training for strengthening of health system - ASHA training - Skill based trainings The districts are required to indicate the trainings conducted for all categories of health personnels with reference to the training load. The cumulative number of trained manpower and the number of trained during the current year along with percentage of achievement may be specified.	

The role of the Medical Colleges in training under National Disease Control Programmes should also be included.

3.7 BCC Infrastructure-Template 7

Another important crosscutting support programmatic area is the BCC. It will be useful to assess availability of resources to undertake demand generation activities in the district?? Hence for assessing BCC infrastructure in the district following information has to be collected. It is suggested to collect this information from the I/C of the IEC/BCC in district.

BCC Infrastructure in the district-Template 7

Human Resources for BCC i.e. District Media officers, Dy Media officers and block level staff Any trainings the staff has undergone in media planning or material development in past five years Any functional Mass media audio- visual aids such as 16 mm projectors, Video cameras, VCD/DVD players	
-Did the district prepare a BCC plan in the past year? -If yes, what BCC activities were planned and undertaken? -In the absence of plan, find out what BCC activities were undertaken?	
Are there other institutions available in the private sector for conducting communication activities using modern media or folk media???	

The above information and the areas of strengthening will be useful in planning for necessary inputs at the time of formulating the district health action plan.

3.8 Private Health Facilities and Type of Facilities - Template 8

In order to increase access to health care services, there is a need to explore the presence of private sector facilities in the district. Furthermore, with the government seeking public-private partnership through its programme, it becomes more important. Forging alliances through various schemes will enable in addressing the problem of access. Hence, there is a need to collect information on the number of private institutions and type in terms of:

Private Services Facilities	Number and location in case of sub district facilities.
Multi-Specialty Nursing Homes	
Solo Qualified Practitioners	
Practitioners from AYUSH	
Approved MTP centres in Private sector	
RMPs (Less than formal qualified practitioner)	
Number of nursing homes with facilities for comprehensive emergency obstetric care	
Accredited centres for sterilization service	
Accredited centres for IUD services	

- District may have some multi specialty nursing homes. It will be useful to have information on the maternity nursing homes so that these centres can be contracted for services under JSY after accreditation. Similarly, surgical nursing homes could be accredited for providing clinical methods of family planning under PPP.

- Solo practitioners can be important allies in enhancing access to services. In case district is planning to have social franchising models for RCH services, programmatic interventions could be worked out accordingly. Social franchising through these solo practitioners could cover services under the package of Primary RCH services, VCTC, STI management, microscopy and treatment

centre under RNTCP. Private provider facilities may be used as training sites, if they evince interest.

- Mainstreaming AYUSH is also one of the core strategies in the NRHM. Information about availability and spread of the qualified AYUSH practitioners in private sector will also help in developing programmatic interventions.

- Information on availability of approved MTP centres in private sector will help in developing PPP mechanisms for enhancing access for early and safe abortion services.

- NRHM proposes to optimally use services of a large pool of the diverse range of RMPs who practice in rural areas and urban slums. District planning teams may get a full picture through HH surveys. Capacity building programmes should be developed after taking in to cognizance their core competencies and also which health care needs cab be serviced through these practitioners

The information collected can be used for forging linkages with the private sector. Depending on the motivation of the private provider to be a partner in the PPP mechanism, appropriate strategies and interventions could be planned on the basis of facilities and expertise of the institution. During the district/block level consultations, there is a need to invite the private practitioners or heads of private institutions and for this purpose the help of local IMA /FOGSI /IAP /other associations of private doctors could be sought.

3.9 ICDS Programme - Template 9

This is one of the most critical programmes from the convergence viewpoints. The complementary nature of job functions of ICDS worker at the village level with that of the ASHA/ANM strongly vouch for convergence of services and assures better accessibility to health care services. Given this backdrop, information about the programme in terms of coverage, human resources will have to be collected.

Details of ICDS programme-Template 9

	Name of the block with ICDS Programme	Number of AWCs		CDPOs and ACDPOs		Supervisors		AWWs		AW helpers	
		S	F	S	IP	S	IP	S	IP	S	IP
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
	Total										

S=Sanctioned; F=Functional; and IP=In Position

When district and block level consultation meetings are planned, it is important to ensure the presence of ICDS functionaries. Joint monitoring meetings at sector or block level could be considered.
District Women and Child development officer will be in position to provide information on the functional AWCs, AWWs/helpers, Lady Supervisors and CDPOs in the district. It will be useful to know if there are more vacancies in the tribal blocks or in the sectors, which are in remote areas. Presence of any training institution for AWWs in the district will help in implementing capacity development programmes not only for AWWs but may be for ASHAs and other community based health resources.

It will be also useful to assess range of convergence activities with health sector in the district. Joint training of peripheral service providers, organisation of health day at AWCs with participation from Health functionaries, referral of severely malnourished children to health facilities are such activities.

4.10 Elected Representatives of PRIs - Template 10

The NRHM has placed strong emphasis in addressing local issues and solutions and making it community centric through the involvement of PRI's. In the process, the responsibility of preparing village health plans has been entrusted to the village health committee of the Gram Panchayats. It is therefore, necessary to get their views endorsed not only in the formulation process but also in implementation and monitoring of the programme. Information on the following will have to be collected:

Elected representatives to Panchayat institutions-Template 10

	Name of the block	Total panchayat villages	Total ZP members		Total BDC/Mandal members		Total Panchayat Pradhans	
			Male	Female	Male	Female	Male	Female
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
	Total							

The District Panchayat chief heads District Health Missions. NRHM implementation manual envisages that PRIs should have greater say in management of NRHM and this will set out a process of communitization. Information from this matrix will help to plan capacity development interventions for PRIs and also help the planning team to design local area -specific interventions with PRIs. Furthermore, it is possible to expend some earmarked resources at the level of PRIs.

3.11 NGOs & CBOs - Template 11

In the RCH programmes, mother and field NGOs are supported to organise service delivery activities in the district. The important role of non-governmental and community based organizations in community mobilization and ensuring their involvement is a proven testimony. NRHM strongly advocates their involvement and ownership, as essential pre-requisites for achieving the best results. Listing and locating

such resources in the district could be useful. Appropriate linkages can be planned and implemented through these agencies and carrying out demand-generation activities can be thought off.

NGOs & CBOs - Template 11

Names of NGOs	Key Activities in Health/Nutrition/community organisation	Block/Villages of NGOs operations

In many districts MNGOs and FNGOs are already working under RCH programme. There may be other NGOs actively working in areas of water and sanitation, nutrition etc. The District planning team may review these data for enhancing service access in under covered blocks/ sectors or even cluster of villages or working on the demand side.

3.12 Analysis of Key Health Indicators

In this section, an overview of health and reproductive and child health status of the district will have to be presented. The district level household survey (DLHS) supported by Government of India has covered most of the reproductive and child health indicators and the results for the 2002-03 round is available. This data has to be analyzed by comparing urban and rural areas, SC/ST and others, gender and by SLI. By doing so, one gets an idea of the utilization pattern among the different categories and will provide necessary inputs as to what needs to be done to enhance services. Besides this analysis, the service statistics data on health programmes have to be analyzed. Common diseases in the area, endemic pockets, and seasonality of diseases will have to be compiled. Blocks that have reported more number of cases of communicable and non-communicable diseases will have to be identified.

Refer steps detailed in Box for interpretation of DLHS data.

Box 1

- Analyze the trends in above indicators by selected background characteristics (urban/rural, SC/ST/others, gender and by SLI
- Compare with the state average and the best performing district in the state
- Draw inferences on the basis of the analysis

The above analysis should lead to identification of issues in terms of access, quality and demand**.** Further, examine the block-wise utilization of maternal health services to see variations through service statistics reports. This information will be further useful for conducting block level consultations.

- Identify blocks with poor or inadequate utilization and reasons there of.
- Also, look at utilization data by BPL and SC/ST category
- Summarize the reasons of poor utilization
- Identify the reasons and make a note such as staff vacancies

3.13 Maternal Health-Template 12

This template will give an overview of the utilization pattern of maternal health services in the district specifically by comparing urban and rural areas, SC/ST and others and by SLI. By analyzing trends from survey data, one gets an idea of changes in the utilization pattern over the reference period and what needs to be done to enhance the services. In here, we have restricted to just four indicators that pertain to utilization pattern, quality in terms of adherence to complete package of antenatal care services and complicated deliveries.

Examine the performance on the following indicators of:

1. Percent of pregnant women who availed complete package of ANC services
2. Percentage of institutional deliveries
3. Percentage of safe deliveries
4. Percentage of C-section deliveries
5. Percentage of Maternal deaths audited
6. Maternal mortality
7. Maternal death audit esp.
8. verbal autopsies

Note: Follow steps listed in Box 1

3.14 Family Planning – Template 13

An overview of the current use of modern contraceptives in the district will have to be synthesized in this template. Only one indicator on current use by methods has been considered while the other is on unmet need for family planning. The unmet need for family planning will help us in estimating the potential users who need to be identified, counseled and provided services of their choice. While analyzing these indicators, also look into the reasons for discontinuation or non-use among current non-users and highlight the major findings.

Examine the performance on the following family planning indicators of:

Summarize the salient findings in bulleted form by urban/rural & SC/ST

- Contraceptive use by methods
  - Limiting ------ NSV / Conv. Vasectomies
    Minilep
    Laparoscopic Sterilization
  - Spacing ------- IUD
    OC
    CC
- Unmet need by limiting and spacing
  - % of sub district hospitals / CHCs / Block PHCs providing Sterilization services
  - % CHCs / PHCs / Sub Centres providing IUD insertions
  - Number of facilities providing NSV services on fixed day
- Sterilization failures / any deaths / complications requiring hospitalization (Use data from District Quality Assurance committee)
- Implementation of National FP insurance scheme in the district
  - % of deaths / failures / complications compensated
- Quality care monitoring
  - % of deaths / complication requiring hospitalization / failures monitored by Quality Assurance Committee

Also, review contraceptive use in terms of state performance and for the best performing district from the RHS state reports. Rank your district in light of this information and later analyze block-wise data on sterilization from service statistics and identify good and low performing blocks. Find out reasons; this may be attributable to less number of certified providers for sterilization services or non-availability of contraceptive supplies.

The data for unmet need for limiting and spacing should be reviewed and also analyzed in with reference to Standard of Living Index (SLI). If unmet need for spacing is higher than state average, then draw your inferences and think of designing interventions to enhance access through alternate service delivery channels.

Any failures due to sterilization, deaths and major complications (requiring hospitalization) should be reviewed. If there are too many failures occurring in a particular block, then reasons in terms of skills of surgeons providing sterilization services and quality issues will have to be looked into and proper capacity building interventions will have to be planned.

3.15 Child Health - Template 14

The status of child health has to be summarized in the template. The indicators of child health relate to the immunization status of children (12-23 months), details pertaining to exclusive breastfeeding, prevalence of diarrhea and ARI and more importantly their nutritional status in terms of grade III/IV malnutrition. These indicators together will provide an essence of child health status in the district. While analyzing immunization status, also observe the dropout rate between doses and children who haven't received any dose of the vaccine. From the programme perspective, it is important to know the percentage of children who have not received any childhood vaccine at all. Further, it is necessary to understand the breastfeeding practices in the community and depending on that necessary behavioural change strategy will have to be devised at the time of formulating the action plan. Examine the following child health indicators of:

Examine the performance on the following child health indicators of:

Summarise the salient findings in bulleted form by urban/rural & SC/ST

- Full Immunization coverage rate (12-23 months)
- BCG-Measles drop out rates (should be less than or equal to 15 percent), DPT_1 to DPT_3
- Percentage of planned immunization sessions held
- Initiation of breast-feeding
  - Collustrum
  - Exclusive breast-feeding
- Incidence of grade III/IV malnutrition (collect from ICDS)
- Vitamin A coverage with two mega doses each year of children in 9-36 months
- Prevalence of ARI
  - Treatment seeking behaviour
- Prevalence of Diarrhoea
  - Treatment seeking behaviour
  - ORS use

It would be useful to scan the proportion of planned immunization sessions being held in the blocks and sector PHCs. If less than 80% sessions are being held in a particular area than this needs additional inputs for providing immunization services.

Proportion of newborn children being initiated with colostrums feeding within half an hour of birth needs to be reviewed. You may also like to get the information from the in-charges of major hospitals in the district regarding when breastfeeding is initiated in cases of institutional deliveries. Similarly data on prevalence of exclusive breastfeeding should be reviewed and any variations across blocks (if possible), socio cultural groups should be acknowledged. This would help in designing appropriate BCC interventions.

ICDS MIS is an important source for magnitude of malnutrition in below 6 yrs. Identify if there are blocks with high levels of severe grades of malnutrition. In block level meetings planning team may probe about the reasons for high prevalence, referrals to PHCs and guidelines being followed for the management of severe grades of malnutrition.

With reference to Vitamin A it will be useful to assess availability of supplies round the year, coverage with two rounds in the year and analyzing coverage with respect to SC/ST and gender parameters.

3.16 RNTCP, NVBDCP, NPCB, IDSP, NLEP & NIDDCP - Template 15

Information on these two diseases will have to be compiled along with other programmes under consideration. Until now, the planning for national health programmes has remained vertical. However, as part of National Rural Health Mission (NRHM), efforts will have to be made to evolve a bottom-up and an integrated planning process. Unlike RCH indicators, survey data on health is not available and hence will have to be compiled from district service statistics. The national monitoring of malaria and tuberculosis has confined to a few critical indicators that are compiled from the district-level. Information on these indicators will have to be put together and along with it, other health problems in the area will have to be stated block-wise and presented in Template 15. In the remarks column, specify seasonality and endemic pockets that may need attention during plan formulation. If disaggregated data is available then it can be useful.

The information on malaria indicators should be available with the AMO (person responsible for malaria programme in the district). This information needs to be reviewed in the light of the state API, plasmodium Falciparum rate, and any deaths due to malaria or resistance to Chloroquine. It would also be useful to review the slide positivity rates (total and parasite specific) as per blocks as the distribution of parasite may vary in blocks.

Examine the performance on the following indicators of:

Summarize the salient findings in bulleted form by urban/rural & SC/ST, Male/Female

- Collect information on API for Malaria
  - Endemic pockets
- Slide Postivity Rate and Plasmodium Falciparum Rate (PFR)
- Annual Blood examination Rate
- Number of Fever Treatment depots and DDCs

Collect information for the TB programme

- Percentage of TB suspects examined out of the total outpatients.
- Annualized New Smear Positive (NSP) case detection rate per 100,000 population
  - It is the no. of new smear positive tuberculosis cases registered for treatment in a year per lakh population. In India, the estimated incidence of NSP cases is 75 per 100,000 population per year. The national goal is to detect at least 70% of the estimated cases, such as, 53 NSP cases per 100,000 population per year.
- Annualized Total Case detection rate per 100,000 population
  - It is the number of total TB cases (new and re-treatment) registered for treatment per 100,000 population per year.
- Treatment success rate
  - Percentage of new smear positive patients who are documented to be cured or to have completed successfully treatment. The global and national goal is to achieve and maintain atleast 85% treatment success rate among the new smear positive cases registered for treatment. This indicator is reported 13-15 months after patients are registered for treatment.

Collect information for National Programme for Control of Blindness

- Cataract Surgery Rate (CSR): Targeted CSR is up to 450/100,000 population over 3 years
  - Analyze data for gender (ensure more that 50% coverage in women)
  - SC/ST
  - Economic criteria (at least 60% people living below the poverty line)
  - At least 80% of the surgeries should be having IOL
- All School children in the age group of 10-14 years should be screened for refractive errors
  - Percentage of children detected with refractive error should be 5-7%
- Also identify number of screening camps organised last year, personnel trained, service delivery points having quality assurance guidelines, percentage of teacher's trained, number of NGOs receiving assistance and beneficiary assessments.

Collect information for National Leprosy Eradication Programme

- PR – Leprosy cases per 10,000 population
- ANCDR – New leprosy cases per 1,00,000 population
- Proportion of MB, Female, Child, ST, SC cases among the new cases among the new cases detected
- Proportion of Patients completed treatment (RFT)

Collect Information about activities undertaken for IDSP in the district

- Percentage of facilities sending their reports in time
- Up gradation of labs
- Training of staff in disease surveillance

Collect Information about activities undertaken for IDD in the district

- No. of persons suffering from IDD
- Number of persons consuming Iodated salt

The district tuberculosis officer who is also reporting person for RNTCP should be in the position to provide information on the key performance indicators for the programme. If the district is lagging behind with the state averages then the planning team should assess the reasons and what all needs to be done to improve the programme performance.

Similarly Information on the performance indicators of NPBC and NLEP should be obtained from the respective programme officers in the district.

The list should include District Malaria Officer (DMO) and not AMO as the person responsible for implementation of Vector Borne Disease Control Programme in the district.

3.17 Locally endemic diseases in the district - Template 16

Locally endemic diseases in the district

Names of locally endemic diseases such as JE, chikengunya, filariasis, endemic goitre, kala azar, endemic flourosis or other occupational diseases Chemical contamination of water sources or other zoonotic diseases such as Anthrax etc	Names of affected Blocks

In some districts there may be endemic health problems and DHAP should reflect on the strategies to respond to these problems. The information could be obtained from the hospital MIS or through surveys/ research. Any research reports available should also be reviewed. The distribution of the diseases as per blocks or cluster of villages (in cases of chemical contamination of water sources) should be mapped.

3.18 New interventions under NRHM - Template 17

NRHM activities are being implemented in the districts since 2005-06. It will help the planning team to review performance with respect to certain key activities.

This is not an exhaustive list of the activities which district may have undertaken during the last year under NRHM. Opportunity should be taken to analyze the reasons for low performance such as in case of ASHAs, or disbursements for JSYs or registration of RKS etc.

