

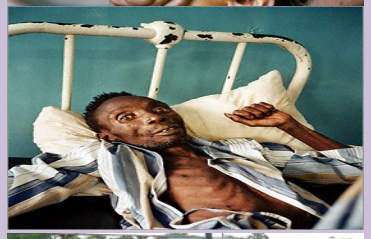




Training Module for DPMU Staff

Compiled & developed by:

State Institute of Health and Family Welfare, Jaipur
(An ISO 9001:2008 Certified Institution)

Supported by:
NRHM, Rajasthan

BSCIC Certifications Pvt. Ltd.

Certificate Of Registration

QUALITY MANAGEMENT SYSTEM

This is to certify that:

STATE INSTITUTE OF HEALTH & FAMILY WELFARE, RAJASTHAN
SOUTH OF DOORDARSHAN KENDRA
JHALANA INSTITUTIONAL AREA
JAIPUR – 302 004, RAJASTHAN, INDIA

Hereby granted the certificate Number BN1646/1169:0909

Subsequent to the assessment conducted on 26 Sept. 2009 and the organisation found operating a Quality Management System which complies with the requirements of ISO 9001:2008 for the following Scope:

To Develop Human Resources for Health (HRH) through Capacity Building, Training and Organization Development (OD) through Operation Research.

Originaly registered: 29 Sept. 2009 Latest issue. 29 Sept. 2009 Expiry Date: 28 Sept. 2012

For BSCIC CERTIFICATIONS PVT.LTD.:

Sanjay Seth
Managing Director

JAS-ANZ

ISO 9001 REGISTERED

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Mission

State Institute of Health & Family Welfare, Rajasthan is committed to improvement in health care through HRD, Health Service Research, Consultancy and networking in aiming at enhancement in the quality of life.

HEALTH SCENARIO:

	India	Rajasthan
Population 2001 [Million]	1028.6[1]	56.50[1]
Projected Population 2010 [Million]	1176.7[1]	66.75[1]
Health Care Infrastructure		
Community Health Centers	4276[2]	368[3]
Primary Health Centers	23458[2]	1503[3]
Sub Centers	146036[2]	11488[3]
Total FRUs	1813[2]	237[3]
Manpower Status		
Total Allopathic Doctors	725190[4]	26592[4]
Total Allopathic Doctors in Govt.	84852[4]	6285[4]
Total Dentist	73057[4]	364[4]
Total Ayurvedic Doctors	458418[4]	23861[4]
Total Registered ANMs	549292[4]	22239[4]
Total ANMs in Govt.	153568[2]	12150[3]
Total Registered GNMs	971574[4]	37667[4]
Total Registered LHVs	51497[4]	850[4]
Total Specialist at CHCs	4279[2]	811[3]
MBBS Doctors at PHCs	24375[2]	1379[3]
Mortality Indicators		
Infant Mortality Rate	53[5]	63[5]
Maternal Mortality Ratio	254[5]	388[5]
Total Fertility Rate	2.7[5]	3.4[5]
Crude Birth Rate	22.8[5]	27.5[5]
Crude Death Rate	7.4[5]	6.8[5]
Life Expectancy	66.9[4]	67.6[4]
Under 5 Mortality Rate	74.3[6]	85.4[6]
Health Care Indicators		
Doctor Population Ratio [per 1000]	0.63[4]	0.41[4]
Nurse Population Ratio [per 1000]	1.37[4]	0.94[4]
Bed Population Ratio	0.87[7]	0.67[8]
Population per Sub centre Ratio	7838[2]	5714[3]
Population per PHC	48799[2]	43679[3]
Population per CHC	267711[2]	178396[3]
Couple Protection Rate	54.1[9]	57[9]
Proportion of fully immunized children [12-24 months]	54.1[9]	48.8[9]
Proportion of Pregnant receiving ANC [Full ANC]	19.1[9]	6.6[9]
Proportion of Safe Deliveries	52.6[9]	52.7[9]
Institutional Deliveries	47[9]	45.5[9]

3. Census of India, 2. RHS-08, 3.DM & HS, Raj. 4. NHP-08, 5.SRS-09, 6.NFHS-3, 7.CBHI, 8.Pragati Partivedan, 2009, 9.DLHS-3

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National Rural Health Mission (2005-2012)

Conceived on: April, 2005 (May 2005 in Rajasthan)

Need:

1. Declining Public Health expenditure (1.3 % of GDP in 1990 to 0.9% in 1999)
2. Limited synergism in Vertical and Horizontal Health Programs
3. Lack of community ownership
4. Lack of integration of issues
5. Regional inequalities
6. Population stabilization still not met
7. Curative services favor rich
8. Poor coverage by Health insurance (only 10%)
9. Hospitalization eats 58% of annual income, 25% pop. falls below poverty line following hospitalization expenses.