	Activity	Goal for District	Achievement %
1.	Number of ASHAs selected		
2.	Number of ASHAs undergone First Orientation training for seven days		
3.	No of Fully trained Accredited Social Health Activist (ASHA) for every 1000 population/large isolated habitations.		
4.	Number of clients benefited under JSY		
5.	No of Village Health and Sanitation Committee constituted and untied grants provided to them.		
6.	No of 2 ANM Sub Health Centres strengthened/established to provide service guarantees as per IPHS,		
4	No of PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS.		
5	No of CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS.		
6	No of Sub Divisional Hospitals strengthened to provide quality health services.		
7	No of District Hospitals strengthened to provide quality health services.		
8	No of Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals.		
10	No of Untied grants provided to each Village Health and Sanitation Committee, Sub Centre, PHC, CHC to promote local health action.		
11	Annual maintenance grant provided to every Sub Centre, PHC, CHC and one time support to RKSs at Sub Divisional/ District Hospitals.		
12	Systems of community monitoring put in place.		
13	Procurement and logistics streamlined to ensure availability of drugs and medicines at Sub Centres/PHCs/ CHCs.		
14	No PHCs/CHCs/Sub Divisional Hospitals/ fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB, HIV/AIDS, leprosy etc.		
15	District Health Plan reflects the convergence with wider determinants of health like drinking water, sanitation, women's empowerment, child development, adolescents, school education, female literacy, etc.		
16	Facility and household surveys carried out or not		
17	Annual State and District specific Public Report on Health published		
18	Institution-wise assessment of performance against assured service guarantees carried out.		
19	Mobile Medical Units provided		.
20	No. of Ayush dispensaries re-located to PHCs		
21	No. of PHCs where AYUSH physicians appointed		

Chapter

5

5.1 Block Level and Stakeholders Consultations

Towards ensuring that the district health action plans (DHAPs) represent the voices on the ground and address community's needs in the area of holistic health care, it is proposed to hold block level consultations in each block of the concerned district. National Rural Health Mission (NRHM) places emphasis on community participation and need-based service delivery with an improved outreach to disadvantaged communities. In keeping with this focus, the outcome of the block level consultations will be a vital part of the information to guide district plans. The information brought forth from the village to the Gram Panchayats (GPs) and subsequently presented at the block level consultation is not expected to be comprehensive but should be indicative enough to help prioritize activities and budgets of different sectors which will be included in the overall district plan.

There are several enabling ingredients in the policies, plans of the state, districts, the health and family welfare programs under NRHM. The trick is to identify the enablers, the opportunities and use them to turn around existing constraints and problems. Block level consultation is one such opportunity that can help the community and the service providers jointly identify the ways in which they can plan to effectively meet their needs under NRHM.

5.2 Why undertake block level consultations to prepare a district action plan?

Objectives:

- To actively engage a wide range of stakeholders from the community, including the panchayats, in the planning process
- To identify local issues and concerns as well as vulnerable groups and areas to reach consensus on feasible solutions/intervention strategies
- To take advantage of opportunities for inter sectoral convergence that exist at the block level in making the planning process more holistic in nature
- To identify priorities at the grassroots and carve out roles and responsibilities at the panchayat and block levels in design and implementation of DHAPs for greater ownership and need-based implementation of NRHM

It is expected that the district planning process will harmonise the information received through the different block level consultations to identify sectoral and geographical priorities and accordingly request line departments to undertake activities on priority basis in the identified panchayats. Specific health related information that emerges from the block level consultation could be utilised by the Medical Officer/s as a part of the facility planning process. The health information that is outside his/her purview will be taken up for discussion at the district consultation with the presence of CMHO/RCHO for prioritization by the health department.

5.3 What is the approximate timeframe to prepare for and hold block level consultations? Who will facilitate the entire process?

The district level planning team should engage a designated facilitating agency or the MNGO/FNGO to facilitate the process so that the consultations can be completed in an efficient and timely manner. If an NGO or MNGO/FNGO is not available for a given block/s an external agency from the district or from the neighbouring district can be identified. The following generic criteria should be kept in mind while identifying the agency:

- Involved with the development/social sector
- Familiar with health issues, government programmes and schemes and has an understanding of the field/community
- Has staff (both men and women) with analysis and documentation skills required to facilitate the process and to deliver in a timely manner

The timeframe is likely to be about a month and a half for the full process. The preparatory processes can be started simultaneously and should take about a month. The next 15 days should be used to hold the actual consultations in each block of the district, set priorities and finalise outcome of the consultation for each block. This kind of planning will allow the district planning team to participate in consultations in all blocks.

The district planning team will have to decide the steps it will like to follow to engage with the panchayats and the community, based on which the time taken may vary from district to district. However, on an average any given district should not take more than 45 days to complete the process.

It is a novel idea to involve MNGO/FNGO or an external agency for facilitating block level consultation. However, the issues of sustainability uniformity, contents and the quality of the outcome need to be looked into. It would be more appropriate if the district health plan is empowered to carry out such consultations by involving MNGO/FNGO.

5.4 What preparatory processes need to be undertaken before holding the consultation?

Step I

An administrative block is likely to consist of about 30-40 gram panchayats. While the block level consultation will involve the Sarpanches from these panchayats, it will be necessary that the information they provide capture the situation and the needs on the ground. The MNGOs/FNGOs already involved under RCH 2 should be made a part of this process. To facilitate this process, the concerned facilitating agency/ NGO/ consultant needs to hold a one-day orientation of the gram panchayat representatives (at least two from each GP) and share an indicative checklist on the basis of which information on health concerns can be collected and subsequently shared at the block level consultation. The checklist does not aim to collect household level data on health indicators. DLHS data may be referred to give a general sense of the district and further supplemented with facility level service data, if possible. The checklist is aimed at understanding the access, demand and quality related concerns in accessing health services and priorities of the GP to address these concerns. (Refer to the checklist 1).

On the service side, the medical officers can be requested to bring to the block level consultation information on health resources available in the block. This could include information on health facilities- govt. and others ayurveda/ homeopathy/ unani dispensary, private nursing homes and clinics, government and private sector testing laboratories, essential staff, equipment and supplies and infrastructure. The gaps in resources should be highlighted at the consultation.

To summarize Step I,

- Involve MNGOs/FNGOs in the process of holding block level consultations
- Orient Gram panchayat representatives on the process and collection of village/ GP level information prior to the consultation
- Share and explain the use of the indicative checklist to collect GP level information. Remember that the checklist is only indicative and should be modified based on assessment at the field level as to the kind of information that will be useful and easily available.
- Service side information to be collected and gaps identified by the medical officers
- If possible, complement the information collected from the GPs with block/sub-centre level service data available at the facilities

Step II

The NGO/ facilitating agency will consolidate the information received from the different gram panchayats and if possible, organise a one-day meeting for the validation of information received and filling of information gaps if any. The discussions will also be aimed at each gram panchayat arriving at the priority areas that it would like to address under NRHM.

If the one-day meeting to validate information is not possible, then discussion on priority setting should be held during the consultation where both the panchayat members and the health staff will place on the table their priorities. The NGO/facilitating agency will consolidate the information collected from GP and circulate a brief note providing a consolidated picture during the consultation. (Format for preparing the brief note based on an analysis of access, quality and demand side concerns is at checklist2).

To summarize, Step II

- Following the collection of GP level information, the facilitating agency/NGO to hold a meeting to validate the information (optional, to be held only if possible)
- Facilitating agency/NGO to consolidate the information collected and prepare note for circulation based on the indicative format at checklist 2. Service side information should be taken from the concerned medical officers.
- The panchayats and the service providers to undertake priority setting during the consultation based on the consolidated picture presented by the facilitating agency/NGO

5.5 Who will participate in the block level consultation?

It will be useful to include people from diverse sectors to bring in a range of perspectives – each from his/her own lens. The team players will be:

- Sarpanches from the Panchayats
- Pradhan of the Panchayat Samiti
- Representatives from the district planning team
- Child Development Project Officer, ICDS
- Block Development Officer
- Block Medical Officer and health service providers
- Education extension officer
- Other community representatives
- Representatives of local NGOs/CBOs
- Other line department officials linked with NRHM functioning at the block level

It would also be important to include some very important stakeholders in the process of block planning

- Service Associations of the Health Staff existing .E,g ANMs Association, Anganwadi Association etc
- Occupational Groups like fishermen , miners etc
- Representatives of the disadvantaged groups esp women and the disabled

What methodology will be followed for holding the actual consultation?

The consultation should be chaired by the Chairperson of the Block mission – the Pradhan of the panchayat Samiti and may be co-chaired by the BDO and the MO, Block PHC/CHC.

Suggested Agenda for the Consultation

- Objectives of the consultation (district planning team)
- Briefing on the preparatory process followed (facilitating agency/NGO/consultant)
- Outcome of the information collected and analysed from community and service providers (facilitating agency/NGO/consultant)
- Discussion and highlights of the service gaps and concerns of the service providers (MOs/ frontline functionaries/others)
- Discussion on the community concerns and priorities (sarpanches/woman representatives/ NGO/Asha /ANM/Anganwadi worker)
- Agreeing on key problems and solutions and presentation of the matrix to the district planning team (facilitating agency/NGO/consultant)

Step I: Problem Identification

The general process of the consultation should include a sharing of health priorities by each Sarpanch based on his/her interactions in the GP and the information collected. Information will also be shared by the NGO on the outcome of the discussions held with the women's groups and their concerns. This will be followed by a presentation from the NGO/ facilitating agency on the overall picture emerging from the information collected through the checklist and that provided by MO/service providers. Based on discussion on both demand and supply side concerns in the block, the priorities should be set and agreed. Following indicative format may be used for the purpose identifying the problems, corresponding solutions.

Indicative example of a problem – solution matrix,

Problem	Main Causal factor/s	Solutions	Primary Role
E.g. Poor maternal health	Distance, connectivity, home deliveries, costs involved	Possibility of strengthening ANM skills, input on skilled birth attendance, training of TBA, role of Asha in accessing JSY for transport and institutional delivery	Health department Panchayats SHGs
E.g. High incidence of malaria	Delayed identification of cases, limited access to medicated bed nets, limited elimination of breeding sites for mosquitoes	Improved service outreach and early detection	Health department Water and Sanitation Panchayats
E.g. Minimal no. of functional and safe ANM quarters	Lack of running water and safety, located away from habitation	Making the residential quarters functional – use of untied funds, addressing grievances of the ANM, taking safety measures. Taking innovative measures such as ensuring that the ANM stays at least 2-3 times each month till the problems are completely sorted out. Providing information to community of her availability and ensuring her safety on these days	Panchayats/NRHM CBOs
E.g. Limited ANC coverage and lack of community ownership of the outreach services and its monitoring	Women and children from remote/tribal hamlets not included, lack of awareness about services to be expected during outreach sessions (urine exam during ANC, taking weight, use of auto-disenabling syringe),	Executing demand-side strategies – building awareness among panchayats and SHGs on services to be expected through outreach, ward panches take responsibility for supervising outreach sessions and monitor time spent by the ANM, to ensure involvement of Asha and AWW, panchayat to identify and ensure better coverage of unreached areas, joint orientation of	Health department/NRHM Panchayats /SHGs Women and child development department

Problem	Main Causal factor/s	Solutions	Primary Role
	limited home visits by ANM, lack of coordination between AWW, ANM and Asha	GP, AWW, ANM and Asha under NRHM	
E.g. Staff vacancies - ANMs and medical officers	Transfers, post not filled yet, leave of absence	Expediting filling of posts, recruiting contractual ANM/s, exploring options for partnership with private sectors, organising PHC level camps with wide publicity	Health department
E.g. Greater stock-outs during rains/landslides as facilities become inaccessible	Limited systematic planning of demand for drugs based on seasonal illnesses and inaccessibility during certain periods	Requesting stocks on priority while anticipating gaps in supply during specific periods, improved planning to address seasonality of health care seeking behaviour and pattern of illness, Close monitoring of incidents of stock-outs and corrective action taken, identifying alternative sources of supply – social marketing options	Health department
E.g. Poor coverage for immunisation amongst children, especially girls from BPL families	Lack of information, limited access to services, provider attitudes, limited outreach to fringe/remote areas	Close monitoring by ANMs, greater coordination between Ashas and Anganwadi workers, involvement of ward panchs and SHGs in identifying critical households and ensuring service, involvement of local informal / caste leaders to help in breaking myths, providing service information and ensuring coverage.	Health department, Women and Child Development department, panchayats, SHGs, informal leaders through CBOs

Other critical areas of priority could include improving ANC coverage, reduction in home deliveries, improving outreach to remote areas – especially in case of immunisation and nutrition, addressing specific problems of women, etc.

What will be the outcome of this block level process? How will it contribute to the district plan?

The facilitating agency/NGO will prepare a detailed report of the consultation and forward it to the district planning team. The report will consist of general details of the discussion and agreed priorities –both service side and community side included. The information collected from the GPs and the women's groups will be annexed to the report.

The district planning team can use the information received from each block level consultation to prioritize activities and resources as a part of the district health action plan. It will also be useful in identifying vulnerable pockets and isolated areas requiring greater attention. The priorities arrived at through the block level consultation will also concern sectors such as sanitation, drinking water,

women and child development. Therefore, the block level report will also help steer discussions during the district consultation on inter-sectoral priorities and budget allocations by other line departments.

To summarize, through the block level consultation information will be available on

1. Community level health concerns, specifically those of women and vulnerable groups
2. Concerns of the providers and service gaps as identified by the functionaries at the block level
3. Geographical areas/panchayats requiring greater focus and attention
4. Possible roles that need to be played by the panchayats and community groups such as the self-help groups
5. Areas for inter-sectoral dialogue, coordination, budget and activity planning

Checklist 1

For collecting information at the Gram Panchayat level

A. Status of households

Name of the GP:
Total no. of villages under the GP:
Approx. total population/total no. of households
Average households per village in the GP:
Total no. of hamlets (specifically mention tribal hamlets if any)
Total no. of BPL households
Total no. of households that own agricultural land
Total no. of households involved in wage labour more than 6 months a year
Total no. of women headed households (widows or families where male members have migrated)
Total no. of births registered in 2005: No. of boys - No. of girls -

B. Information on resources

No. of villages not connected by motorable road:
Average distance of villages from the nearest Primary Health Centre (PHC)
Average no. of tube wells/ handpumps/piped water supply per village
Approx. no. of households with functional toilets
No. of functional ANM residential quarter/s
No. of functional sub-centre/s with ANM
No. of functional Anganwadi centres with Anganwadi worker and helper
No. of villages connected with electricity and /or telephone connectivity
No. of private medical practitioners in the GP
No. of Registered Medical Practitioners in the GP
No. of trained Traditional birth attendants in the GP

C. Information to be collected through the Village Health Committee

Average household health related annual expenditure
In general, the type of illness/ health condition where private healthcare is availed
In general, the type of illness/health condition where public healthcare is availed
Average no. of times that money is borrowed to meet health expenses
Average amount borrowed
Proportion of home deliveries to total deliveries
No. ANM outreach sessions held in the last 3 months
No. of health drives undertaken in last six months – chlorination of wells, toilets built under TLC, distribution of medicated bednets, mop-up immunisation drives, ORS distribution, drives to ensure inclusion of children from vulnerable households in Anganwadi, etc.

D. Information to be collected during women's group meeting at the gram panchayat level

(The meeting can be facilitated by an NGO/Asha or Sahyogini/women's development worker and should involve at least 2 women's group representatives from each village)

Separately mention for each, what are the common health problems faced by women, men and children?
Where do you go in case of a health problem? Sub-centre, PHC, to a private provider or a local village person or Dai/TBA or use home remedies

In your perception, what is the reason for a majority of health problems? Water, sanitation, lack of food, lack of services or bad quality services or lack of awareness and knowledge, etc.

If you had to improve the health status of your village what would be your priorities – access to safe drinking water, better sanitation and access to toilets, improved access to public facilitates or access to financial resources to avail healthcare or access to a health worker closer to home, etc. Specifically highlight two most important priorities for the group.

What is your perception of the

What are your expectations from the panchayat to improve the status of health in your village?

Checklist 2

Format for the consolidated picture emerging from the GP level information

To start with, summarise general information on status of households and resources in Gram panchayats

(i) An analysis of BPL households and vulnerable households- on an average per gram panchayat state the number of households that require close monitoring by the panchayat and service departments to improve access and quality to services (this number will include household information collected from points A. 6, 7, 8, 9 of the checklist)

(ii) An analysis of bottom five GPs with lowest numbers of girls to boys born in 2005 – requiring health department intervention in implementing Act against sex selection, closer monitoring on misuse of ultrasound, monitoring of birth registration of panchayats, community monitoring to ensure early registration and tracking of pregnancy until delivery with the help of Asha and AWW (point A.10)

(iii) No. of GPs with no ANMs/ non-functional sub-centres or non-functional ANM quarters – requiring intervention from panchayat and health department/NRHM (point B.5, 6)

(iv) No. of villages requiring anganwadis/ Anganwadi worker or helper (point B.7)

(v) No. of GPs where TBAs require stipulated training on recognising emergency signs, information on referrals and safe delivery kits (point B. 11)

(vi) No. of GPs showing in general a high utilisation of private sector services irrespective of the seriousness of the illness – this information should be seen in the context of which GPs are also showing larger no. of times that money is borrowed to meet health expenditure. The analysis should signal improved service outreach to vulnerable populations who are accessing private sector services through borrowed resources (point C. 2, 3)

- Area-wise division of areas in the block with greater no. of home deliveries (point C. 8)
- GPs with no outreach session held in last three months (point C. 9)
- GPs with no health drives initiated in last six months (point C. 10)
- Concerns of women (point D.)

a. Mention the health facility/ provider most frequented by women
b. List the most common health priorities highlighted by women
c. List the general expectations of women from panchayats with regard to health
d. GPs with no AYUSH infrastructure

Chapter

6

Setting Objectives of the DHAP

The District Planning team entrusted with the task of formulating DHAP should take into account the state NRHM PIP and the Memorandum of Understanding between the state and the national government. In line with the state goals, the district should make an attempt to complete the following matrix, which is illustrative.

The inputs for this matrix will largely come from the situational analysis conducted (as indicated earlier in the chapter 4) and the block-level consultations should guide you in deciding what a district can achieve pragmatically, in the given time frame. This apart, block level consultation will also enable in identifying the geographical distribution of the interventions and what blocks/ cluster of village's needs special attention for achieving certain outcomes. Additionally, problems such as adverse sex ratio (based on census data) or endemic health problems have to be factored in.