Objectives:

1. To provide effective health care to rural population with focus on 18 States those have poor health indicators
2. To raise public health expenditure from 0.9% of GDP to 2-3% of GDP

Goals:

1. Reduction in IMR & MMR (Rajasthan)
    a. Infant Mortality Rate to be reduced to 56/1000 live births by 2011
    b. Maternal Mortality Ratio to be reduced to 285/100,000 by 2011
2. Universal access to public health services
3. Prevention & Control of Communicable diseases.
4. Access to integrated comprehensive primary health care
5. Population stabilization, gender and demographic balance.
6. Revitalize local health traditions and mainstream of AYUSH.
7. Promote healthy life styles.

National Goals in context of MDGs

	Current	**10th FY Plan**	**NPP 2010**	**MDG 2015**
Total Fertility Rate	**3 (2003)**	**2.3**	**2.1**	**--**
Infant Mortality Rate	53 (SRS-2009)	45	<30	<27
Neonatal Mortality rate	37 (NFHS III)	26	<20	<20
Maternal Mortality Rate	254 (SRS 2006)	200	<100	<100
Institutional deliveries	45.5 % (DLHS-3)	80%	80%	-

The NRHM carries a paradigm shift with-

- **Decentralised planning**
- **Outputs and Outcome based**
- **Pro-Poor Focus: Equitable systems**
- **Quality of Care and the IPHS norms**
    - Rights based service delivery
    - Pre stated entitlements at all levels
    - Inputs computed as function of the entitlements and estimated patient load
    - Judicious mix of dedicated budget lines - untied funds
    - Monitor quality
    - Community Participation
- **Bringing the public back into public health**
    - At hamlet level: ASHA, VHSC, SHGs, Panchayats.
    - At the facility level: RKS
    - At the management level : health societies
- **Governance reform**
    - Manpower, Logistics & Procurement processes.
    - Decision making processes
    - Institutional design, Accountability framework
- **Convergence**
    - Water and sanitation
    - Nutrition
    - Education

The Mission outcomes are expected to follow a phased approach and are at two levels:

1. National Level

a. Infant Mortality Rate to be reduced to 30/1000 live births
b. Maternal Mortality Ratio to be reduced to 100/100,000
c. Total Fertility Rate to be brought to 2.1
d. Malaria mortality reduction rate – 50% up to 2010, additional 10% by 2012
e. Kala Azar to be eliminated by 2010.
f. Filaria/Microfilaria reduction rate: 70% by 2010, 80% by 2012 and elimination by 2015
g. Dengue mortality reduction rate: 50% by 2010 and sustaining at that level until 2012
h. Japanese Encephalitis mortality reduction rate: 50% by 2010 and sustaining at that level until 2012
i. Cataract Operation: increasing to 46 lacs per year until 2012.
j. Leprosy prevalence rate: to be brought to less than 1/10,000.
k. Tuberculosis DOTS services: from the current rate of 1.8/10,00, 85% cure rate to be maintained through the entire Mission period.
l. 2000 Community Health Centers to be upgraded to Indian Public Health Standards
m. Utilization of First Referral Units to be increased from less than 20% to 75%
n. 250,000 women to be engaged in 18 states as Accredited Social Health Activists (ASHA).

2. Community Level

a. Availability of trained community level worker at village level, with a drug kit for generic ailments
b. Health Day at Anganwadi level on a fixed day/month for immunization, ante/post natal checkups mother & child healthcare, including nutrition
c. Availability of generic drugs for common ailments at Sub-centre and hospital level

d. Good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level
e. Improved access to Universal Immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization services under the program
f. Improved facilities for institutional delivery through provision of referral, transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the Below Poverty Line families
g. Availability of assured healthcare at reduced financial risk through pilots of Community Health Insurance under the Mission
h. Provision of household toilets
i. Improved Outreach services through mobile medical unit at district-level.

Areas addressed:

1. AYUSH
2. Maternal & Reproductive health
3. Population stabilization
4. HMIS
5. Micro planning
6. Integration of programs and services
7. Health expenditure pattern and quantum
8. Indian Public Health Standards (IPHS)
9. Interstate and inter district disparities
10. Access, Availability, Affordability and equity

Components of NRHM:

1. RCH-II
2. All activities of NRHM
   a. ASHA
   b. JSY (Janani Suraksha Yojana)
   c. Institutional deliveries and cash assistance
   d. United fund of Rs. 10000/- for each Sub Centre
   e. Dai Training
   f. RCH camps
   g. On-Contract staff deployment
   h. Immunization
   i. National Health Programs
   j. Inter-sectoral and inter-departmental coordination
3. Vector Borne Disease Control Program
4. TB control program
5. Blindness control
6. Leprosy Eradication
7. Iodine Deficiency Disorders
8. Disease Surveillance project
9. HMIS

Reach:

18 High focus statesStates (UP, Uttaranchal, MP, Chhattisgarh, Bihar, Jharkhand, Orissa, **Rajasthan,** HP, J&K, Assam, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Mizoram, Sikkim and Tripura)
Now extended to entire country

Approach:

The 5 main approaches under NRHM are-

1. **Communitize**
    a. Hospital Mgt. Committees/ PRIs at all levels
    b. Untied grants to communities / PRI bodies
    c. Funds, functions and functionaries to local community
    d. Decentralized planning
    e. Intersectoral convergence
2. **Flexible Financing**
    a. Untied grants
    b. NGOs for public health goals
    c. NGOs as implementers
    d. Risk pooling
    e. More resources for more reforms
3. **Improved management through capacity building**
    a. Block and District health offices through mgt.
    b. NGOs in capacity building
    c. NHSRC/ SHSRC/ DRG/BRG
    d. Continuous skill development support
4. **Monitor progress against standards**
    a. Setting IPHS standards
    b. Facility surveys
    c. Independent monitoring committees at Block, District & State
5. **Innovation in human resource management**
    a. More nurses-Local resident criteria
    b. 24 x 7 emergencies by Nurses at PHC. AYUSH
    c. 24 x 7 emergencies by Nurses at CHC
    d. Multi skilling.

Strategy:

1. Capacity building of PRIs to own and manage public health services.
2. Promote access to improved health care at house hold level through ASHA (Accredited Social Health Activists).
3. Health plan for each village (micro-planning) through village Panchayat health committees.
4. Strengthening sub-centre through a united fund to enable local planning and action.
5. Strengthening existing CHCs with provision of 30-50 beds per lac population for improved curative care to a normative standard (IPHS) regarding personnel, equipment, and management standards.
6. Preparation and implementation of an inter-sectoral district Health plan prepared by District Health Mission including Water, Sanitation & Hygiene and Nutrition.
7. Integration of Vertical Health & Family Welfare Programs at National, State, District and Block levels.
8. Technical support to National, State and District Health Missions.
9. Strengthening capacity for information management and evidence based planning, monitoring and supervision.
10. Developing capacity for preventive health care.
11. Promoting Non-profit sector particularly in under served areas.

12. Supplementary strategy-
    a. Regulation of private sector
    b. Promotion of Private Public Partnership
    c. Mainstreaming AYUSH
    d. Re-orienting Medical Education towards rural health issues
    e. Effective and viable risk pooling and social health insurance

Situation at the time of rolling out of NRHM

Indicator	source	National situation	Current value
IMR	SRS 25, RGIs Office	58 (Kerala:14, MP: 76)	53 (SRS, Oct.2009) Rajasthan-63
Maternal Mortality Ratio		301 (Kerala:4,UP: 517)	254 (Special bulletin on MMR-SRS 2004-06, Rajasthan-388
Non hospitalized treatment on Govt. facilities	NSS 60 th round 2004	22% (Bihar 5%, HP-68%)	
In patient treated in Public Hospitals	NSS 60 th round 2004	41.7% (Bihar-14.4%, J&K-91.3)	
Average medical expenditure per Hospitalisation	NSS 60 th round 2004	Rs. 3238 in Govt. Hospitals to Rs.7408 in pvt. Hospitals in rural areas	
State of Health facilities	DLHS and facility survey coordinated by IIPS 2003	Adequacy cut off- 60% Infrastructure- 76% FRU's, 63% of CHC's, Equipment: 61% FRU's, 46% CHC's Manpower: 37% FRU's and 14% CHC's	
Anemia among children and women	NFHS-III (2005-06)	79.1%-6-35 months 56.1% women	
Immunization	UNICEF's coverage evaluation survey 2005	54.5% children	Rajasthan-FI-48.8% (DLHS-3)
Institutional births, 3 antenatal care visits, post natal care	NFHS-III (2005-06)	40.7% institutional births , 50.7% 3antinatal care visits, 36.4% post natal	Rajasthan-ID-46% (DLHS III, 2008), ANC-56%, PNC-38.2%
Child morbidity	FOCUS survey 2004 (Jean Dreaz et al) in Tamil Nadu, HP, Maharashtra, Raj, Chattisgarh, and UP	Fever-32%, Dioarrrohea-21%,persistant cough-17%, extreme weakness- 11%, skin rashes-5%, eye infections - 2%, 50% children had one of the above problems	

Institutional mechanism:

Under the NRHM, institutional mechanisms have been created at each level to support National Health Programs & improve delivery of health care services. These are-

1. Village Health & Sanitation Committee (VHSC)
2. Accredited Social Health Activist (ASHA)
3. Rogi Kalyan Samities (RKS/RMRS in Rajasthan)
4. Panchayati Raj Institutions (PRIs)
5. Finance Management Group (FMG)

Execution & Monitoring:

Institutional Set-up-

Mission Steering Group:

1. **National Level-**

   Chairman - Union Minister H & FW
   Members - Rep. of Planning Commission
   - Secretaries of 4 States from Rural Development Panchayati Raj HRD H & FW
   - 10 Public Health Representatives

2. **State Level-**

   Chief Secretary, GOR, Chairperson.
   Addl. Chief Secretary (Development), GOR, Co-Chairperson.
   Principal Secretary, Health & Family Welfare, GOR, Vice-Chairperson.
   Principal Secretary-Finance, Member.
   Principal Secretary-Panchyati Raj and Rural Development, GOR, Member
   Principal Secretary-Women & Child Development, GOR, Member.
   Secretary FW & Mission Director-NRHM, GOR, Executive Secretary.