The NRHM implementation framework makes a strong reference to achieve outcomes for the defined outlays and allocations. Hence it is critical to provide quantified outcomes that are clearly measurable in the district context, without spending too many resources on means of verification. Following matrix lists quantifiable objectives, which may be considered by the District planning teams.

Objectives to be Achieved by the district	Current levels i.e baseline (give data sources if possible)	Levels to be achieved in 07-08	Levels to be achieved in 08-09
1. Universal coverage of all pregnant women with package of quality ANC services as per national guidelines	DLHS, 2003-04		
2. Increase in deliveries with skilled attendance at birth including institutional deliveries	MIS & Surveys		
3. FRUs (including DHs, CHCs/PHCs) made functional as defined in the National RCH 2 PIP	MIS		
4. Universal coverage of all eligible pregnant women under JSY scheme	MIS		
5. Increase in percentage of new born babies given colostrums	Survey		
6. Increase in prevalence of exclusive breast feeding	Survey		
7. Increase in percentage of fully protected children in 12-23 months as per national immunization schedule	Survey		
8. Universal coverage with Vitamin A prophylaxis in 9-36 months children	MIS & Survey		
9. Percentage of severely malnourished children below 6 yrs referred to medical institutions	ICDS MIS		

Objectives to be Achieved by the district	Current levels i.e baseline (give data sources if possible)	Levels to be achieved in 07-08	Levels to be achieved in 08-09
10. Unmet demand for contraception -Spacing -Limiting A. Number of Govt. Health Institutions providing: i) Female sterilization services } DH/ SDH / CHC / PHC ii) Male sterilization services } iii) IUD insertion services --------- CHC / PHC / SC B. Number of accredited private institutions providing: i) Female sterilization services ii) Male sterilization services iii) IUD insertion services	Survey		
11. Number of health institutions in PHCs/CHCs offering ARSH services	MIS		
12. Number of health institutions providing services for management of STIs and RTIs	MIS		
13. Performance indicator for NVBDCP -API for MP -Annual blood examination rate for MP increased (over 10 % of all OPD cases) -Slide Postivity Rate -Number of deaths due to malaria	MIS MIS		
14. Performance indicator for RNTCP -Percentage of TB suspects examined out of the total outpatients -Annualized New Smear Positive (NSP) case detection rate per 100,000 populations -Annualized Total Case detection rate per 100,000 populations -Treatment success rate	MIS		
15. Percentage (as planned) of ASHAs functional in the district (received induction training)	MIS		
16. Number of RKS registered /established	District reports/FMIS		
17. Number of Health care delivery institutions upgraded – SHCs – PHCs – CHCs to FRUs fulfilling the 4 basic criteria in FRU guidelines Upgrading to IPHS will come later (these institutions should be in conformity with IPHS)	District report/FMIS		
18. Village health and sanitation committees Constituted – Grants given	District report/FMIS		
19. Number of SCs strengthened – Additional ANMs hired – Annual maintenance grants given	Partly from MIS/District financial reports		
20. Number of PHCs strengthened to provide 24x7 – 3 staff Nurses hired – Annual maintenance grants given	District reports/FMIS		

Objectives to be Achieved by the district	Current levels i.e baseline (give data sources if possible)	Levels to be achieved in 07-08	Levels to be achieved in 08-09
21. National Blindness Control Programme - Cataract surgery rate (450/100,000 population) -% surgery with IOL - School Eye Screening in the age group of 10-14 years should be screened for refractive errors - Oral Health Screening for: Community School Children	MIS		
22. National Leprosy Eradication Programme - PR – Leprosy cases per 10,000 population - ANCDR – New leprosy cases per 1,00,000 population - Proportion of MB, Female, Child, ST, SC cases among the new cases detected - Proportion of Patients completed treatment (RFT)	Monthly Progress Reports from States		
23. Integrated Disease Surveillance programme - Number of labs to be upgraded (L1 and L2) - Number of staff to be trained in surveillance activities			
24. Staff for mobile medical units in place 25.	MIS		
26. Number of facilities to be covered for facility survey - SHCs - PHCs - CHCs			
27. Number of Villages to be covered for HH survey			
28. Number of Community hearings planned			
29. District Training plan developed and implemented			
30. District BCC plan developed and implemented			
31. District Procurement and Logistics plan developed			
32. No. of PHCs/CHCs where AYUSH physicians posted	Survey		

The district planning team after weighing the pros and cons of the field situation and considering the past trends and additional inputs that are forthcoming should set realistic objectives and there has to be consensus on what has been proposed. Further, the teams will have to consider different options of achieving the objectives. The exercise of detailing out strategies and interventions can be carried out after block-level consultations.

During the block-level consultations, the situational analysis from DLHS and service statistics data comprising of block-level analysis on few critical indicators should be shared in the form of power point presentations. Later, the objectives decided by the district can be shared and the views of block stakeholders can be solicited. Further, the district planning team can use a simple process by conducting **force field analysis** to determine the pros and cons of achieving each of the objectives stated above. An illustration of how it can be applied is shown below:

Force-field analysis is a useful technique for assessing all forces for and against a decision. In effect this is a specialized method of weighing pros and cons.

By carrying out this analysis one can:
- ❑ Plan to strengthen forces supporting a decision
- ❑ Plan to reduce impact of opposition

The following steps have to be adopted:
- ❑ List all forces for change in one column
- ❑ List all forces against in another column

Once you have these viewpoints you can decide if you wish to go ahead with the proposed objective or would like to make any changes at this stage.

Example: Force-Field analysis for Institutional Delivery

Factors for Change	**Objective**	**Factors against change**
▪ JSY will facilitate/financial incentives ▪ Additional ANMs/SNs ▪ BCC for danger signs ▪ People value Institutional Delivery	Increase Institutional delivery from current *20*% to *40*% in 2 years	▪ Social/cultural norms for HH delivery ▪ Women from BPL treated with contempt in facilities ▪ Staff not available round the clock ▪ Staff takes money

After the force-field analysis is carried out for each of the objectives, then the block will have to determine ways of addressing the stated objectives.

Suggested list of Interventions to address the objectives

It is important for district planning teams to be aware of evidence based technical strategies to achieve programme goals. In following matrix an attempt has been made to give the plausible list of interventions can be suggested, which the district can choose or add and convert them into activities. An indicative matrix of strategies by programme areas has been compiled and shown below. Specific strategies could emerge during the consultative meetings at block and district levels. These specific strategies should be factored in during the formulation of work-plan and budget.

To achieve the established programme objectives, the strategies and interventions will have to be planned on the basis of suggestions obtained during block-level consultation meetings. As the format for getting inputs proposes to use access, quality and demand framework, it is necessary to define the strategies for programme areas by these parameters.

Merely identification of strategies and interventions, although necessary as a first step, is not sufficient. Activities to operationalize these strategies will have to be identified. This process manual does not plan to give a menu of activities, as this may preclude discussions.

Objectives & Strategies

District Plan Objectives	Suggested Strategies
1. Universal coverage of all pregnant women with package of quality ANC services as per national guidelines	◆ Schedule out-reach sessions for ANC especially in inaccessible areas/ blocks by developing visit schedules and activity plans ◆ Re-orient ANMs in new guidelines for ANC as an integral component of SBA ◆ Ensure availability of supplies i.e. ANC kits such as BP instrument, foetoscope, Hb measurement, Urine examination ◆ Organise demand side so as to encourage pregnant women to seek care as per schedule
2. Increase in deliveries with skilled attendance at birth including institutional deliveries	◆ Civil works in form of labour rooms at facilities ◆ Additional human resources ANMs at sub centres ◆ Skill up gradation of ANMs in SBA ◆ Need based supplies for normal deliveries ◆ BCC: linkages with ASHA
3. FRUs (including DHs, CHCs/PHCs) made functional as defined in the National RCH2 PIP	◆ Establishment of Blood Storage Facilities ◆ Civil works in identified facilities for LR, OT and staff residences ◆ Need based supplies of equipments/drugs ◆ Deployment of critical staff as per guidelines ◆ Skill up gradation of Doctors – life saving skills in anesthesia, Emergency Obstetric Care (CS Section) ◆ Training in Management of common obstetric complications
4. Universal coverage of all eligible pregnant women under JSY scheme	◆ Adapt / Develop district specific guidelines for eligibility, transfer of money and reporting mechanisms ◆ Accreditation of private providers for eligible for benefits under JSY ◆ BCC strategy for the communication objective of raising awareness
5. Increase in percentage of new born babies given colostrums	◆ Orientation of community based functionaries such as AWWs/TBAs/ASHAs ◆ BCC with women's group and PRI members
6. Increase in prevalence of exclusive breast feeding	◆ Orientation of AWW/ASHA on lactation management ◆ Communication activities
7. Increase in fully protected children in 12-23 months as per national immunization schedule	◆ Development of facility based micro plans for out-reach sessions ◆ Cold chain plan ◆ Surveillance of VPDs ◆ BCC for Immunization
8. Universal coverage with Vitamin A prophylaxis in 9-36 months children	◆ BCC ◆ Ensuring supplies of Vit A through distribution system
9. Percentage of severely malnourished children below 6 yrs referred to medical institutions	◆ Orientation of AWWs on grade III and grade IV malnutrition. ◆ Orientation of Doctors at PHCs in management of grade III and grade IV
10. Unmet demand of Contraception – Spacing – Limiting	◆ BCC on contraception ◆ Alternative service delivery mechanism for FP supplies ◆ 24 x 7 PHCs provide regular clinical contraceptive services including IUD insertions & IUD insertion ◆ Accreditation of private providers for providing sterilization of IUD services ◆ Skill upgradation of Doctors in IUD insertion, male & female sterilization ◆ Skill upgradation of ANMs in IUD insertion

District Plan Objectives	Suggested Strategies
	◆ Regular contraceptive update trainings to health providers ◆ Need based supplies ◆ Block PHCs / CHCs / Sub District Hospital to provide fixed day female and male sterilization services
11. Number of health institutions in PHCs/CHCs offering ARSH services	◆ Orientation of MOs and ANMs in ARSH services ◆ Linkages with WCD/Education department
12. Number of health institutions providing services for management of STIs and RTIs	◆ Skill upgradation in new management protocols ◆ Hiring of lab technicians ◆ Need based equipments/supplies
13. Performance indicator for NVBDCP – API for MP – Annual blood examination rate for MP increased (over 10% of all OPD cases) – Slide Postivity Rate – Number of deaths due to malaria a. Malaria – As given in the document b. Filaria – Percentage of target population consumed DEC during MDA (Applicable to endemic states only) c. Kala-azar – Number of kala-azar cases detected and received complete treatment	◆ Identify pockets populations at risk to have increased access to early diagnosis and prompt treatment. ◆ Activities such as antyi larval measures and spray to reduce malaria transmission using appropriate preventive measures. ◆ Ensure inter-sectoral collaboration at different levels to achieve the collaboration between health and related sectors, private and NGO sectors etc. ◆ Bring about an improvement in surveillance, epidemic preparedness and response. ◆ Emphasize upon Behavioural Change communication and social mobilization. ◆ Human resource development and capacity building. ◆ Convening meeting of district coordination committee under the Chairmanship of District Collector ◆ Identification and training of drug distributors at the village level ◆ All PHCs/CHCs having the facility for diagnosis and treatment of kala-azar cases. ◆ Quarterly observance of kala-azar fortnight for active cases detection.
14. Performance indicator for RNTCP – Annual case detection rate – Proportion of new positives out of total new cases – Treatment Success Rate – Conversion Rate	◆ BCC for improved treatment seeking behavior for TB suggestive symptoms ◆ Improvement in case finding activities in terms of strengthening, identification and referral of TB suspects ◆ Quality assurance of sputum microscopy network ◆ Ensure proper categorization of TB patients ◆ Ensure treatment compliance by the patient ◆ Ensure regular drug supply
15. Performance indicator for NLEP District Plan Objective - Further reduce prevalence at district and sub-district level - Reduce new case Detection Rate gradually - Provide quality leprosy services to all leprosy patients	◆ Ensure quality diagnosis and proper categorization of patients at PHC ◆ Ensure completion of treatment ◆ BCC for motivation of patients having suggested signs of leprosy for self reporting ◆ Enhancing IEC activities to further reduce social stigma ◆ Proper counseling of leprosy patients to prevent deformities ◆ Human Resource Development and capacity building
16. Percentage (as planned) of ASHAs functional in the district (received induction training)	◆ Plan for identification of ASHAs ◆ Finalize ASHA training programme ◆ Procurement of kits to ASHAs ◆ Support Mechanism for ASHA

District Plan Objectives	Suggested Strategies
17. Number of RKS registered/established	◆ Development/adaptation of model MOU ◆ Formation of RKS and opening of bank accounts ◆ Guidelines for RKS ◆ Training of RKS members
18. Number of Health care delivery institutions upgraded – SHCs – PHCs – CHCs (these institutions should be in conformity with IPHS)	◆ Facility survey completed ◆ Deployment of staff ◆ Civil works ◆ Equipment and supplies
19. Village Health and Sanitation Committees constituted – Grants given	◆ Guidelines for VHSC finalised ◆ Opening of Bank Account ◆ Orientation of VHSC members in NRHM
20. Number of SCs strengthened – Additional ANMs hired – Annual maintenance grants given	◆ Criteria for identification of sub-centres ◆ Contractual ANMs ◆ Guidelines for use of maintenance grants by SCs
21. Number of PHCs strengthened to provide 24 x 7 – 3 staff nurses hired – Annual maintenance grants given	◆ Hiring of additional staff, Nurses for 24 x 7 PHCs as per RCH-PIPs ◆ Guidelines for use of maintenance grants by PHCs
22. National Blindness Control programme – Cataract surgery rate (450/100,000 population) – % surgery with IOL	◆ Strengthening service delivery, ◆ Developing human resources for eye care, ◆ Promoting outreach activities and public awareness and ◆ Developing institutional capacity.
23. Integrated Disease Surveillance Programme – Number of labs to be upgraded (L1 and L2) – Number of staff to be trained in surveillance activities	◆ Assessment of labs and identification of needs for strengthening surveillance activities ◆ Training of staff for surveillance work ◆ Contractual staff appointed for labs as per plan
24. Staff for mobile medical units in place	◆ Identification of blocks requiring visits from the MMU ◆ Staff deployment ◆ Services to be offered through MMU ◆ Procurement of drugs and medicines
25. Number of facilities to be covered for facility survey – SHCs – PHCs – CHCs	◆ Finalisation of format for facility survey ◆ Training/orientation of staff in conduct of facility survey ◆ Sharing findings in monthly meeting and also with RKS
26. Number of villages to be covered for HH survey	◆ Constitution and orientation of teams for HH survey ◆ Finalisation of format and analysis plan
27. Number of Community Hearings planned	◆ Guidelines for public hearings finalised
28. District Training plan developed implemented	◆ Assessment of training needs for different stakeholders ◆ Development of a training plan based on the state guidelines ◆ Implementation of the district training plan ◆ Assessment of– existing availability; – gaps – yearly quantifiable training loads.

District Plan Objectives	Suggested Strategies
	◆ Detailed training heads: egs. - No. to be trained in female sterilization - No. to be trained in male sterilization - No. to be trained in IUD - No. to be trained in contraceptive update
29. District BCC Plan developed and implemented	◆ Assessment of Communication needs for the district in the context of NRHM ◆ Development and Implementation of Communication Plan
30. District Procurement and Logistics Plan developed	◆ Assess need for supplies and equipments based on norms and facility survey ◆ Develop plan for procurement at district level for supplies not coming from the state ◆ Finalise plans for reaching supplies at different levels of care including ASHAs
31. Monitoring Mechanism Type of Services — Services to be evaluated — Mechanism (a) Monitoring of FP Service - Evaluation of contraceptive service provider - Similar to RET (b) Monitoring of Maternal Services- Evaluation of institutional deliveries (A team of district official/ (c) Monitoring of Immunization - Evaluation of complete immunization NGO / PRI)	
32. No. of PHCs/CHCs where AYUSH physicians posted	◆ Re-location of existing AYUSH dispensaries ◆ Contractual appointment of AYUSH manpower

This process should be repeated for all the objectives/programme areas and should be put together at the district level consultative meeting for finalizing the strategies and later details of rolling out the strategies.

Chapter

7

District Planning Workshop

7.1. You are here now

After setting your objectives as given in the chapter VI, at this stage of the DHAP preparation, you should have with you the following:

1. Information collated through the situational analysis[1]
2. Objectives and key strategies from the Block Level Consultations
3. Objectives, interventions and activities

And now this is also a time to roll in the plan centre stage and announce the plan and its proposed outcomes. Refer the second column in the table under section 5.2 for ideas.

This purpose of this chapter is to provide some guidance on the District Planning Workshop.

7.2 The District Planning Workshop

The objective of the District Planning Workshop could be as follows:

- To review and vet objectives of the District Health Action Plan (DHAP);
- To assess appropriateness and adequacy of suggested strategic interventions/and activities to meet the objectives of the DHAP;

The purpose of this workshop is also to share with a larger stakeholder group, the proposed outcomes for the District and get a critical review and additional inputs.

While the scope of this chapter is to guide us through a District Planning Workshop to finalize the first drafts DHAPs, the District Mission may decide to have one additional half day meeting. This could be held after the first Draft of the DHAP is shared with the Blocks to consider any suggestions from the blocks.

[1] Refer Chapter 4 and 6 of the Manual.

Here is an indicative list of participants for the District Level Planning Workshop. This list is not exhaustive and you may like to add few more names

- District Collector – Chair for the workshop
- CEO of the Zilla Parishad
- NRHM Mission Director
- Members of the District Mission
- PRI representatives (10 at least 50 percent should be women)
- District level officials from Health and Family Welfare Departments
- District level officials from Line departments i.e. WCD, Water and Sanitation
- Block Level Departmental Functionaries (especially from WCD, Health and Water Sanitation)
- NGOs/CBOs
- Networks of the Private service providers

7.4 The Design of Workshop

Planning Team

We assume that the District will establish a team to facilitate the overall DHAP process. The same team could take responsibility to facilitate District Level Planning workshop.