State Health Mission:

State Health Mission's role includes the following:

1. Actively undertake Policy and Institutional Reforms to enable effective implementation of NRHM
2. State level planning, implementation and monitoring.
3. Support District level planning, implementation and monitoring.
4. Provide Training support to districts.
5. Coordination across relevant departments.
6. Sharing of experiences across districts.
7. Management of cash flows.
8. Financial accounting/ administration.

The state has registered a single State Health Society through merger of all state level societies in the Health and Family Welfare sector, except the State Aids Control Society.

These Societies will maintain separate Bank Accounts even under the unified structure. Funds for separate programs would continue to flow under Sub-Budget Heads of the NRHM Budget Head. The Integrated State Health and Family Welfare Society has a full-time secretariat to act as the State Program Management Support Unit (SPMSU), headed by a full time Executive Director. The SPMSU will

(a) Assist the Directorate of Health & FW in implementation,

(b) Act as the coordinating agency with other Departments for the Mission and

(c) Perform the role of the secretariat of the State Health Mission

State Health Society:

Objectives

The Society shall serve in an additional managerial and technical capacity to the Department of Health & Family Welfare, Government of Rajasthan for the implementation of National Rural Health Mission (NRHM) in the State.

Scope of functions

To achieve the above objectives, the Society shall direct its resources towards performance of the following key tasks:

1. Receive, manage (including disbursement to implementing agencies e.g. Directorate, District Societies, NGOs etc.) and account for the funds received from the Ministry of Health & Family Welfare, Government of India and other sources.
2. Manage the NGO / PPP (public–private partnership) components of the NRHM in the State, including execution of contracts, disbursement of funds and monitoring of performance.
3. Function as a Resource Centre for the Department of Health & Family Welfare in policy/situational analysis and policy development (including development of operational guidelines and preparation of policy change proposals for the consideration of State Government).
4. Strengthen the technical / management capacity of the State Directorate as well as of the Districts Societies by various means including through recruitment of individual / institutional experts from the open market (with total program management costs for the State as a whole not exceeding 6% of the total program costs).
5. Mobilize financial / non-financial resources for complementing/supplementing the NRHM activities in the State.
6. Organize training, meetings, conferences, policy review studies / surveys, workshops and inter-State exchange visits etc. for deriving inputs for improving the implementation of NRHM in the State.
7. Undertake such other activities for strengthening NRHM in the State as may be identified from time to time, including mechanisms for intra and inter-sectoral convergence of inputs and structures.

District Health Mission & Society:

At the district level all existing societies have been merged into the District Health Society with its apex body performing the functions of the District Health Mission (DHM). It is envisaged that the Secretariat of the District Health Society should have a small but dedicated unit for inter-sectoral co-ordination, which may directly report to the CEO, Zilla Parishad.

Roles and Responsibility of District Health Mission include:

1. District health planning, implementation and monitoring
2. Coordination across relevant Departments
3. Management of cash flows
4. Financial accounting/ administration

Members of District Health Society:

1. District Collector Chairperson
2. CEO-Zila Parishad Co-Chair person
3. CM &HO Chief Executive officer
4. Project Director DRDA Member

5. Dy. Director ICDS Member
6. Officer in charge-Total Sanitation Campaign. Member
7. Executive Engineer-PHED Member
8. District Education Officer-Primary & Secondary Member
9. CHC incharges Member
10. Three Representative of Medical Associations/MNGOs/SNGOs to be dominated by collector.
11. Member
12. Additional CMHO- Member
13. RCHO- Member
14. District Ayurved Officer- Member
15. District Program Officer - Convener

Program Management Units:

State Program Management Unit (SPMU)

The main objective of establishing this unit is to strengthen the existing management structures/functions at the state and district levels respectively as RCH-II is characterized by allocation of flexible funds to states, preparation of program implementation plans by States and districts and performance linked disbursement based on MOU.

The SPMU consists of following four positions:

State Program Manager
State Finance Manager
State Accounts Manager
State Data Officer
Role of SPMU

The SPMU is responsible for the overall state level planning and monitoring for NRHM, management of flexi-pool funds, initiation of health sector reforms, continuous process improvement and for secretarial functions to the State Health Mission and State Health Society.

District Program Management Unit (DPMU)

While the Collector would continue to be the Chairperson of District RCH Society, suitable manpower resources for program management and finance/accounts functions has been provided. The district level functions include planning, implementation and monitoring of all EAPs including RCH II, finance and accounting, training and capacity building, MIES and district plans etc.
The district PMU is composed of three skilled personnel i.e. Program Manager, Accounts Manager and Data Assistant;

District Action Plan

District Health Action Plan is to be prepared by each District. The Key strategies suggested for DAP are as follows:

Block will be the key level for development of decentralized plans so each block will be covered under the DAP and a block level plan will be prepared for each block in each district.
Technical resource agency/ groups will be identified for each block to assist in planning.
A technical resource agency would be identified for the District to support the implementation of the DAP.

Four broad categories of programs have been indicated under NRHM.

1. RCH-II activities and programs
2. NRHM activities such as IPHS, Untied funds, JSY, and integration, AYUSH, nutrition and child development
3. National Disease Control Program
4. Immunization
5. A number of inputs have been suggested under NRHM implementation framework. A detailed plan for additional ties will be incorporated in the DAP.

Facility survey of the PHCs, CHCs and Sub Centre is a critical part of the DAP. As State has taken the decision to conduct the Facility Survey of health institutions (CHC/PHC) separately, from the DAP but in the frame work of DAP there should be clearly indicated the provision of facility survey under NRHM. Cost for the facility survey will not be the part of DAP.

Under NRHM there is provision of untied fund for the different levels Village, Block and District. GoI is yet to indicate the amount of untied funds. So under plan there should be the action points for utilizing the untied funds.

Under NRHM & RCH-II, a list of proposed activities have been worked out and a templates of the activities have been developed this template will be used as worksheet for the action plan for each year activities.

Under NRHM DAP will be prepared with involvement of different sectoral departments such as DWCD, PHED and Rural Development, Panchayati Raj and AYUSH etc. All the activities of NRHM related to other departments will be spelt out clearly with budget provisions.

Village Health Sanitation Committee (VHSC)

The NRHM framework support decentralized planning & monitoring up to the grass root level. Therefore it was decided to entrust village level committees of the users group, community based organization for the planning monitoring & implementation of NRHM activities into the 41000 revenue villages of the State.

The VHSC will be the key agency for developing Village Health Plan & the entire planning of village Panchayat for NRHM. This committee comprises of Panchayat representatives, ANM, MTW, Aganwari workers, Teachers, Community health volunteers, ASHA.

NRHM Funding:

Amount: 6713 crores for 2005-06, Rs. 20300 crores (2008-09), Rs. 55800 (2011-12)
Rajasthan-1010 crores for 2009-10
State contribution –minimum 10% increase per year in State Health Budget for Public Health Expenditure under signed MoU with GOI
More than 70% going to block level and below

Fund flow: Advance to States
State plans to be funded through RCH-II and NDCP
Societies for H & FW to be merged into one Society at District and State level for funneling of funds

Addl. Inputs: Rs. 20 lacs per district for 2 CHCs for up gradation up to IPHS
Maintenance grant of Rs 1 lac per CHC after constitution of RKS
United fund of Rs. 10000 per Sub Centre
Supply of Additional drugs
Mobile Medical units at District

Key Activities (2005-06):

1. Constitution of State & District Health Missions
2. Merger of Health & Family Welfare Societies
3. Preparation of State Action Plans-identifying sectoral needs and priorities
4. Finalizing performance bench marks for MoU
5. Signing of MoU between State & GOI
6. Preparation of District Plans
7. Upgrading 2 CHCs in each District as per IPHS with provision of 2 rooms for AYUSH
8. Formation of Rogi Kalyan Samitis (RMRS in Rajasthan)
9. Strengthening Immunization
    a. Induction of Auto-disabled Syringes
    b. Arrangement for alternate vaccine delivery at immunization sites
10. Organizing mobile medical services at District level
11. Organizing health camps at AWW level on fixed day each month
12. Provision of House hold toilets
13. Strengthening institutional delivery under JSY
14. Establishing systems to increase accountability of Health System to PRIs
    a. Selection & Training of ASHA, including provision of drug kits
    b. Organizing Health Melas to inform & educate people about NRHM
    c. Provision of generic drugs (for AYUSH & Allopathic) at village/ SC/ PHC/ CHC level for common ailments

Key activities planned under PIP (2009-10)

A. Strengthen the sub centres

1. United fund for local action @ Rs.10, 000 per annum.
2. Supply of essential drugs, both allopathic and AYUSH ,
3. Sanction of new Sub – centres as per 2001 population norm.
4. Upgrading existing Sub – centres,

B. Strengthen the Primary Health Centres

1. Adequate and regular supply of essential quality drugs and equipment to PHCs,
2. Provision of 24 hour services in 50%
3. Mainstreaming AYUSH manpower,
4. Standard treatment guideline & protocols,
5. Supply of Auto Disabled Syringes, for immunization, intensification of ongoing communicable Disease control programs, new programs for control of non – communicable diseases,
6. Up gradation of 100% PHCs as FRUs , and provision of 2nd doctor at PHC level(1male, 1 female)

C. Strengthening CHCs for first referral care

This includes, operationalizing CHC (30-50 beds) as 24 Hour FRUs, including posting of anesthetists, - 2 CHCs per district initially, SC/PHC/CHC to be upgraded to IPHS, promotion of Rogi Kalyan Samitis for hospital management, developing standards of services and costs in hospital care, creation of new CHCs (30-50 beds) to meet the population norm as per Census 2001.