Suggested Agenda for District Planning Workshop

Time	Sessions/Activity	Responsibility
0930 hrs	◆ Welcome and workshop objectives ◆ Introduction of participants ◆ Remarks by Chief Guest	District Planning Team Convenor
1000 hrs to 1100 hrs	◆ District NRHM Scenario – Presentation – Discussions	NRHM focal point of the discussions
1100 hrs to 1200 hrs	◆ Suggested programme objectives and strategies – Presentations	Planning Team Member
1200 hrs to 1300 hrs	◆ Key problems and solutions engaging the block consultants – Presentation – Discussions	Member of Planning Team
1300 hrs to 1400 hrs	LUNCH	
1400 hrs to 1600 hrs	Group Work (Divide participants in 5 groups, i.e., New intervention under NRHM,RCH, Immunisation, Disease Control Programme and Intersectoral convergence) Terms of Reference Each group to suggest solutions in from of feasible activity to achieve programme objectives	Group work Terms of Reference to be presented by the member of the Planning Team
1600 hrs to 1700 hrs	Plenary Sessions Wrap-up and follow-up	Rapporteurs will make the presentation

Chapter

8

Work Plan and Budget

As part of the operational manual for developing the NRHM District Health Action Plans, it was decided that we should develop a model work plan. This would help facilitate the district group preparing their DHAP to look at a model Work Plan and try to develop their own work plans based on their own situations.

Program Managers and their staff use Work Plans as a management tool to plot their various main and sub-activities at the beginning of the year. Once the activities have been planned, the managers would then need to see how they have been adhering to the planned programs, where the pitfalls are, the reasons why they lag behind the time schedule and the mid-course action required to correct them. In effect, it is a monitoring tool for the program management staff.

Keeping these in mind, we have prepared two model Work Plans – viz, one month-wise and the second quarterly. The month-wise plan is for one year, which would help the programmers to plan the activities by month. The quarterly work plan is for two years, which could be used in plotting activities for a quarter and would give a broad picture as to when the activity/program could happen.

We have looked at some of the State PIPs and have compiled the model work plan taking most of the details given in them. We would, however, like to suggest the district team preparing their work plan that they should use our compilation as a model only. We would urge that they should suitably adapt it according to their and state's priorities for NRHM/RCH II activities, while also taking into account the national objectives and goals.

We have also done an average unit costing for some of the training programs and average costs for other activities, which would happen in 2006-07. Again these are only average costs for 2006-07, which we took from a particular state PIP. We would like to emphasize that the costs may vary from district to district and from state to state. The district team and the state authorities are the best judges in determining the costs. What we have given is only indicative average costs and you should use your own judgment while working out the costs.

An indicative matrix containing average/unit costs is attached as annex 2 to the manual.

8.1 Work Plan of Activities

These activities have to be listed under the strategy and put in a matrix form wherein the time of initiation of the activity, the tentative duration of implementation and completion should be specified for each of them and more importantly, persons/agency responsible should be explicitly stated. Scheduling of activities in a systematic way is another important feature of this exercise. All activities whether costed or not costed should be included in the Workplan.

When all the activities are worked out and time-line defined with responsibility, it will give an overview of activities against which monitoring can be undertaken. In other words, this matrix will facilitate in not only providing information on when the activities have to be initiated and completed but can be effectively used for tracking the status of each of the defined activities along with monthly monitoring. Since the responsibility has been assigned for each of the activity, it is expected to enhance accountability of the person.

Let us now continue with the example cited in Chapter 6 where maternal health strategies were defined for access, quality and demand. The broad strategies now have to be converted into implementable activities. How can this be done is illustrated in the following discussions:

8.2 Programme Component: Maternal Health

Programme Objective:
Universal coverage of all pregnant women with package of quality ANC services as per national guidelines

Programme Strategy:
Strengthening outreach sessions for ANC

Programme Activities:
The question one should ask is what all activities have to be initiated to implement this strategy and how best it can be done? Invariably these activities and sub-activities may link during block and district level meetings. During the block level consultation and district planning meeting, strategies and activities are likely to be spelled out. A sub-group of district planning team should develop a role out plan for the activities. The Workplan gives a framework to schedule the activities, time duration.

In order to strengthen outreach sessions for ANC, locations have to be decided, frequency of conducting outreach, any partnership with other stakeholders is required or not should be discussed, what demand generation activities will have to be undertaken have to be decided. This apart, orientation of ANM's to the new national guidelines and then necessary supplies for conducting outreach sessions will have ensured and implemented. All these activities will have to be scheduled systematically and put in the work plan.

These are more facility-based activities and the listing of activities for operationalizing the strategy look simple and straightforward but in reality it is not so. At district level, the manager has to ensure that necessary pre-requisites are in place. These will guide the manager more because absence of it means, it is difficult to roll out the activities.

For instance, the manager has to see and analyze what are the activities around the strategy. If the activity depends on training, the manager needs to know whether it is imparted or not and in regard to

ensuring supplies, which is true in most of the interventions, logistics management system is in place or not and if not what other actions will have to be initiated. Further, the manager will have to make sure that appropriate demand generation capacity building is undertaken and later the activities are rolled out and monitored periodically. To do all these, there is a need to identify focal points at the district level.

While these factors guide the district manager the facility level is guided by operationalizing the activities. This distinction applies to all the other strategies and the district level activities cuts across other strategies as well. In other words, the district level activities would be more or less common.

At the district level, there is therefore a need to identify focal points for undertaking each of the specialized tasks stated above and with NRHM adopting decentralization approach the onus of responsibility is more at the district level. So, if district in intending to implement this strategy then the following steps will have to be followed:

Strategy: Strengthen Outreach sessions for ANC services

Activities-District

- Ensured training of trainers in new guidelines of ANC care-This would, by and large, depend on when the state initiates training of trainers. So the work plan or initiation of the activity should align with state-level strategies.
- Initiated training of ANMs in new guidelines and on-going
- Logistics System in place and staff oriented-This is also a state-level activity and with decentralized procurement being the modality in NRHM, necessary capacity should be made available. Knowledge of rate contract list and procedures of tendering etc. are essential inputs necessary for smooth management
- Necessary kits required for ANC sessions procured and distributed
- Staff identified and made responsible for BCC activities- Usually multi-media activities are undertaken at state level. However, to roll out district-specific interventions and for imparting IPC skills to staff it is necessary to have trained persons
- Training of staff members in IPC and demand generation initiated and on-going
- District officers tasked with responsibilities for roll out
- Calendar for conducting monthly outreach sessions for ANC prepared and finalized along with ICDS department and shared with District society members
- Implementation calendar for outreach sessions for ANC shared with block level officers
- Monitoring system put in place and outreach sessions initiated

Activities-Facility level

- Calendar of outreach sessions prepared and finalized for the area
- Necessary supplies for ANC sessions estimated and supplied
- PRI's, AWW's and ASHA's oriented in undertaking mobilization activities
- Calendar of outreach in the area of each PRI shared in advance and type of services that will be provided shared
- PRI's along with AWW's and ASHA's undertake publicity activities
- Outreach sessions on ANC initiated in AWC villages

After having listed these activities, we will now use this information and assign them in the matrix below.

ILLUSTRATIVE TEMPLATE FOR PREPARING WORK PLAN

DISTRICT ACTION PLAN: WORK PLAN FOR TWO YEARS

Sr No.	Activity	Time frame 2007-09								Responsible Person(s)
		2007-08				2008-09				
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	
1	MATERNAL HEALTH									
	Universal coverage of all pregnant women with package of quality ANC services as per national guidelines									
1.1	Strengthen outreach sessions for ANC-District Level									
	1.1.1 Access: ◆ Develop guidelines for sector-wise micro plans for outreach sessions and use of money ◆ Additionally identify under-served areas									
	1.1.2 Quality ◆ Orientation training of ANMs in new guidelines ◆ Procurement of kits for ANC									
	1.1.3 Demand ◆ Organise of safe motherhood day by village health and sanitation committee ◆ Development and multiplication of Flash Book to be used by ASHA/AWWs									

From the above matrix, we have been able to demonstrate of how to convert strategies into activities. The timing of activities was planned and the responsibility for each activity was assigned as well. This way, each of the strategies listed in Chapter 6 will have to be operationalized. By doing so, concurrent and complementary activities can also be identified.

Chapter

9

Monitoring & Evaluation including Programme Management

After having finalized the work-plan and initiated the proposed interventions, there is a need to not only continuously monitor the inputs but also collect basic information on the progress of activities and its performance periodically, so that the programme manager is able to track both the inputs and processes as well. Monitoring of indicators proposed in the work-plan will enable in input monitoring of whether the activities have been initiated as per the schedule or not while monitoring the performance at regular intervals will give an idea of the progress made in these indicators. The two together will give an overview of progress that has to be addressed during monthly review meetings held at different levels of the health system.

The state RCH PIP document has already listed a set of input and process indicators and has decided on the frequency of monitoring. Likewise, there are set of indicators for communicable and non-communicable diseases, which is being collated and sent to the respective divisions of the central health ministry. Presently, the requirements of the NRHM have changed and an integrated approach is envisaged with disaggregated information on a few selected indicators. Hence the monitoring system for all the health and reproductive and child health programmes will have to be fine tuned at different levels of the health system to address the specific NRHM requirements and collated into a single format.

Further, the NRHM has strongly advocated community monitoring and reporting. Although this element is yet to be piloted or pre-tested within the health system, there have been few instances where such similar experiments have been undertaken external to the health system. Through this mechanism, dialogue between providers and community has taken place and the results have been encouraging (Refer: Jansuvahi in Haryana supported by UNFPA and that of JSA network). The experiences of these project-based experiments will have to be internalized and mainstreamed with the routine monitoring system. Besides, the establishment of citizen's charter and the activation of Village Health and Sanitation Committees provide additional opportunities for experimenting community monitoring and reporting. It is therefore, suggested to develop different mechanisms of community reporting and choose the most appropriate mechanism for the district.

This apart, a system for assessing quality of services is being developed through a pilot study. The details of assessing quality of services, is being worked out. To begin with, this activity will be pre-tested in districts of few selected states through external facilitation, wherein the methodology of conducting the study, details of number of health institutions to be covered, frequency of visiting the institutions, pedagogy and so on will be finalized and replicated. As the aim is to ultimately institutionalize quality assessment in routine monitoring, the M&E cell along with the contracted agencies will work out a practical mechanism for institutionalizing these elements. This would not only facilitate in creating in-house resource, but will also help in capacity building of programme managers at the district and below levels.

Performance evaluation mechanism will mostly rely on baseline (CNAA, RHS reports at district level and other special studies), concurrent, mid-term and end-line surveys. There would be both internal and external as government and non-government agencies will be involved. Besides, qualitative studies and community reporting will be done to supplement impact assessment studies. Mainly, the evaluation system will rely on District surveys (RHS and Facility) of 2007 and 2010 respectively. List of input, programme and output indicators that have to be monitored and evaluated as part of NRHM are as follows:

9.1 Input Indicators

- Number of additional ANMs positions filled against required
- Number of ASHAs selected and trained
- Number of SC's strengthened against proposed
- % of ASHAs in position
- Number of VH&SC constituted and grants given (proposed vs actual)
- Number of RKS registered/established against proposed
- Number of CHCs upgraded as per IPHS
- Number of PHCs strengthened to provide 24*7 services (No. proposed and actual functioning)
- % of upgraded CHCs providing EmOC services (No. proposed and actual functioning)
- Number of static facilities offering sterilization services (Male and Female)
- Number of DH/SDH/CHC/Block PHC providing sterilization services
  – male – NSV
  – Female – Minilap / Laparo. Ster.
- Number of CHC/PHC/SC providing IUD services
- Frequency of provision of service at different places (DH/SDH/CHC/PHC/SC) – fixed day or not
- Number of trained and certified trainers and providers available for NSV/minilap / laparo / IUD
- Number of CHCs/PHCs providing RTI services (% of the total)
- Number of PHCs/CHCs providing ARSH services
- % of health facilities (CHCs/PHCs) not having at least one month stock of anti-TB drugs, measles vaccine, OCP and gloves
- % of outreach sessions where AD syringe and safe disposal needles are used (Total outreach session is the base)

Process Indicators

9.2 Maternal Health

- ANC registration during the first trimester (Separately for vulnerable groups and others)
- Total ANC Coverage for different ANC services (Separately for vulnerable groups and others)
- Number of eligible pregnant women receiving complete ANC package (Base 7-9 months pregnant women) (Separately for vulnerable groups and others)
- % of pregnant women with obstetric complications identified and treated (Separately for vulnerable groups and others)
- % deliveries with skilled attendance including institutional deliveries (Separately for vulnerable groups and others)
- % of C-section deliveries and institution break-up of C-sections (Separately for vulnerable groups and others)
- Coverage of eligible pregnant women covered under JSY (Separately for vulnerable groups and others)
- Number of women receiving post-partum care within two weeks of delivery (Separately for vulnerable groups and others)

- % of pregnant women having 4 or more living children
- Number of maternal deaths by weeks after births (by caste) (Separately for vulnerable groups and others)
- Number and percent of 24 hour PHCs conducting minimum of 10 deliveries per month
- Number and percent of FRUs, CHCs and 24 hrs. PHCs reporting having conducted at least 10 wet mount test in the months

9.3 Child Health

- Number of live births by sex and caste
- % of live births weighed
- % of infants underweight
- Number of infant/child deaths
- Number of infants (0-11 months) by vaccination status-by sex and caste
- Number of 9-36 month old given Vit A-by sex and caste
- Number of children severely malnourished children (<6 yrs by sex and caste) referred to institutions
- Number of children who suffered from diarrhoea/ARI and % who sought treatment

9.4 Family Planning

- Number of female and male sterilization operations performed during the month
- Number of new and continuing spacing method users
- Parity of sterilization acceptors
- Mean age of sterilization acceptor
- % deaths, failures, complications reported
- % compensated through National FP Insurance Scheme
- % of correctness of Sterilizations and IUDs reports
- Release of compensation money as against number of cases done
- % of ELAs covered

NVBDCP
NVBDCP should be considered with the following input and programme output indicators.
Input

- Percentage of PHCs having functional laboratory for malaria microscopy
- Percentage of DDCs/FTDs/ASHA/AWW reporting stock out of antimalarial drugs/anti kala-azar drug (endemic PHCs only) during last three month
- Percentage of PHCs/CHCs with facilities for treatment of Acute Encephalitis Syndrome (in JE endemic areas)
- Percentage of PHCs/CHCs having facilities for detection and treatment of Kala-azar cases

Programme Output Indicator

- Percentage of target population screened for malaria parasite
- Percentage of positive malaria cases radically treated within 72 hours of blood smear collection
- Number of severe cases of malaria treated at the PHCs/CHCs
- Number of cases of Acute Encephalitis Syndrome managed at PHCs/CHCs (in JE endemic districts)
- Number of hydrocele operations conducted at PHCs/CHCs (in Filaria endemic districts)
- Number of Kala-azar patients completely treated at the PHCs/CHCs

-API for MP
-Annual blood examination rate for MP increased (over 10 % of all OPD cases)
-Slide Postivity Rate
-No of deaths due to malaria

RNTCP should be considered with the following indicators.
-Percentage of PHC/CHC having RNTCP DMC with functional BM (Binocular Microscope) and trained Lab technician
-Percentage of TB suspects examined out of the total outpatients
-Annualized New Smear Positive (NSP) case detection rate per 100,000 populations
-Annualized Total Case detection rate per 100,000 populations
-Treatment success rate

NLEP should be considered with the following indicators.

- PR
- ANCDR
- Proportion of MB, Female, Child, ST, SC cases among the new cases detected
- Proportion of Patients completed treatment

NIDDCP should be considered with the following indicators.

Indicator	Numerator	Denominator
No. of districts surveyed/resurveyed & endemic to IDD where prevalence is >10% in the State	Total No. of districts surveyed/ resurveyed & endemic having >10% quarterly	Target for IDD Survey/Resurvey for the year
No. of iodated salt samples analyzed per district	Total No. of iodated analyzed quarterly	Target for iodated salt analysis for the year
No. of urinary iodine excretion samples analyzed per district	Total No. UIE samples quarterly	Target for UIE sample analysis for the year
Expenditure of State IDD Cell, IDD Monitoring lab, survey and health education monthly	Expenditure made quarterly	Fund allocated for the year

National Blindness Control Programme

- Cataract surgery rate (450/100,000 population)
-% surgery with IOL (80%)
- % School Eye Screening
- Screening of school children for defection of refractive errors and providing 3.1 lakh free spectacles to poor children
- Collection of 1.75 lakh donated eyes (after death) for transplantation in persons with corneal blindness
- Setting up 2000 vision centres in rural areas at Primary Health Centres and NGO facilities for providing basic services to rural population
- Providing non-recurring to 50 voluntary organizations for strengthening/expanding eye care services

Output Indicators through evaluation

- Contraceptive prevalence rate
- % eligible couples using any spacing method for more than 6 months
- % of eligible couples of higher order of births (3 & 3+), accepted permanent method
- % of women delivered during past one year who received 100 IFA tablets
- % deliveries conducted by skilled providers (doctors, nurses or ANMs)
- % of 12-23 months children fully immunized
- % of mothers and newborn children visited within 2 weeks of delivery by a trained community level health provider/AWW or health staff (ANM/Nurse/Doctor)
- % of children suffering from diarrhea during past 2 weeks received Oral Rehydration Solution
- Polio free status achieved
- Total number and percentage of vulnerable groups with reference to the total population of the area and total number and percentage of the vulnerable groups covered under the programme vis-à-vis others.

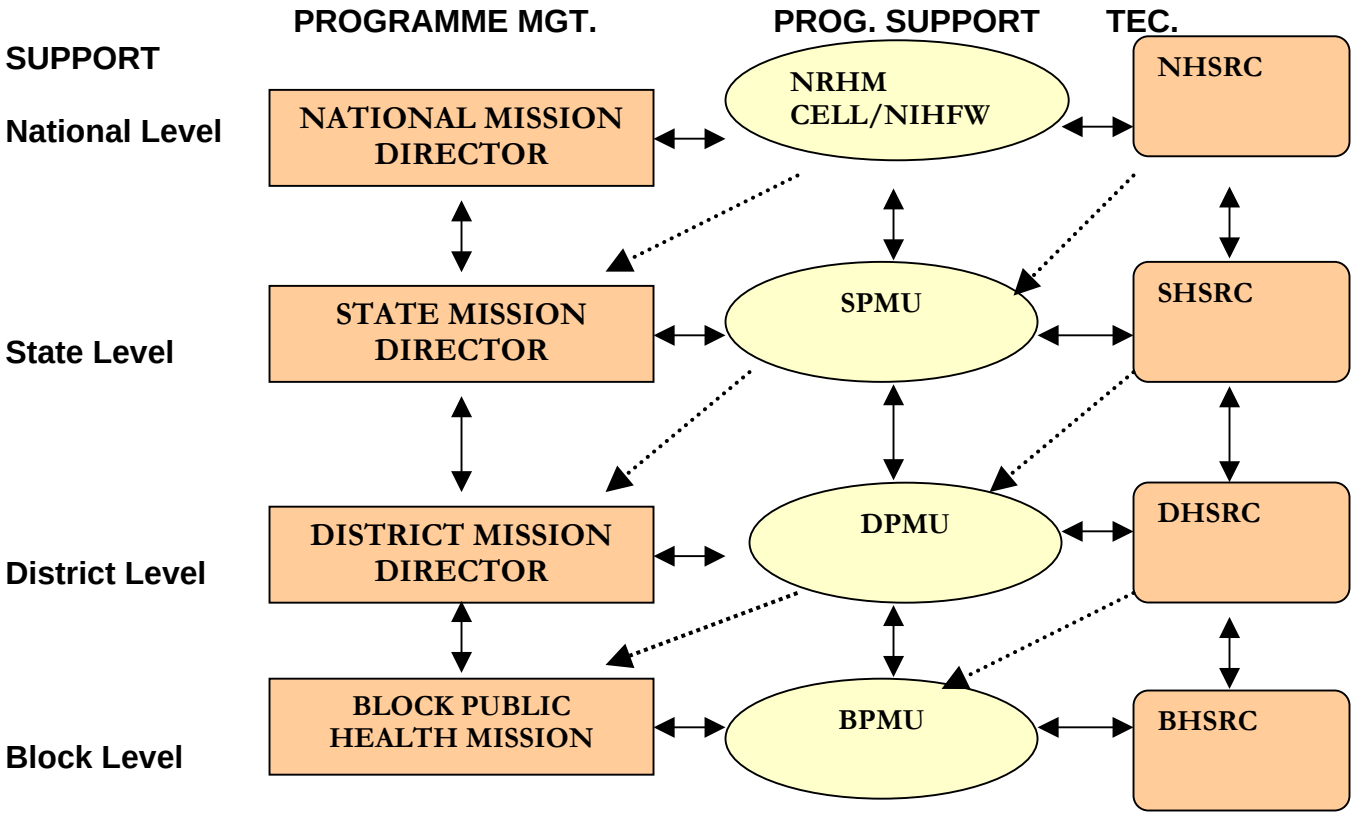
In sum, information on these indicators will have to be gathered by SC, ST and others and wherever applicable by male and female. The new monitoring format that is going to be introduced from the state to national levels is being finalized and takes the above elements into consideration.

NRHM Management Structures

A programme that seeks to decentralize with adequate devolution of powers and delegation of responsibilities has to have an appropriate implementation mechanism that is accountable. In order to facilitate this process and implement the DHAP, the NRHM has proposed a structure right from the village to the national levels with details on key functions and financial powers (Refer the document on NRHM-Framework for District Planning for Health, Ministry of Health and Family Welfare, 2006 for more details).

Broadly, the flow chart from National to Block levels would be:

FLOW CHART



This way, the NRHM proposes to support rolling out of activities and the programme and the technical units will have to be put in place by the respective states in accordance to the guidelines.

The Ministry is currently finalizing the MIS format for NRHM. However, the preliminary monitoring format is at Annexure-VIII.

Chapter

10

Structure of the District Health Action Plans (DHAP)

Activities suggested in the previous sections of this manual will enable by the district planning team to organise in form of DHAP document. The DHAP is the ultimate product of the entire planning exercise and will be reference document for district NRHM management. In this chapter a structure of this document is being suggested:

10.1 Background:

This section should include information on geographic location, socio-demographic profile of the district and also information on key health indications from recent data sets.

10.2 Situation Analysis

District team should reflect on following parameters while giving analysis in key programme areas:

- Coverage with preventive/promotive interventions
- Income and Gender equity
- Underserved population groups
- Quality of services – service quality and community perspectives
- Programme environment – vacancy, physical, infrastructure etc.

10.3 Process for Plan Development

It will be appropriate to describe processes undertaken such as any specific desk reviews commissioner, block and district level consultations and profile of participants, participation from other sectoral departments in the planning process. A brief introduction to profile of members included in the district planning team may be also useful.

10.4 Objectives

As per Chapter 6 and also Chapter 7, objectives set out for the districts in year 2007-2008 and 2008-2009 should be spelled out giving qualitative levels of achievements. This should be followed by a Matrix on key strategies and activities to operationalise the key strategies. Both costed and has costed activities be reflected here. Wherever possible activities should be quantified and geographical spread be delineated.

10.5 Workplan

Workplan should reflect in a matrix form and how different activities will be conducted with special references to time frame and also identify responsible official or agency as the case may be.

10.6 Monitoring & Evaluation

Essential components of this Chapter should be in synergy with larger NRHM monitoring. Flow of data from different levels, i.e., service delivery, community monitoring and long scale data sets is considered.

10.7 Budget

Unit costs should be given for each costed activity and source of funding be also reflected.

Annexures, if any

ANNEX – I

Village Health Information Schedule

Block O. Identification Block

State/UT	
District	
Taluk / Block	
Village	
Panchayat	
Household Address	
Reference Month	
Reference Year	

Block 1. Household Details

S.No.				
1.1.	**Name of the Head of Household**			
1.2.	**Sex of the Head of Household**			
1.3.	**Number of Members in the Household**			
1.3. a.	**Males**			
1.3. b.	**Females**			
1.4.	**Type of House**	**Pucca**	**Semi-pucca**	Kachha
1.5.	**Ownership of House**	**Own**	**Rented**	

S.No.		
1.6.	Number of separate rooms in the house	
1.7.	Is there a separate room for kitchen? (Yes / No)	
1.8.	Whether toilet facility available inside the household? (Yes / No)	
1.9.	Is there a community toilet facility in the village? (Yes / No)	
1.10.	What is the main source of lighting in the household? (Specify) (Electricity/Kerosene lamp/ others)	
1.11.	Is there a regular source of drinking water in the household? (Yes / No) (Specify the source of drinking water)	
1.12.	Whether the source of drinking water change from season to season? (Yes / No)	
1.13.	What type of fuel is used for cooking? (Specify)	
1.14.	Main occupation of the household	
1.15.	Number of earning members in the household	
1.16.	Monthly income of the household	
1.17.	Whether food is available throughout the year? (Yes / No)	
1.18.	If no, the difficult months for food availability	
1.19.	What is the mode of transport available in the household (if any)?	
1.20. a.	Does the household own a TV? (Yes / No)	
1.20. b.	Does the household own a Radio (Yes/No)	
1.21.	Does the household own any agricultural land? (Yes / No)	
1.22.	Area of the agricultural land, if any	
1.23.	Area of the agricultural land irrigated, if any	
1.24.	Does the household own any livestock? (Yes / No) (Specify)	

Block 2. Health and Family Welfare

S.No.					
2.1.	Number of children aged less than one year (Infants)	Male		Female	
2.2.	Number of children aged 0 to 5 years	Male		Female	
2.3.	Number of children aged 6 to 14 years	Male		Female	
2.4.	Number of births in the family during last one year	Male		Female	
2.5.	Any marriage in the family during last one year?(Yes / No)				
2.6.	Age of the person at marriage (if answer to column 2.4. is 'yes')				
2.7.	Number of currently pregnant women				
2.8.	Deaths				
2.8.a	Any deaths reported in the family during last one year	Male	Age	Female	Age
2.8.b	Any deaths of children aged less than one year reported during last one year	Male		Female	
2.8.c	Any deaths of children aged less than five years reported during last one year	Male		Female	
2.8.d	Any maternal death reported due to causes related to pregnancy / child birth during last one year				
2.8.e.	Whether any trained medical attention was given to pregnant women?(Yes / No) (if answer to column 2.4.d. is yes)				

2.9.	**Diseases and illness**	
2.9.a	**Anyone suffered from any of the following diseases during last three months**	
	Asthma	
	Tuberculosis (TB)	
	Malaria	
	Jaundice	
	Iodine deficiency disorder	
2.9.b.	**If suffered from TB, has he/she received any treatment? (Yes / No)**	
2.10.	**Food habits**	
2.10.a.	**Food habits of the family (Veg. / Non-veg.)**	
2.10.b.	**Anyone in the family chew Paan Masala or tobacco? (Yes / No)**	
2.10.c.	**Anyone in the family smoke? (Yes / No)**	
2.10.d.	**Anyone in the family drink alcohol? (Yes / No)**	
2.11.	**Health services**	
2.11.a.	**When members of the household get sick, where do they generally go for treatment?**	
2.11.b.	**Whether health service provided public or private?**	
2.11.c.	**Expenditure incurred on seeking health care during last one month**	
2.11.d.	**Items on which money spent for seeking health care during last one month (Doctors fee / drugs / special food / transport / others**	

ANNEX – II

Proforma for Sub Centres on IPHS

Proforma for Sub Centres on IPHS

Identification

Name of the State:
_____

District:_____

Tehsil/Taluk/Block
_____

Name of the Village

Location Name of Sub Centre:_____

Date of Data Collection

Day Month Year

Name and Signature of the Person Collecting Data

I. Services

S.No.		
1.1.	**Population covered (in numbers)**	
1.2.	**MCH Care including Family Planning**	
1.2.1.	**Service availability (Yes / No)**	
a.	Ante-natal care	
b.	Intranatal care	
c.	Post-natal care	
d.	New born Care	
e.	Child care including immunization	
f.	Family Planning and contraception	
g.	Adolescent health care	
h.	Assistance to school health services	
i.	Facilities under Janani Suraksha Yojana	
j.	Treatment of minor ailments	
k.	First aid (specify)	

1.2.2.	**Availability of specific services (Yes / No)**	
a.	Does the doctor visit the Sub centre at least once in a month?	
b.	Is the day and time of this visit fixed?	
c.	Are the residents of the village aware of the timings of the doctor's visit?	
d.	Does the Health Assistant (male) or LHV visit the Sub Centre at least once a week?	
e.	Is the Antenatal care (Inj. T.T, IFA tablets, weight and BP checkup) provided by those in the Sub centre?	
f.	Is the facility for referral of complicated cases of pregnancy / delivery available at Sub centre for 24 hours?	
g.	Does the ANM/any trained personnel accompany the woman in labor to the referred care facility at the time of referral?	
h.	Are the Immunization services as per Government schedule provided by the Sub centre	
i.	Is the ORS for prevention of diarrhea and dehydration available in the Subcentre?	
j.	Is the treatment of minor illness like fever, cough, cold, worm disinfestation etc. available in the Sub centre	
k.	Is the facility for taking Peripheral blood smear in case of fever for detection available in the Sub centre?	
l.	Are the contraceptive services like insertion of Copper-T, distributing Oral contraceptive pills or condoms provided by the Sub centre?	
m.	Is it a DOT centre?	
1.3.	**Other functions and services performed (Yes / No)**	
a.	Disease surveillance	
b.	Control of local endemic diseases	
c.	Promotion of sanitation	
d.	Field visits and home care	
e.	National Health Programmes including HIV/AIDS control programes	
1.4.	**Monitoring and Supervision activities (Yes / No)**	
a.	Training of traditional birth attendants and ASHA	
b.	Monitoring of Water quality in the village	

c.	Watch over unusual health events	
d.	Coordinated services with AWWs, ASHA, Village Health and Sanitation Committee, PRIs	
e.	Coordination and supervision of activities of ASHA	
f.	Proper maintenance of records and registers	
g.	Is there a Village Health Plan / Sub Centre Plan?	
h.	Is the scheme of ASHA implemented in Sub Centre?	

II.
Manpower

S.No.	Personnel	Existing	Recommended	Current Availability at Sub Centre (Indicate Numbers)	Remarks / Suggestions / Identified Gaps
2.1.	Health Worker (Female)	1	1 or 2 (Optional)		
2.2.	Health Worker (Male)	1	1 or 0 (optional; may be replaced by female health worker)		
2.3.	Voluntary worker to keep the Sub Centre clean and assisting ANM. She is paid by the ANM from her contingency fund @ Rs. 100 per month	1 (optional)	1 (optional)		

III. Physical Infrastructure (As per specifications)

S.No.		Current Availability at Sub Centre	If available, area in Sq. mts.)	Remarks / Suggestions / Identified Gaps
3.1.	Location			
a.	Where is this Sub Centre located?			
	Within Village Locality			
	Far from village locality			

	If far from locality specify in km			
b.	Whether located at an easily accessible area? (Yes/No)			
c.	The distance of Sub Centre (in Kms.) from the remotest village in the coverage area			
d.	Travel time to reach the Sub Centre from the remotes place in the coverage area			
e.	The distance of Sub Centre (in Kms.) from the PHC			
f.	The distance of Sub Centre (in Kms.) from the CHC			
3.2.	Building			
a.	Is a designated government building available for the Sub Centre? (Yes / No)			
b.	If there is no designated government building, then where does the Sub Centre located			
	Rented premises			
	Other government building			
	Any other specify			
c.	Area of the building (Total area in Sq. mts.)			
d.	What is the present condition of the existing building			
e.	What is the present stage of construction of the building			
	Construction complete			
	Construction incomplete			
f.	Compound Wall / Fencing (1-All around; 2-Partial; 3-None)			
g.	Condition of plaster on walls (1- Well plastered with plaster intact every where; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster)			
h.	Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring)			
i.	Whether the cleanliness is Good / Fair / Poor?(Observe)			
j.	Are any of the following close to the Sub Centre? (Observe) (Yes/No)			
i.	Garbage dump			
ii.	Cattle shed			
iii.	Stagnant pool			
iv.	Pollution from industry			
k.	Is boundary wall with gate existing? (Yes / No)			
3.3.	Prominent display boards in local language (Yes/No)			
3.4.	Separate public utilities for males and females (Yes/No)			
3.5.	Suggestion / complaint box (Yes/No)			
3.6.	Labour room			
a.	Labour room available? (Yes/ No)			
b.	If labour room is present, are deliveries carried out in the labour room?			
	Yes			
	No			
	Sometimes			

c.	If labour room is present, but deliveries not being conducted there, then what are the reasons for the same?			
	Staff not staying			
	Poor condition of the labour room			
	No power supply in the labour room			
	Any other specify			
3.7.	Clinic Room			
3.8.	Examination room			
3.9.	Water supply			
a.	Source of water (1- Piped; 2- Bore well/ hand pump / tube well; 3- Well; 4- Other (specify))			
b.	Whether overhead tank and pump exist (Yes / No)			
c.	If overhead tank exist, whether its capacity sufficient? (Yes/No)			
d.	If pump exist, whether it is in working condition? (Yes / No)			
3.10.	Waste disposal			
	How the medical waste disposed off (please specify)?			
3.11.	Electricity			
	Regular electric supply available? (Yes / No)			
3.12.	Communication facilities			
a.	Telephone (Yes/No)			
3.13.	Transport facility for movement of staff (Yes / No)			
3.14.	Residential facility for the staff	**Current Availability at Sub Centre**	**If available, area in Sq. mts.)**	**If available, whether staff staying or not?**
	Health Worker (Female)			
3.15.	Whether Health Worker (Male) available in the Sub Centre?			
3.16.	Is he staying at Sub Centre Head Quarter village? (Yes / No)			

IV. Equipment (As per list)

Equipment	Available	Functional	Remarks / Suggestions / Identified Gaps

V. Drugs (As per essential drug list)

Drug	Available	Remarks / Suggestions / Identified Gaps

VI. Furniture

S.No.	Item	Current Availability at Sub Centre	If available, numbers	Remarks / Suggestions / Identified Gaps
6.1.	Examination Table			
6.2.	Writing Table			
6.3.	Armless chairs			
6.4.	Medicine chest			
6.5.	Labour table			
6.6.	Wooden screen			
6.7.	Foot step			
6.8.	Coat rack			
6.9.	Bed side table			
6.10.	Stool			
6.11.	Almirahs			
6.12.	Lamp			
6.13.	Side wooden racks			
6.14.	Fans			
6.15.	Tube lights			
6.16.	Basin stand			
6.17.	Buckets			
6.18.	Mugs			
6.19.	Kerosene stove			
6.20.	Sauce pan with lid			
6.21.	Water receptacle			
6.22.	Rubber / plastic shutting			
6.23.	Talquist Hb scale			
6.24.	Drum with tap for storing water			
6.25.	Others (specify)			

VII. Quality Control

S.No.	Particular	Whether functional / available as per norms	Remarks
7.1.	Citizen's charter in local language(Yes/No)		
7.2.	Internal monitoring: supportive supervision and record checking at periodic intervals by the male and female health supervisors from PHC (at least once a week) and by MO (at least once in a month)		
7.3.	External monitoring: Village health and sanitation committee, evaluation by independent external agency		
7.4.	Availability of various guidelines issued by GOI or State Govt. (specify)		

ANNEX – III

Proforma for PHCs on IPHS

Identification

Name of the State:
_____

District:_____

Tehsil/Taluk/Block _____

Location Name of PHC:_____

Is the PHC providing 24 hours and 7 days delivery facilities

Date of Data Collection

Day Month Year

Name and Signature of the Person Collecting Data

I. Services

S.No.		
1.1.	**Population covered (in numbers)**	
1.2.	**Assured Services available (Yes/No)**	
a.	OPD Services	
b.	Emergency services (24 Hours)	
c.	Referral Services	
d.	In-patient Services	
1.3.		
a.	Number of beds available	
b.	Bed Occupancy Rate in the last 12 months (1- less than 40%; 2 - 40-60%; 3 - More than 60%)	
1.4.	Average daily OPD Attendence	
a.	Males	
b.	Females	
1.5.	**Treatment of specific cases (Yes / No)**	
a.	Is surgery for cataract done in the PHC?	
b.	Is the primary management of wounds done at the PHC?	
c.	Is the primary management of fracture done at the PHC?	

d.	Are minor surgeries like draining of abscess etc done at the PHC?	
e.	Is the primary management of cases of poisoning / snake, insect or scorpion bite done at the PHC?	
f.	Is the primary management of burns done at PHC?	