D. District Health Plan as per Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition

E. Convergence of sanitation and hygiene under NRHM

F. Strengthening disease control program

G. Public Private Partnership for public health goals, including regulation of private sector

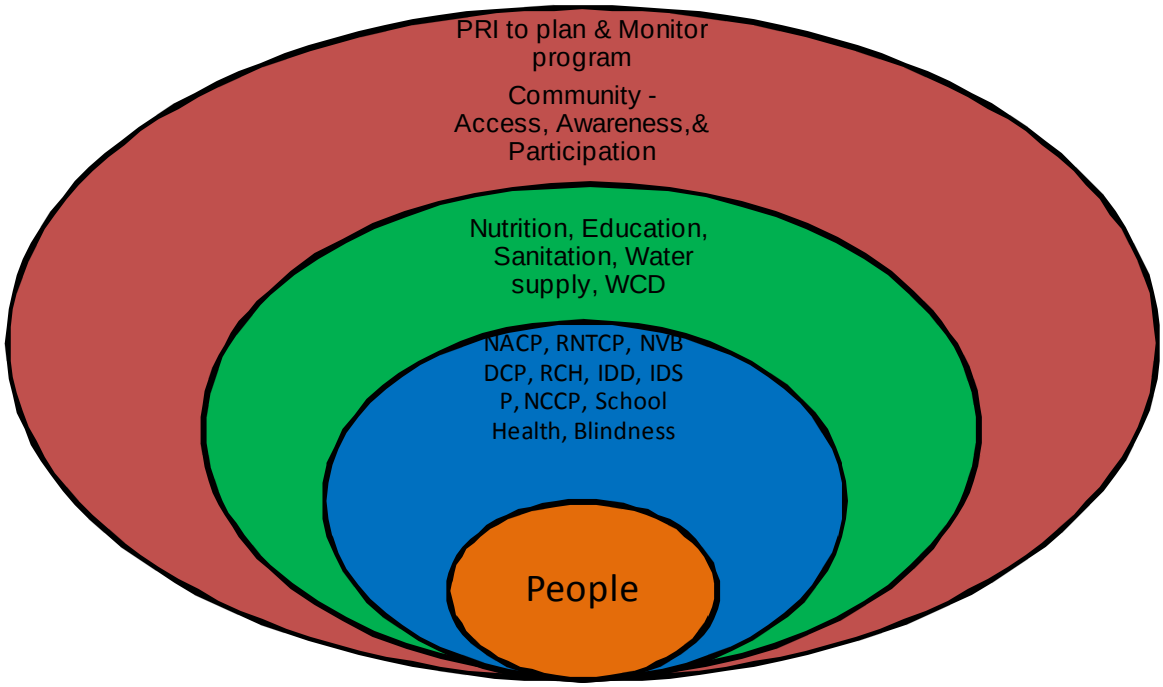
H. New health financing mechanisms

I. Measures to re-orient health/medical education to support rural health issues

The Mission envisages the following roles for PRIs;

1. ASHAs would be selected by and be accountable to the Village Panchayat.
2. The Village Health Committee of the Panchayat would prepare the Village Health Plan, and promote intersect oral integration.
3. The united fund at Sub-centres to be deposited in a Bank Account, jointly operated by the ANM and Sarpanch.
4. District health Mission to be led by the Zila Parishad.
5. The DHM would also guide activities of sanitation.
6. States are to indicate in their MOUs devolution of funds and programs to PRIs.
7. The DHM will control, guide and manage all public Health institutions in the district, Sub-centres, PHCs and CHCs.
8. PRI involvement in Rogi Kalyan Samitis is to ensure good hospital management.
9. Training to members of PRIs and making available health related databases to all stakeholders, including Panchayats at all levels are planned under NRHM.

Integrated Service delivery under NRHM:



Health care delivery system in India

Milestones in Health services development in India

1. **1947**
    a. Bhore committee appointed.
    b. India became independent country
    c. Establishment of Ministries Of Health And Director General Of Health Services
    d. Became the member of WHO
    e. Development of Primary Health Centers as the nodal centers for providing health services
    f. Integrated approach with referral system
    g. Health as a state subject
    h. Launching of national programs on malaria, small fox, Filaria, TB etc.
2. **1948**
    a. Establishment of dental council of India
    b. Health subcommittee of the National Planning Committee
    c. Committee suggested preventive approach to Primary health care
    d. Preservation and maintenance of the health of the people should be the responsibility of the state
3. **1949:** Establishment of Pharmacy council of India, Family Planning Association of India.
4. **1952:** Appointed population policy committee Creation of Family Planning Cell in the Director General of Health Services.
5. **1951-56: First five year plan** launched
    a. Million rupees allocated to family planning and only 1 million was spend, voluntary effort.
    b. Launching of Malaria Eradication Program in 1953,
    c. Leprosy control program in 1954
    d. Filaria control program in 1955,
    e. National TB sample survey 1955
    f. Establishment of institutions like AIMS, CPHEO
    g. Still low priority to health sector
    h. Only 725 PHC are opened with limited staff
1. **1956-61: Second Five year plan** was launched –143 Crores for health sector out of 4672
    a. Establishment of Indian medical council and Central Health education Bureau
    b. Mudaliar committee was appointed to review the first and second five year health plans.
    c. Malaria Control program was renamed as National Malaria eradication program
    d. National TB survey completed and national TB institute was established
    e. Total 1840 new PHC were opened
2. **1961-66: Third Five-year plan** was launched.
    a. Mudaliar committee report published. Allocated 342 Crores for health sector.
    b. UN Health mission visit and suggestion of Population control.
    c. Central Bureau of health intelligence was established
    d. Small pox eradication program,
    e. Goiter control program,
    f. District TB program were launched.
    g. National institute of communicable diseases,
    h. National institute of health administration and education were created.
    i. Family welfare given priority.
    j. Malaria program became successful and other progress with the other programs.
    k. Family welfare became an independent department.