1.6.	**MCH Care including Family Planning**	
1.6.1.	**Service availability (Yes / No)**	
a.	Ante-natal care	
b.	Intranatal care (24 - hour delivery services both normal and assisted)	
c.	Post-natal care	
d.	New born Care	
e.	Child care including immunization	
f.	Family Planning	
g.	MTP	
h.	Management of RTI / STI	
i.	Facilities under Janani Suraksha Yojana	
1.6.2.	**Availability of specific services (Yes / No)**	
a.	Are antenatal clinics organized by the PHC regularly?	
b.	Is the facility for normal delivery available in the PHC for 24 hours?	
c.	Is the facility for tubectomy and vasectomy available at the PHC?	
d.	Is the facility for internal examination for gynaecological conditions available at the PHC?	
e.	Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC?	
f.	If women do not usually go to the PHC, then what is the reason behind it?	
g.	Is the facility for MTP (abortion) available at the PHC?	
h.	Is there any precondition for doing MTP such as enforced use of contraceptives after MTP or asking for husband's consent for MTP?	
i.	Do women have to pay for MTP?	
j.	Is treatment for anemia given to both pregnant as well as non-pregnant women?	

k.	Are the low birth weight babies managed at the PHC?	
l.	Is there a fixed immunization day?	
m.	Is BCG and Measles vaccine given regularly in the PHC?	
n.	How is the vaccine received at PHC and distributed to Sub Centres?	
o.	Is the treatment of children with pneumonia available at the PHC?	
p.	Is the management of children suffering from diarrhea with severe dehydration done at the PHC?	

1.7.	**Other functions and services performed (Yes / No)**	
a.	Nutrition services	
b.	School Health programmes	
c.	Promotion of safe water supply and basic sanitation	
d.	Prevention and control of locally endemic diseases	
e.	Disease surveillance and control of epidemics	
f.	Collection and reporting of vital statistics	
g.	Education about health / behaviour change communication	
h.	National Health Programmes including HIV/AIDS control programes	
i.	AYUSH services as per local preference	
j.	Rehabilitation services (please specify)	
1.8.	**Monitoring and Supervision activities (Yes / No)**	
a.	Monitoring and supervision of activities of sub-centres through regular meetings / periodic visits, etc.	
b.	Monitoring of National Health Programmes	
c.	Monitoring activities of ASHAs	
d.	Visits of Medical Officer to all sub-centres at least once in a month	
e.	Visits of Health Assistants (Male) and LHV to sub-centres once a week	

II.
Manpower

S.No.	Personnel	Existing pattern	Recommended	Current Availability at PHC (Indicate Numbers)	Remarks / Suggestions / Identified Gaps
2.1.	Medical Officer	1	2 (one may be from AYUSH and one other Medical Officer preferably a Lady Doctor)		
2.2.	Pharmacist	1	1		
2.3.	Nurse - Midwife (Staff Nurse)	1	3 (for 24 hour PHCs; 2 may be contractual))		
2.4.	Health Worker (Female)	1	1		
2.5.	Health Educator	1	1		
2.6.	Health Assistant (One male and One female	2	2		
2.7.	Clerks	2	2		
2.8.	Laboratory Technician	1	1		
2.9.	Driver	1	Optional; vehicles may be out-sourced		
2.10.	Class IV	4	4		
	Total	**15**	**17/18**		

III. Training of personnel during previous (full) year

3.1.	Available training for	Number trained			
a.	Tradition birth attendants				
b.	Health Worker (Female)				
c.	Health Worker (Male)				
d.	Medical Officer				
e.	Initial and periodic training of paramedics in treatment of minor ailments				
f.	Training of ASHAs				
g.	Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care				
h.	Training of Health Workers in antenatal care and skilled birth attendance				
i.	Lab Technician				
j.	Other health workers on RNTCP				

IV. Essential Laboratory Services

S.No.		Current Availability at PHC	Remarks / Suggestions / Identified Gaps
4.1.	Routine urine, stool and blood tests		
4.2.	Blood grouping		
4.3.	Bleeding time, clotting time		
3.4.	Diagnosis of RTI/STDs with wet mounting, grams stain, etc.		
4.5.	Sputum testing for TB		
4.6.	Blood smear examination for malaria parasite		
4.7.	Rapid tests for pregnancy		
4.8.	RPR test for Syphills / YAWS surveillance		
4.9.	Rapid tests for HIV		
4.10.	Others (specify)		

V. Physical Infrastructure (As per specifications)

S.No.		Current Availability at PHC	If available, area in Sq. mts.)	Remarks / Suggestions / Identified Gaps
5.1.	Where is this PHC located?			
a.	Within Village Locality			
b.	Far from village locality			
c.	If far from locality specify in km			
5.2.	Building			
a.	Is a designated government building available for the PHC? (Yes / No)			
b.	If there is no designated government building, then where does the PHC located			
	Rented premises			
	Other government building			
	Any other specify			
c.	Area of the building (Total area in Sq. mts.)			
d.	What is the present stage of construction of the building			
	Construction complete			
	Construction incomplete			
e.	Compound Wall / Fencing (1-All around; 2-Partial; 3-None)			
f.	Condition of plaster on walls (1- Well plastered with plaster intact every where; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster)			
g.	Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring)			
h.	Whether the cleanliness is Good / Fair / Poor?(Observe)			
	OPD			

	Rooms			
	Wards			
	Toilets			
	Premises (compound)			
l.	Are any of the following close to the PHC? (Observe) (Yes/No)			
i.	Garbage dump			
ii.	Cattle shed			
iii.	Stagnant pool			
iv.	Pollution from industry			
j.	Is boundary wall with gate existing? (Yes / No)			
5.3.	Location			
a.	Whether located at an easily accessible area? (Yes/No)			
b.	Distance of PHC (in Kms.) from the farthest village in coverage area			
c.	Travel time (in minutes) to reach the PHC from farthest village in coverage area			
d.	Distance of PHC (in Kms.) from the CHC			
e.	Distance of PHC (in Kms.) from District Hospital			
5.4.	Prominent display boards regarding service availability in local language (Yes/No)			
5.5.	Registration counters (Yes/No)			
5.6.				
a.	Pharmacy for drug dispensing and drug storage (Yes/No)			
b.	Counter near entrance of PHC to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes / No)			
5.7.	Separate public utilities for males and females (Yes/No)			
5.8.	Suggestion / complaint box (Yes/No)			
5.9.	OPD rooms / cubicles (Yes/No) (Give numbers)			
5.10	Adequate no. of windows in the room for light and air in each room (Yes/No)			
5.11.	Family Welfare Clinic (Yes/No)			
5.12.	Waiting room for patients (Yes/No)			
5.13.	Emergency Room / Casualty (Yes/No)			
5.14.	Separate wards for males and females (Yes/No)			
5.15	No. of beds : Male			
5.16	No. of beds : Female			
5.17.	Operation Theatre (if exists)			
a.	Operation Theatre available (Yes/No)			
b.	If operation theatre is present, are surgeries carried out in the operation theatre?			
	Yes			
	No			
	Sometimes			

c.	If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same?			
	Non-availability of doctors /staff			
	Lack of equipment / poor physical state of the operation theatre			
	No power supply in the operation theatre			
	Any other reason (specify)			
d.	Operation Theatre used for obstetric / gynaecological purpose (Yes / No)			
e.	Has OT enough space (Yes / No)			
5.18.	Labour room			
a.	Labour room available? (Yes/ No)			
b.	If labour room is present, arc deliveries carried out in the labour room?			
	Yes			
	No			
	Sometimes			
c.	If labour room is present. But deliveries are not being conducted there, then what are the reasons for the same?			
	Non-availability of doctors / staff			
	Poor condition of the labour room			
	No power supply in the labour room			
	Any other reason (specify)			
d.	Is separate areas for septic and aseptic deliveries available? (Yes / No)			
5.19.	Laboratory:			
a.	Laboratory (Yes/No)			
b.	Is the laboratory a RNTCP Designated Microscopy Centre (DMC) under RNTCP? (Yes/No)			
c.	Are adequate equipment (including function Binocular Microscope) and chemical reagents available?			
d.	Is laboratory maintained in orderly manner? (Yes / No)			
5.20.	Ancillary Rooms - Nurses rest room (Yes/No)			
5.21.	Water supply			
a.	Source of water (1- Piped; 2- Bore well/ hand pump / tube well; 3- Well; 4- Other (specify))			
b.	Whether overhead tank and pump exist (Yes / No)			
c.	If overhead tank exist, whether its capacity sufficient? (Yes/No)			
d.	If pump exist, whether it is in working condition? (Yes / No)			
5.22	Sewerage			
	Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage)			
5.23.	Waste disposal			
	How the waste material is being disposed (please specify)?			
5.24.	Electricity			

a.	Is there electric line in all parts of the PHC? (1- In all parts; 2- In some parts; 3- None)			
b.	Regular Power Supply (1- Continuous Power Supply; 2- Occasional power failure; 3- Power cuts in summer only; 4- Regular power cuts; 5- No power supply			
c.	Stand by facility (generator) available in working condition (Yes / No)			
5.25.	Laundry facilities:			
a.	Laundry facility available(Yes/No)			
b.	If no, is it outsourced?			
5.26.	Communication facilities			
a.	Telephone (Yes/No)			
b.	Personal Computer (Yes/No)			
c.	NIC Terminal (Yes/No)			
d.	E-Mail (Yes / No)			
e.	Is PHC accessible by			
i.	Rail (Yes / No)			
ii.	All whether road (Yes / No)			
iii.	Others (Specify)			
5.27.	Vehicles			
	Vehicle (jeep/other vehicle) available? (Yes / No)			
		Current Availability at PHC	**If available, area in Sq. mts.)**	**Remarks / Suggestions / Identified Gaps**
5.28.	Office room (Yes/No)			
5.29.	Store room (Yes/No)			
5.30.	Kitchen (Yes / No)			
5.31.	Diet:			
a.	Diet provided by hospital (Yes/No)			
b.	If no, how diet is provided to the indoor patients?			
5.32.	Residential facility for the staff with all amenities			
	Medical Officer			
	Pharmacist			
	Nurses			
	Other staff			
5.33.	Behavioral Aspects (Yes / No)			
a.	How is the behaviour of the PHC staff with the patient			
	Courteous			
	Casual/indifferent			
	Insulting / derogatory			
b.	Any fee for service is charged from the users? (Yes / No). If yes, specify.			
c.	Is there corruption in terms of charging extra money for any of the service provided? (Yes / No)			
d.	Is a receipt always given for the money charged at the PHC? (Yes / No)			

e.	Is there any incidence of any sexual advances? Oral or physical abuse, sexual harassment by the doctors or any other paramedical? (Yes / No)			
f.	Are woman patients interviewed in an environment that ensures privacy and dignity? (Yes / No)			
g.	Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (Yes / No)			
h.	Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (Yes / No)			
i.	If the health centre is unequipped to provide the services how and where the patient is referred and how patients transported?			
j.	Is there a publicly displayed mechanism, whereby a complaint/grievance can be registered? (Yes / No)			

k.	Is there an outbreak of any of the following diseases in the PHC area in the last three years?			
	Malaria			
	Measles			
	Gastroenteritis			
	Jaundice			
l.	If yes, did the PHC staff responded immediately to stop the further spread of the epidment			
m.	Does the doctor do private practice during or after the duty hours? (Yes/ No)			
n.	Are there instances where patients from particular social background dalits, minorities, villagers) have faced derogatory or discriminatory behavior or service of poorer quality? (Yes / No)			
o.	Have patients with specific health problems (HIV/AIDS, leprosy suffered discrimination in any form? (Yes / No)			

VI. Equipment (As per list)

Equipment	Available		Functional	Remarks / Suggestions / Identified Gaps

VII. Drugs (As per essential drug list)

Drug	Available	Remarks / Suggestions / Identified Gaps

VIII. Furniture

S.No.	Item	Current Availability at PHC	If available, numbers	Remarks / Suggestions / Identified Gaps
8.1.	Examination Table			
8.2.	Delivery Table			
8.3.	Footstep			
8.4.	Bed Side Screen			
8.5.	Stool for patients			
8.6.	Arm board for adult & child			
8.7.	Saline stand			
8.8.	Wheel chair			
8.9.	Stretcher on trolley			
8.10.	Oxygen trolley			
8.11.	Height measuring stand			
8.12.	Iron bed			
8.13.	Bed side locker			
8.14.	Dressing trolley			
8.15.	Mayo trolley			
8.16.	Instrument cabinet			
8.17.	Instrument trolley			
8.18.	Bucket			
8.19.	Attendant stool			
8.20.	Instrument tray			
8.21.	Chair			
8.22.	Wooden table			
8.23.	Almirah			
8.24.	Swab rack			
8.25.	Mattress			
8.26.	Pillow			
8.27.	Waiting bench for patients / attendants			
8.28.	Medicine cabinet			
8.29.	Side rail			
8.30.	Rack			
8.31.	Bed side attendant chair			
8.32.	Others			

IX. Quality Control

S.No.	Particular	Whether functional / available as per norms	Remarks
9.1.	Citizen's charter (Yes/No)		
9.2.	Constitution of Rogi Kalyan Samiti (Yes/No) (give a list of office order notifying the members)		
9.3.	Internal monitoring (Social audit through Panchayati Raj Institution / Rogi Kalyan Samitis, medical audit, technical audit, economic audit, disaster preparedness audit etc. (Specify)		

9.4.	External monitoring /Gradation by PRI (Zila Parishad)/ Rogi Kalyan Samitis		
9.5.	Availability of Standard Operating Procedures (SOP) / Standard Treatment Protocols (STP)/ Guidelines (Please provide a list)		

ANNEX – IV

Proforma for CHCs on IPHS

Identification

Name of the State: _____

District:_____

Tehsil/Taluk/Block _____

Location Name of CHC:_____

Is This Health Facility Recognized as FRU? (Yes/No)

Date of Data Collection

Day Month Year

Name and Signature of the Person Collecting Data

I. Services

S.No.		
1.1.	Population covered (in numbers)	
1.2.	Specialist services available (Yes/No)	
a.	Medicine	
b.	Surgery	
c.	OBG	
d.	Pediatrics	
e.	National Health Programmes (Specify)	
f.	Emergency services (24 Hours)	
g.	24 - hour delivery services including normal and assisted deliveries	
h.	Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions	
i.	New-born care	
j.	Emergency care of sick children	
k.	Full range of family planning services including Laparoscopic Services	
l.	Safe abortion services	

m.	Treatment of STI / RTI	
n.	Essential Laboratory Services (Specify the type of lab tests conducted)	
o.	Blood storage facility	
p.	Referral transport service	
1.3.	Bed Occupancy Rate in the last 12 months (1- less than 40%; 2 - 40-60%; 3 - More than 60%)	
1.4.	Average daily OPD Attendence	
a.	Male	
b.	Female	
1.5.	Types of Surgeries performed (specify)	
1.6.	HIV / AIDS	
a.	Availability of Counseling facility on HIV/ AIDS / STD etc. (Yes/No)	
b.	Is it a Voluntary Council and Testing Centre (VCTC)?	
1.7.	Service availability	Number of days in a month the services are available
a.	Ante-natal Clinics	
b.	Post-natal Clinics	
c.	Immunization Sessions	
1.8.	Number of cases of caeserian delivery (During last one year)	
1.9.	Total number of pediatric beds	
1.10.	Is separate septic labour room available	
1.11.	Availability of facilities for out-patient department in Gynecology/ obstetric (Yes / No)	
a.	Board /Name plates to guide the clients	
b.	Adequate working space	
c.	Privacy during examination	
d.	Facility for counselling	
e.	Separate toilet with running water	
f.	Facility for Sterilizing instruments	
g.	Male specialist	
h.	Female specialist	

II.
Manpower

S.No.	Personnel	IPHS Norm	Current Availability at CHC (Indicate Numbers)	Remarks / Suggestions / Identified Gaps
A.	**Clinical Manpower**			
2.1.	General Surgeon	1		

2.2.	Physician	1		
2.3.	Obstetrician / Gynaecologist	1		
2.4.	Pediatrics	1		
2.5.	Anaesthetist	1		On contractual appointment or hiring of services from private sectors on case to case basis
2.6.	Public Health Programme Manager	1		On contractual appointment
2.7.	Eye Surgeon	1		For every 5 lakh population as per vision 2020 approved Plan of Action
2.8.	Other specialists (if any)			
2.9.	General duty officers (Medical Officer)			

B. Support Manpower

S.No.	Personnel	IPHS Norm	Current Availability at CHC (Numbers)	Remarks / Suggestions / Identified Gaps
2.10.	Nursing Staff	7+2		1 ANM and 1 Public Health Nurse for family welfare will be appointed under the ASHA scheme
a.	Public Health Nurse	1		
b.	ANM	1		
c.	Staff Nurse	7		
d.	Nurse/Midwife			
2.11.	Dresser	1		
2.12	Pharmacist / compounder	1		
2.13.	Lab. Technician	1		
2.14.	Radiographer	1		
2.15.	Ophthalmic Assistant	1		Ophthalmic Assistant may be placed wherever it does not exist through redeployment or contract basis
2.16.	Ward boys / nursing orderly	2		

2.17.	Sweepers	3		
2.18.	Chowkidar	1		Flexibility may rest with the State for recruitment of personnel as per needs
2.19.	OPD Attendant	1		
2.20.	Statistical Assistant / Data entry operator	1		
2.21.	OT Attendant	1		
2.22.	Registration Clerk	1		
2.23.	Any other staff (specify)			

C. Training of MOs during previous (full) year

2.24	Available training in	Number of MOs trained
a.	Sterilization	
b.	IUD Insertions	
c.	Emergency contraception	
d.	RTI / STI, HIV/ AIDS	
e.	Newborn care	
f.	Emergency obstetric care	
g.	Other subjects (mention)	
h.	Training of Medical Officers on RNTCP	

III. Investigative Facilities

S.No.	IPHS Norm	Current Availability at CHC	Remarks / Suggestions / Identified Gaps
3.1.	Availability of ECG facilities (Yes / No)		
3.2.	X-Ray facility (Yes / No)		
3.3.	Ultrasound facility (Yes / No)		
3.4.	Appropriate training to a nursing staff on ECG (Yes / No)		
3.5.	Lab test facilities (specify kind of tests done)		
3.6.	Any lab test / diagnostic test outsourced to private lab / hospital (please specify the test)		
3.7.	All necessary reagents, glassware and facilities for collection and transportation of samples (Yes / No)		

IV. Physical Infrastructure (As per specifications)

S.No.		Current Availability at CHC	If available, area in Sq. mts.)	Remarks / Suggestions / Identified Gaps
4.1.	Where is this CHC located?			
a.	Within Village Locality			
b.	Far from village locality			
c.	If far from locality specify in km			
4.2.	Building			

a.	Is a designated government building available for the CHC? (Yes / No)			
b.	If there is no designated government building, then where does the CHC located			
	Rented premises			
	Other government building			
	Any other specify			
c.	Area of the building (Total area in Sq. mts.)			
d.	What is the present stage of construction of the building			
	Construction complete			
	Construction incomplete			
e.	Compound Wall / Fencing (1-All around; 2-Partial; 3-None)			
f.	Condition of plaster on walls (1- Well plastered with plaster intact every where; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster)			
g.	Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring)			
h.	Whether the cleanliness is Good / Fair / Poor?(Observe)			
	OPD			
	OT			
	Rooms			
	Wards			
	Toilets			
	Premises (compound)			
I.	Are any of the following close to the hospital? (Observe) (Yes/No)			
i.	Garbage dump			
ii.	Cattle shed			
iii.	Stagnant pool			
iv.	Pollution from industry			
4.3.	Location			
a.	Whether located at less than 2 hours of travel distance from the farthest village? (Yes/No)			
b.	Whether the district head quarter hospital located at a distance of less than 4 hours travel time? (Yes/No)			
c.	Feasibility to hold the workforce (e.g. availability of degree college, railway station, municipality, industrial/mining belt) (Yes/No) (specify)			
4.4.	Availability of Private Sector Health Facility in the area			
a.	Private laboratory/hospital/Nursing Home (Yes/No)			
b.	Charitable Hospital (Yes/No) (specify)			
c.	Hospital run by NGO (Yes/No)			
4.5.	Prominent display boards in local language / Charter of Patient Rights (Yes/No)			
4.6.	Registration counters (Yes/No)			
4.7.				

a.	Pharmacy for drug dispensing and drug storage (Yes/No)			
b.	Counter near entrance of hospital to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes / No)			
4.8.	Separate public utilities for males and females (Yes/No)			
4.9.	Suggestion / complaint box (Yes/No)			
4.10.	OPD rooms / cubicles (Yes/No) (Give numbers)			
4.11.	Adequate no. of windows in the room for light and air in each room (Yes/No)			
4.12.	Family Welfare Clinic (Yes/No)			
4.13.	Waiting room for patients (Yes/No)			
4.14.	Emergency Room / Casualty (Yes/No)			
4.15.	Separate wards for males and females (Yes/No)			
4.16.	No. of beds : Male			
4.17.	No. of beds : Female			
4.18.	Operation Theatre			
a.	Operation Theatre available (Yes/No)			
b.	If operation theatre is present, are surgeries carried out in the operation theatre?			
	Yes			
	No			
	Sometimes			
c.	If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same?			
	Non-availability of doctors / anaesthetist / staff			
	Lack of equipment / poor physical state of the operation theatre			
	No power supply in the operation theatre			
	Any other reason (specify)			
d.	Operation Theatre used for obstetric / gynaecological purpose (Yes / No)			
e.	Has OT enough space (Yes / No)			
f.	Is OT fitted with air conditioner? (Yes / No)			
g.	Is the air conditioner working? (Yes / No)			
h.	Is generator available for OT? (Yes / No)			
i.	Is emergency light available in OT? (Yes / No)			
j.	Is fumigation done regularly? (Yes / No)			
k.	Is the days of sterilization in a week displayed on the public notice on OT? (Yes / No)			
4.19.	Operation Theatre Equipment	Available (Yes/No)	Working (Yes/No)	
	Boyles apparatus			
	EMO Machine			
	Cardiac Monitor for OT			
	Defibrillator for OT			
	Ventilator for OT			
	Horizontal High Pressure Sterilizer			
	Vertical High Pressure sterilizer 2/3 drum capacity			

	Shadowless lamp ceiling trek mounted			
	Shadowless lamp pedestal for minor OT			
	OT care / fumigation apparatus			
	Gloves & dusting machines			
	Oxygen cylinder 660 Ltrs 10 cylinders for 1 Boyles Apparatus			
	Nitrous Oxide Cylinder 1780 Ltr. 8 for one Boyles Apparatus			
	Hydraulic Operation Table			
4.20.	Labour room			
a.	Labour room available? (Yes/ No)			
b.	If labour room is present, arc deliveries carried out in the labour room?			
	Yes			
	No			
	Sometimes			
c.	If labour room is present. But deliveries are not being conducted there, then what are the reasons for the same?			
	Non-availability of doctors / staff			
	Seepage in the labour room			
	No power supply in the labour room			
	Any other reason (specify)			
4.21.	X-ray room with dark room facility (Yes/No)			
4.22.	Laboratory:			
a.	Laboratory (Yes/No)			
b.	Is the laboratory a RNTCP Designated Microscopy Centre (DMC) under RNTCP? (Yes/No)			
c.	Are adequate equipment (including function Binocular Microscope) and chemical reagents available?			
d.	Is laboratory maintained in orderly manner? (Yes / No)			
4.23.	Cold Chain	Available?	In working condition?	
a.	Walk-in coolers (Yes / No)			
b.	Walk-in freezers available (Yes / No)			
c.	Icelined freezers (Yes / No)			
d.	Deep freezers (Yes / No)			
e.	Refrigerators (Yes / No)			
4.24.	Blood Storage Unit			
a.	Blood Storage Unit available(Yes/No)			
b.	Is the CHC having linkage with district blood bank? (Yes / No)			
c.	Is regular blood supply available? (Yes / No)			
4.25.	Ancillary Rooms - Nurses rest room (Yes/No)			
4.26.	Water supply			
a.	Source of water (1- Piped; 2- Bore well/ hand pump / tube well; 3- Well; 4- Other (specify))			
b.	Whether overhead tank and pump exist (Yes / No)			

c.	If overhead tank exist, whether its capacity sufficient? (Yes/No)			
d.	If pump exist, whether it is in working condition? (Yes / No)			
4.27.	Sewerage			
	Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage)			
4.28.	Waste disposal			
a.	Is there an incinerator? (Yes / No)			
b.	If yes, type (1- electric; 2- Other (specify)			
c.	If no, how the medical waste disposed off?			
4.29.	Electricity			
a.	Is there electric line in all parts of the hospital? (1- In all parts; 2- In some parts; 3- None)			
b.	Regular Power Supply (1- Continuous Power Supply; 2- Occasional power failure; 3- Power cuts in summer only; 4- Regular power cuts; 5- No power supply			
c.	Stand by facility (generator) available (Yes / No)			
4.30.	Laundry facilities:			
a.	Laundry facility available(Yes/No)			
b.	If no, is it outsourced?			
4.31.	Communication facilities			
a.	Telephone (Yes/No)			
b.	Number of different telephone lines available			
c.	Personal Computer (Yes/No)			
d.	NIC Terminal (Yes/No)			
e.	E-Mail (Yes / No)			
f.	Is CHC accessible by			
i.	Rail (Yes / No)			
ii.	All whether road (Yes / No)			
iii.	Others (Specify)			
4.32.	Vehicles	Number of Vehicles		
a.	If running	Sanctioned	Available	On road
	Ambulance			
	Jeep			
	Car			
b.	If vehicle is not running	Reason		
		Driver not available	Money for POL not available	Money for repairs not available
	Ambulance			
	Jeep			
	Car			

		Current Availability at CHC	If available, area in Sq. mts.)	Remarks / Suggestions / Identified Gaps
4.33.	Office room (Yes/No)			
4.34.	Store room (Yes/No)			
4.35.	Kitchen (Yes / No)			
4.36.	Diet:			
a.	Diet provided by hospital (Yes/No)			
b.	If no, how diet is provided to the indoor patients?			
4.37.	Residential facility for the staff with living condition			
	General Surgeon			
	Physician			
	Obstetrician / Gynaecologist			
	Paediatrics			
	Anaesthetist			
	General Duty Medical Officer			
	Public Health Programme Manager			
	Eye Surgeon			
	Public Health Nurse			
	ANM			
	Staff Nurse			
	Nurse/Midwife			
	Dresser			
	Pharmacist / compounder			
	Lab. Technician			
	Radiographer			
	Ophthalmic Assistant			
	Ward boys / nursing orderly			
	Sweepers			
	Chowkidar			
	OPD Attendant			
	Statistical Assistant / Data entry operator			
	OT Attendant			
	Ambulance driver			
	Registration Clerk			
4.38.	Accommodation facility for families of admitted patients			
a.	Facility for stay available (Yes / No)			
b.	Attached toilet available (Yes / No)			
c.	Cooking facility available (Yes / No)			
4.39.				
a.	Is the CHC open for outpatient services for the stipulated OPD time?			
	Yes, on all days excepting designated holidays			
	No, it always closes before time			
	Only on some days it functions for the stipulated time			
b.	If yes, specify stipulated OPD hours			

4.40	In cases where a patient needs to be admitted for inpatient care, is he/she admitted?			
	Yes, patients who can be managed at CHC are always admitted			
	Some deserving patients are not admitted but are referred to other facilities			
	Patients usually refused admission			
4.41.	Does the CHC provide treatment to emergency patients /victims of accident medical emergencies etc) at any time of the day/ night?			
	Emergency patients are given treatment. Where necessary, they are referred higher level Govt. hospital			
	Emergency patients are often not treated, referred to a public health care facility			
	Emergency patients are often not treated, referred to a private health care facility			
4.42.	If referred to a higher-level health care facility, how is the patient taken there?			
	Free transport by hospital ambulance			
	By hospital ambulance, but fuel and other charges have to be made by the patient			
	Private/ personal conveyance			

4.43.	Behavioral Aspects			
a.	How is the behaviour of the CHC staff with the patient			
	Courteous			
	Casual/indifferent			
	Insulting / derogatory			
b.	Is there corruption in terms of charging extra money for any of the service provided? (Yes / No)			
c.	Is a receipt always given for the money charged at the CHC? (Yes / No)			
d.	Is there any incidence of any sexual advances? Oral or physical abuse, sexual harassment by the doctors or any other paramedical? (Yes / No)			
e.	Are woman patients interviewed in an environment that ensures privacy and dignity? (Yes / No)			
f.	Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (Yes / No)			
g.	Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (Yes / No)			
h.	If the health centre is unequipped to provide the services needed, are patients transferred immediately without de1ay, with all the relevant papers, to a site where the desired service is available? (Yes / No)			

l.	Is there a publicly displayed mechanism, whereby a complaint/grievance can be registered? (Yes / No)			

V (A). Equipment (As per list)

Equipment	Available		Functional	Remarks / Suggestions / Identified Gaps

V (B). Drugs (As per essential drug list)

Drug	Available	Remarks / Suggestions / Identified Gaps

VI. Furniture

S.No.	Item	Current Availability at CHC	If available, numbers	Remarks / Suggestions / Identified Gaps
6.1.	Examination Table			
6.2.	Delivery Table			
6.3.	Footstep			
6.4.	Bed Side Screen			
6.5.	Stool for patients			
6.6.	Arm board for adult & child			
6.7.	Saline stand			
6.8.	Wheel chair			
6.9.	Stretcher on trolley			
6.10.	Oxygen trolley			
6.11.	Height measuring stand			
6.12.	Iron bed			
6.13.	Bed side locker			
6.14.	Dressing trolley			
6.15.	Mayo trolley			
6.16.	Instrument cabinet			
6.17.	Instrument trolley			
6.18.	Bucket			
6.19.	Attendant stool			

6.20.	Instrument tray			
6.21.	Chair			
6.22.	Wooden table			
6.23.	Almirah			
6.24.	Swab rack			
6.25.	Mattress			
6.26.	Pillow			
6.27.	Waiting bench for patients / attendants			
6.28.	Medicine cabinet			
6.29.	Side rail			
6.30.	Rack			
6.31.	Bed side attendant chair			

VII. Quality Control

S.No.	Particular	Whether functional / available as per norms	Remarks
7.1.	Citizen's charter (Yes/No)		
7.2.	Constitution of Rogi Kalyan Samiti (Yes/No) (give a list of office order notifying the members)		
7.3.	Internal monitoring (Social audit through Panchayati Raj Institution / Rogi Kalyan Samitis, medical audit, technical audit, economic audit, disaster preparedness audit etc. (Specify)		
7.4.	External monitoring (Gradation by PRI (Zila Parishad)/ Rogi Kalyan Samitis		
7.5.	Availability of Standard Operating Procedures (SOP) / Standard Treatment Protocols (STP)/ Guidelines (Please provide a list)		

ANNEX – V

REFERENCE DOCUMENTS

1. RCH Phase II – National Programme Implementation Plan (2005-2012), Ministry of Health & Family Welfare, Government of India (Document and CD available)

2. National Rural Health Mission (2005-2012) – Guidelines for Operationalizing Support Mechanism for ASHA 2006, Training Division, Department of Family Welfare, Ministry of Health & Family Welfare, Government of India

3. National Rural Health Mission (2005-2012) - Mission Document, Ministry of Health & Family Welfare, Government of India
   http://www.mohfw.nic.in/NRHM%20Mission%20Document.pdf

4. ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA) Guidelines, Ministry of Health & Family Welfare, Government of India
   http://www.mohfw.nic.in/eag/accredited_social_health_activis.htm

5. Reading Material for ASHA- Book No. 1, Ministry of Health & Family Welfare, Government of India

6. Facilitators Guide for ASHA- Book No. 1, Ministry of Health & Family Welfare, Government of India

7. National Rural Health Mission (2005-2012), Frequently Asked Questions, Ministry of Health & Family Welfare, Government of India
   http://mohfw.nic.in/Frequently%20Asked%20Questions-March%2022,%202005.pdf

8. Indian Public Health Standards (IPHS) for CHC – Draft Guidelines, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India
   http://www.mohfw.nic.in/draft%20chc%208march_final.pdf

9. Indian Public Health Standards (IPHS) for PHC – Guidelines, March 2006, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India
   http://www.mohfw.nic.in/IPHS%20for%20PHC%20_04.April.2006_.pdf

10. Indian Public Health Standards (IPHS) for SUB-CENTRES – Guidelines, March 2006, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India
    http://www.mohfw.nic.in/IPHS%20for%20SUB-CENTRES%20_07%20April%202006_.pdf

11. Janani Suraksha Yojana – Guidelines for Implementation
    http://www.mohfw.nic.in/layout_09-06.pdf

12. Guidelines for constitution of Rogi Kalyan Samiti / Hospital Management society
    http://www.mohfw.nic.in/Guidelines%20for%20Setting%20up%20Rogi%20Kalyan%20Samitis.htm

13. Implementation Guide on RCH II – Adolescent Reproductive Sexual Health Strategy for State and District Programme Manager, May 2006, Ministry of Health & Family Welfare, Government of India

14. Efficient Management of Community Health Centre, Rajasthan
    http://www.prod-india.com/searnum.asp?PNum=140

15. Good Practices

16. Letter of Mr. P. K. Hota, Secretary (FW), Government of India, Department of Family Welfare, Government of India regarding District Programme Management Units

ANNEX – VI

TIME LINE FOR NRHM ACTIVITIES

	Activity	Phasing and time line	Outcome Monitoring
1	Fully trained Accredited Social Health Activist (ASHA) for every 1000 population/large isolated habitations.	50% by 2007 100% by 2008	Quarterly Progress Report
2	Village Health and Sanitation Committee constituted in over 6 lakh villages and untied grants provided to them.	30% by 2007 100% by 2008	Quarterly Progress Report
3	2 ANM Sub Health Centres strengthened/established to provide service guarantees as per IPHS, in 1,75000 places.	30% by 2007 60% by 2009 100% by 2010	Annual Facility Surveys External assessments
4	30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 60% by 2009 100% by 2010	Annual Facility Surveys External assessments
5	6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 50% by 2009 100% by 2010	Annual Facility Surveys. External assessments.
6	1800 Taluka/ Sub Divisional Hospitals strengthened to provide quality health services.	30% by 2007 100% by 2010	Annual Facility Surveys. External assessments.
7	600 District Hospitals strengthened to provide quality health services.	30% by 2007 60% by 2009 100% by 2010	Annual Facility Surveys. External assessments.
8	Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals.	50% by 2007 100% by 2009	Annual Facility Surveys. External assessments.
9	District Health Action Plan 2005-2012 prepared by each district of the country.	50% by 2007 100% by 2008	Appraisal process. External assessment.
10	Untied grants provided to each Village Health and Sanitation Committee, Sub Centre, PHC, CHC to promote local health action.	50% by 2007 100% by 2008	Independent assessments. Quarterly Progress reports.