l. Target approach to Family Planning evolved. Sterilization approach.
m. Promotion of nutrition education.

3. **1966-69**
   a. Jungalwala committee (small family committee) submitted report.
   b. National Nutrition Monitoring Bureau was started.
   c. Progress on many indicators like death and birth rate.
   d. 315 new PHCs were established.
   e. Sample registration system was launched to generate health data.
4. **1969-74**
   a. Emphasis on training facilities for different cadres of personnel.
   b. Medical termination of pregnancy bill passed.
   c. Post Partum scheme started.
   d. 364 new PHC were opened.
   e. Marginal improvements in indicators.
   f. Integration of Family Planning services with MCH services and increased acceptance of contraceptive methods.
   g. Proposed increased nutrition plan.
   h. Midday meals program to cover 14 million children.
5. **1974-79 : Fifth Five year plan** was launched
   a. National minimum needs program was launched and health services, drinking water supply, environment improvement of slums were included as components.
   b. Srivastava committee recommendation and Community Health worker scheme was launched. Part time and honorarium to be paid to them. Principle thrust was to accelerate the Family planning targets in birth rate.
   c. Compulsive approach in national emergency 1977 through camps, and increased fundings.
   d. Government change and new policy on Immunization, woman's education, and emphasis on family welfare.
   e. National rural health scheme was launched and also NIHFW.
   f. WHO adopted **Health for All by 2000 AD** (Alma-Ata Declaration, 1978)
   g. Improved attention on nutrition status of woman.
   h. **Integrated Child Development Services (ICDS**) was launched.
   i. National population policy was introduced. (Raising of age of marriage for men and woman from 15 to 18 years for females and 18 to 21 for males, Freezing of Peoples representation in legislatures and parliament on the basis of 1971 census till 2001. more central assistance to state on family planning.
6. **1980-85:** National Health Policy formulated, 1983
7. **1985-90**
   a. National AIDS Control Program, 1987
   b. Emphasis on consolidation and operationalization of PHCs and CHCs.
8. **1992-97:** VIII Five year plan launched
   a. Convergence of various schemes provided by different sectors, decentralized planning, urban health centers development.
   b. Draft population policy- suggestion of social development committees at different levels.
   c. Adoption of National Nutrition Policy.
   d. Launching of major projects by states to develop secondary level health infrastructure. Andhra Pradesh, Maharashtra, Orissa, Punjab and West Bengal.
   e. ICDS renamed Integrated Mother and Child Development (IMCD)
   f. IX Five year plan launched (1997-2002)

g. RCH phase- I, 1997 October
h. NSPCD-1997
i. 2000 National population Policy
j. 2002 National Health Policy (revised)
k. 2004 RCH- Phase-II, integration of Japanese Encephalitis, Kalazar, Dengue, Filaria and Malaria into *National Vector Borne Disease Control Program*
l. 2005 National Rural Health Mission launched.

9. **1997-2002:** IX Five year plan launched
10. **2002-2007:** X Five year plan launched
11. **2007-2012:** XI Five year plan launched

The rave review clearly establishes a few facts-

a. There was NO Health Policy for the country for 36 years
b. The Health was left to the wisdom of Committees and Commissions
c. Each Committee addressed to a single specific issue.
d. Comprehension was missing
e. Majority of recommendations of every committee were reiterations of Bhore Committee.
f. Individual "Health" Programs were developed in isolation based on situational exigency.
g. Uni-purpose workers were created later baptized as Multi-purpose.
h. Some Programs worked in complete isolation till 1980 (e.g. NTCP).

Health per se had a fragmented approach till 1978 when Global concern dictated in favor of HFA-2000 and, with a little longer latent period at last, a National Health Policy (1983) was formulated.
It is not that nothing was done till 1983 or that the Programs could not achieve any thing. We have seen Small pox eradicated through the same infrastructure, and Human resource. Somehow, the frequent Paradigm shifts (e.g. Age at which BCG vaccine is to be administered) have made the system cluttered and indifferent.