11	Annual maintenance grant provided to every Sub Centre, PHC, CHC and one time support to RKSs at Sub Divisional/ District Hospitals.	50% by 2007 100% by 2008	Independent assessments. Quarterly Progress Reports.
12	State and District Health Society established and fully functional with requisite management skills.	50% by 2007 100% by 2008	Independent assessment.
13	Systems of community monitoring put in place.	50% by 2007 100% by 2008.	Independent assessment.
14	Procurement and logistics streamlined to ensure availability of drugs and medicines at Sub Centres/PHCs/ CHCs.	50% by 2007 100% by 2008.	External assessment.
15	SHCs/PHCs/CHCs/Sub Divisional Hospitals/ District Hospitals fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB, HOV/AIDS, etc.	30% by 2007 50% by 2008 70% by 2009 100% by 2010	Annual Facility Surveys. Independent assessments.
16	District Health Plan reflects the convergence with wider determinants of health like drinking water, sanitation, women's empowerment, child development, adolescents, school education, female literacy, etc.	30% by 2007 60% by 2008 100% by 2009	Appraisal process. Independent assessment.
17	Facility and household surveys carried out in each and every district of the country.	50% by 2007 100% by 2008	Independent assessment.
18	Annual State and District specific Public Report on Health published	30% by 2008 60% by 2009 100% by 2010.	Independent assessment.
19	Institution-wise assessment of performance against assured service guarantees carried out.	30% by 2008 60% by 2009 100% by 2010.	Independent assessment.
20	Mobile Medical Units provided to each district of the country.	30% by 2007 60% by 2008 100% by 2009.	Quarterly Progress Report.

ANNEX – VII

DELEGATION OF ADMINISTRATIVE AND FINANCIAL POWERS

Level	Key Activities/Functions	**Delegation of administrative and financial powers required for effectiveness**
1. Village level	Constitution and capacity development of Village Health and Sanitation Committee, appointment of ASHA with co-terminality with ICDS, School Health Programme, untied grants for local action, household surveys, availability of drugs, establishment of referral chains, organization of campaigns for cleanliness and behaviour change, organizing Village Health Day at the ICDS center, setting up of revolving fund, performance assessment of ASHA, convergence/merger with other Committees, availability of JSY resources for institutional deliveries, immunization/other campaigns, development of local plans, etc.	1. Issue of implementation framework of the NRHM by Government of India to States, clearly stipulating the setting up of Village Health and Sanitation Committees by merger/fresh constitution, detailing the funds to be made available to these Committees, activities to be taken up from these resources, and specifying the process to be used for maintaining accounts of the VHSC, its audit, submission of utilization certificates, etc. 2. Issue of detailed consolidated instructions by the State Government specifying membership of VHSC, its integration with PRIs, process of its constitution, its account keeping and cheque signing powers, system of maintaining records, social/financial audit of funds, role in decentralized planning for health, convergence with other departments at the village level, etc. This instruction is best issued at the level of the Development Commissioner in consultation with the Panchayati Raj, Women and Child, School Education, Drinking water and Sanitation Departments, etc. 3. Time bound direction to districts for actual constitution of these committees, their training, selection of ASHAs, co-location of ASHA at the ICDS center, transfer of untied funds, etc.
2. Gram Panchayat/ SHC level	Constitution of SHC level Gram Panchayat Committee with representation to VHSCs, appointment of second ANM on local criteria and by local government against specific vacancy, opening of joint account of Sarpanch and ANM for untied funds for local health action and repair and maintenance, identification of Rural Medical Practitioners for skill upgradation, immunization campaigns, drug availability as per local need, ANC/PNC, maintenance of accounts of performance based payments, JSY, etc.	1. Finalization of Framework for Implementation of NRHM by Department of Health and Family Welfare, clearly spelling out the constitution of SHC/Gram Panchayat level Committee, its powers, functions, system of selection of additional ANMs on local criteria, resources to be made available to Gram Panchayats, their account keeping and audit, etc. 2. Issue of detailed consolidated instructions by State Governments on the role, power, functions, membership of the Gram Panchayat/SHC level Committees, its systems of account keeping, audit and record maintenance. 3. Issue of direction to districts to comply with formation and follow up in a time bound manner.

3. PHC/Cluster of Panchayat levels	Setting up PHC level Panchayat led Rogi Kalyan Samiti, appointment of two additional Staff Nurses on local criteria, 24X7 emergencies that could be attended by Nurses, co-location of AYUSH doctors, Posting of Medical Officers based on State's vision for that PHC, availability of drugs, key diagnostic tests, paramedic staff/facilities, provision of labour room/Normal deliveries, key point for national health programmes, etc.	1. Finalization of Framework for Implementation of NRHM by Department of Health and Family Welfare, clearly spelling out the constitution of PHC/Cluster level Committee, its powers, functions, system of selection of Staff Nurses on local criteria, resources to be made available to the PHC/Cluster, their account keeping and audit, etc. 2. Issue of detailed consolidated instructions by State Governments on the role, power, functions, membership of the PHC/Cluster level Committees, its systems of account keeping, audit and record maintenance. 3. Issue of direction to districts to comply with formation and follow up in a time bound manner.
4. Block CHC/ Panchayat Samiti level	Creating a Block level Public Health Team, supervising the network of health functionaries, amalgamating primary, secondary and tertiary care, integration of AYUSH, developing effective systems of distribution of supplies, supervising referral linkages, preparing Block level Health Plans, organizing community action, providing 24X7 Hospital services at Block level, training and skill development of community organizations/PRIs, ASHAs, ICDS workers, skill development of ANMs, Nurses, etc, conducting Facility Surveys, accrediting private providers for public health goals, setting up Block Resource Group, first level for integration of MIS/ Monitoring and evaluation, setting up of Block level Monitoring Group, constitution of RKS for the Block Hospital, Panchayat Samiti Committee for Block Health Plan and its implementation.	1. Issue of implementation framework for NRHM by Department of Health and Family Welfare, mandating a clear role for Block level Management of the Mission, under the umbrella of Panchayati Raj Institutions. 2. Issue of detailed consolidated instructions by the State Government on constitution of Block level Health Committee, Rogi Kalyan Samiti, etc., specifying specific procedures to be followed, composition of the Block level Health Management Mission, its staffing, etc. 3. Direction to districts to constitute and assign funds, functions and functionaries to Block level Panchayati Raj Institutions in a time bound way. 4. Setting up of Block level management team and resource group to meet managerial and capacity development challenges.
5. District Mission/ Zila Parishad level	Responsible for planning, implementing, monitoring and evaluating progress of Mission, preparation of Annual Work Plans and Budgets, suggesting district specific innovations, partnerships with PRIs, NGOs, strengthening training institutions for ANMs/ Para Medic functionaries, provide leadership to village, Gram Panchayat, Cluster and Block level Teams, establish District Resource Group for capacity building , fully operationalize District Hospital to IPHS, experiment with risk pooling, ensure referral chain and timely disbursal of claims, arrange for technical support as per need, nurture community processes, establish transparent systems of procurement and logistics, set up financial, programme, and data management teams to improve	1. Issue of implementation framework for NRHM by Department of Health and Family Welfare, mandating a clear role for District level Management of the Mission, under the umbrella of Panchayati Raj Institutions. 2. Issue of detailed consolidated instructions by the State Government on constitution of District / Zila Parishad level Health Committee, Rogi Kalyan Samiti, etc., specifying specific procedures to be followed, composition of the District level Health Management Mission, its staffing, etc. 3. Direction to districts to constitute and assign funds, functions and functionaries at district level under the umbrella of the Zila Parishad in a time bound way.

	management of an accountable health system, carry out health facility surveys and supervise household surveys, Develop District Health Action Plan under the umbrella of the Zila Parishad for convergent action, coordination with wider determinants of health, etc.	4. Clear constitution of District level Health Mission and the District Resource Group for improved management and capacity building.
6. State Health Mission level	To provide support to District Health Missions as per need, to provide capacity development support at all levels through the State Health System Resource Centre, SIHFW, RRCs, etc. , to develop planning and implementation norms in line with the National level implementation framework for NRHM< to release resources to districts and meet auditing and accounting standards, to engage professionals, NGOs, as per need to ensure that the finest human resource meet the needs of the Mission, to guide and train health teams at all levels, to get independent studies conducted, to establish transparent, timely and quality procurement procedures, to finalize formats for surveys, and reports and ensure their timely submission, to converge with other departments and seek facilitating administrative instructions, to involve non governmental providers and develop models for risk pooling.	1. Setting up of the State level Health Mission with skills needed to carry out the functions assigned to it by deputation, re-deployment and infusion of new skills wherever required. 2. Setting up approval and appraisal committees/bodies as required. 3. Setting up Grants in Aid Committees for consideration of NGO proposals. 4. Laying down clear administrative and financial responsibilities at every level. 5. Issuing clear guidelines for decentralized district level planning and implementation. 6. Set up the State level Health System Resource Centre to provide support for capacity development by hand-holding wherever required.
7.National Health Mission level	To provide a broad framework for implementation, to extend support for capacity development through the NIHFW and the National Health Systems Resource Centre, to appraise and approve District and State Health Action Plans and their Annual Work Plans and Budgets, in partnership with States, to lay down broad parameters for periodic assessment, to set Indian Public Health Standards and to monitor against agreed bench marks, to ensure a rigorous process of appraisal and approval that allows for need based local health action, to set broad framework for risk pooling, non governmental partnership, to develop appropriate management structures for improved service delivery, to push decentralization, delegation and devolution of funds, functions and functionaries within the Panchayati Raj framework, to provide leadership to States wherever required on technical matters, to involve institutions of excellence in building management capacities for improved health care delivery, and to engage with the process of skill development at all levels.	1. Issue of clearly articulated Framework for Implementation to facilitate delegation and decentralization of powers and functions. 2. Constitution of the NPCC, EPC, MSG to carry out its responsibilities with regard to appraisal and approval of proposals. 3. Set up the National Health Systems resource Centre as a registered society to provide support for capacity building at all levels. 4. Develop framework for monitoring, mentoring, independent evaluation, HMIS, human resource planning, financial guidelines, system of account keeping, audit, etc.

ANNEX – VIII

MONITORING FORMAT FOR NRHM

NATIONAL RURAL HEALTH MISSION

			STATUS AS ON		
Sno	Action Point				
	Administrative structure of the state				
1	Rural Population				
2	No.of Districts				
3	Number of Blocks				
4	Number of Villages				
	Rural Health Infrastructure				
5	Number of District Hospitals				
6	Number of Sub Div. Hospitals				
7	No. of CHCs	Available as on date			
		Requirement			
8	No. of PHCs	Available as on date			
		Requirement			
9	No. of Subcentres	Available as on date			
	No. of SCs	Requirement			

	Institutional Framework of NRHM				
10	**Organogram of Mission Directorate at State and District level**				
11	**Number of meetings of State Health Mission held till date during 2006-07**				
12	**Total Number of meetings of District Health Missions held till date during 2006-07**				
13	**Contact details of Mission Director**				
14	**Merger of Societies**	**State level Y/N**			
		No of Districts			
13	**No. of Rogi Kalyan Samitis registered**	**DH level**			
		CHCs			
		PHCs			
15	**MoU with Government of India signed**				

	Appointment of ASHA					
16	**Total num of ASHA to be selected over the Mission period**					
17	**No. of ASHA selected during 2005-06**					
18	**No. of ASHA selected during 2006-07**		**Target**			
			Achieved			
19	**Training Calendar of ASHA finalised (Y/N)**					
20	**Number of ASHA s who have received training**	**1st module**	**2005-06**			
			2006-07			
		2nd module				
		3rd module				
		4th module				
		5th module				
21	**Number of ASHAs who are in position with drug kits**					
22	**Total Num of Monthly Health Days held till date in the state during 2006-07**		**Target**			
			Achieved			

	Infrastructure & Manpower				
Sub Centres					
23	**No. of SCs which are functional with an ANM and Joint account with Pradhan has been operationalsied.**				
24	**No. of SCs where there are two ANMs positioned**				
25	**%of Subcentres which have submitted UC for untied funds released during 2005-06**				
Primary Health Centres (PHCs)					
26	**Total No. of PHCs functioning on 24x7 basis as on 31/3/2004**				
27	**No. of PHCs made functional on 24x7 basis during 2005-06**				
28	**No. of PHCs expected to be made functional on 24x7 basis during 2006-07**	**Target**			
		Achieved			
29	**No. of PHCs where AYUSH practitioners have been co located during 2005-06**	**Target**			
		Achieved			
30	**No. of PHCs where AYUSH practitioners are being co located during 2006-07**	**Target**			
		Achieved			
31	**No. of PHCs where three staff nurses are positioned**				

Community Health Centres (CHCs)					
32	**Total No. of CHCs selected for upgradation to IPHS**				
33	**Total No. of CHCs where facility survey has been completed**				
34	**Number of CHCs where physical upgradation work has been taken up**		**Identified**		
			Started		
			Completed		
First Referral Units (FRUs)					
35	**Number of FRUs working as on 31/3/2004**		**Sub Div Hospital**		
			CHC		
			PHC		
36	**Number of centres upgraded as FRUs during 2005-06**		**Sub Div Hospital**		
			CHC		
			PHC		
37	**Number of centres to be upgraded as FRUs during 2006-07**	**Sub Div Hospital**	**Target**		
			Achieved		
		CHC	**Target**		
			Achieved		
		PHC	**Target**		
			Achieved		

	Availability of Consumables					
38	**% of centres with at least two month supply of essential drugs**		**CHCs**			
			PHCs			
			SCs			
39	**% of centres with at least two month supply of vaccines**		**CHCs**			
			PHCs			
			SCs			
40	**% of centres with at least two month supply of contraceptives**		**CHCs**			
			PHCs			
			SCs			
	Manpower					
41	**Number of contractual manpower positioned during 2006-07**	**Specialist**	**Target**			
			Achieved			
		Doctors	**Target**			
			Achieved			
		SN	**Target**			
			Achieved			
		ANM	**Target**			
			Achieved			
		Others	**Target**			
			Achieved			
42	**Programme Management Unit set up at State level (Y/N)**					
43	**Number of Districts where PMU set up**					
	Number of Districts where the PMU has persons from	**Accounts**				
		Managerial				
		MIS				
44	**Number of Blocks where PMU set up**					

	Institutional Delivery				
45	**Number of Institutional Deliveries during 2005-06**				
46	**No.of beneficiaries of JSY (2005-06)**				
47	**Number of Institutional Deliveries expected during 2006-07**	**Target**			
		Achieved			
48	**No.of beneficiaries of JSY expected 2006-07)**	**Target**			
		Achieved			
49	**No.of pvt institutions accredited under JSY**	**Target**			
		Achieved			
	Decentralised Planning				
#	**Date by when Perspective State Action Plan under NRHM shall be finalised for Mission Period**				
51	**Date by when Annual State Action Plan under NRHM shall be finalised for 2006-07**				
52	**Number of Districts where Annual Integrated District Action Plan under NRHM prepared for 06-07**				
	Funds released to the States for JSY (Rs. In Lakh)				

	Num of Districts where AD syringes				
53	**Number of Districts where mobile medical units are working**				
54	**No. of Health Mela held during 2005-06**				
55	**No. of Health Mela to be held during 2006-07**		**Target**		
			Achieved		
56	**No. of beneficiaries of Male Sterlisation 2006-07**		**Target**		
			Achieved		
57	**No. of beneficiaries of Female Sterlisation 2006-07**		**Target**		
			Achieved		
58	**Total number of MNGOs in the state as on 31-3-2004**				
59	**Number of MNGOs Selected during 2005-06**				
60	**Number of MNGOs Selected during 2006-07**		**Target**		
			Achieved		
61	**Funds released for selection of MNGOs during 2006-07**				

	Financial Matters				
Financial Reporting during 2005-06					
62	**FMR for IV qtr of 2005-06 sent (Y/N)**	RCH II			
		NRHM			
		Immunisation'			
63	**Provisional UCs for 2005-06 submitted (Y/N), due date 30/4/2006**	RCH II			
		NRHM			
		Immunisation'			
64	**Audited statement of accounts for 2005-06 sent (Y/N) (due date 31/7/2006)**	RCH II			
		NRHM			
		Immunisation			
Utilisation of Funds during 2005-06					
65	**Total amount received from GoI during 2005-06**	RCH II			
		NRHM			
		Immunisation			
66	**Unspent Balance as on 31/3/2006**	RCH II			
		NRHM			
		Immunisation			
67	**Funds for JSY during 2005-06**	Allocated			
		Spent			

Financial status 2006-07					
68	**Amount of RCH II envelop (including JSY,Sterlisation, NSV) during 2006-07**	Allocation for year			
		Release till date			
		Transferred to Districts till date			
69	**Total funds available with the state (sum of unspent balance of 2005-06 plus amounts received during 2006-07**	RCH II			
		NRHM			
		Immunisation			
70	**Expenditure reported during previous quarter of 2006-07**	RCH II			
		NRHM			
		Immunisation			
71	**FMR for previous quarter sent (Y/N)**	RCH II			
		NRHM			
		Immunisation			

Financial Status - Disease Control Programmes during 2006-07

68	**RNTCP**	Allocation for year			
		Release till date			
		Total available funds with state (including past balances and current releases			
		Transferred to Districts during 06-07 till date			
68	**NVBDCP**	Allocation for year			
		Release till date			
		Total available funds (including past balances and current releases)			
		Transferred to Districts during 06-07 till date			
68	**NLEP**	Allocation for year			
		Release till date			
		Total available funds (including past balances and current releases)			
		Transferred to Districts during 06-07 till date			

68	**NBCP**	Allocation for year		
		Release till date		
		Total available funds (including past balances and current releases)		
		Transferred to Districts during 06-07 till date		
68	**NIDDCP**	Allocation for year		
		Release till date		
		Total available funds (including past balances and current releases)		
		Transferred to Districts during 06-07 till date		
68	**IDSP**	Allocation for year		
		Release till date		
		Total available funds (including past balances and current releases)		
		Transferred to Districts during 06-07 till date		