Achievements through the Years - 1951-2000 :

Indicator	1951	1981	2000
Demographic Changes			
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
IMR	146	110	70 (99 SRS)

The progress was not restricted to a few demographic indicators wherein substantial improvements were made over last 50 years, and remarkable progress was made in reducing morbidity/ mortality on account of Communicable disease.
A large health care service delivery infrastructure today complements the efforts and inputs provided to accomplish the policy objectives and goals. A quick review of the Epidemiological shifts in communicable diseases and the Infrastructure gives us the following picture

Epidemiological Shifts	1951	1981	2000
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no of cases)	>44,887	Eradicated	
Guinea worm (no. Of cases)		>39,792	Eradicated
Polio		29709	265
Infrastructure			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors (Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)

Encouraged by the said achievements, threshold levels were raised and new goals were set as follows-

Goals to be achieved by 2000-2015:

Eradicate Polio and Yaws	2005
Eliminate Leprosy	2005
Eliminate Kala Azar	2010
Eliminate Lymphatic Filariasis	2015
Achieve Zero level growth of HIV/AIDS	2007
Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
Reduce Prevalence of Blindness to 0.5%	2010
Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
Increase utilization of public health facilities from current Level of <20 to >75%	2010
Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005

Health Care Systems in India

1. **Public Sector**
    a. Rural Health Scheme
        i. Primary Health Centers
        ii. Sub-Health Centers
    b. Hospitals/Health Centers
        i. Community Health Centers
        ii. District Hospitals
        iii. Apex Hospitals
        iv. Teaching Hospitals
    c. Health Insurance Schemes
        i. Employees State Insurance
        ii. Central Government Health Scheme
    d. Other Agencies
        i. Defense Medical and Health Services
        ii. Railways Medical and Health Services
2. **Private Sector**
    a. Hospitals and Nursing Homes
    b. General Practitioners
    c. Medical Insurance

Health system operating in India

The systems in operation in India are classified based on Nature/ Philosophy or Services as follows-

Philosophy of Services:

1. **Official / Allopathic**
2. **Indigenous/Traditional**
    a. Ayurvedic
    b. Unani
    c. Homeopathy
    d. Naturopathy
    e. Siddha
    f. Chinese
    g. Tibetan
    h. Yoga & Meditation
    i. Hypnosis

j. Divination & Exorcism
k. Individual therapies like

Nature of service

1. Indigenous- in rural areas
2. General care- for poor
3. Speciality
4. Corporate- for elite class

Modern medicine (concepts: Hippocrates, Gelen, Lind, J. Graunt, J. Snow, L. Pasteur, William Bud, Robert Koch,)

Strengths

1. Systematic approach
2. Search for cause & causal association
3. Data base
4. Powerful pharmacopeia
5. Diagnostic technology
6. Quick
7. interventional procedures
8. Epidemiological developments

Weaknesses

1. Cost
2. Isolated-anatomical approach
3. Dependence on technology
4. Human touch
5. Iatrogenic diseases.
6. Irrational drug use
7. Voracious resource eater
8. Western

Health system classified in relation to traditional medicine-

Exclusive (tolerant): UK, Germany
Inclusive: India, Pakistan, Burma, Sri lanka, Bangladesh, Thailand
Integrated: China, Nepal

Health systems in India (Inclusive)

Official/ Allopathic

-Cost
-Coverage
-Coordination
-Culture

Traditional (ethno / alternative/ indigenous/ unofficial)

-Roots
-Respect
-Reach
-Rural
-Renaissance
-Role

The fragmented approach to health continued for quite some time till the stubborn complacency was dropped at Alma Ata in 1978 where a global concern by all member countries converged to a goal of Health for All by2000 (HFA-2000).

The basic strategy adopted was "primary health care" in order to make the health care services "Acceptable", "Available", "Accessible", "Affordable", "Appropriate" through "Equitable distribution" and "Community Participation". It was further appreciated, during the process of evolution of National Health Policy (1983) that in order to reach masses with primary health care approach, a large number of manpower shall be required for which practitioners of Traditional medicine, with roots and respect in community, can be of great help.

Over period of last 62 years, some of the laudable achievements are-

a. Decrease in Crude Death Rate
b. Decline in Crude birth rate
c. Increase in Life expectancy
d. S.pox & G. worm eradicated
e. Leprosy eliminated
f. Reduction in IMR
g. Infrastructure – expanded

Public Health Governance in India:

National Development Council

Highest constitutional Policy making body to approve Policies and strategies for development

Composition:

Chairman- PM
Members- Central Ministers
Chief Ministers
Lt. Governors & Administrators of UTs
Dy. Chairman & members of Planning Commission

Planning Commission-

Composition: Chairman—PM
Dy. Chairman
Members 5-7 (Full time)
2-3 (Part time)

Functions:

1. Assess & augment resources-material, capital & human
2. Formulate Plan for utilization of resources
3. Decision on priority based phased implementation
4. Decide on nature of executing machinery
5. Periodic progress review
6. Make appropriate interim recommendations

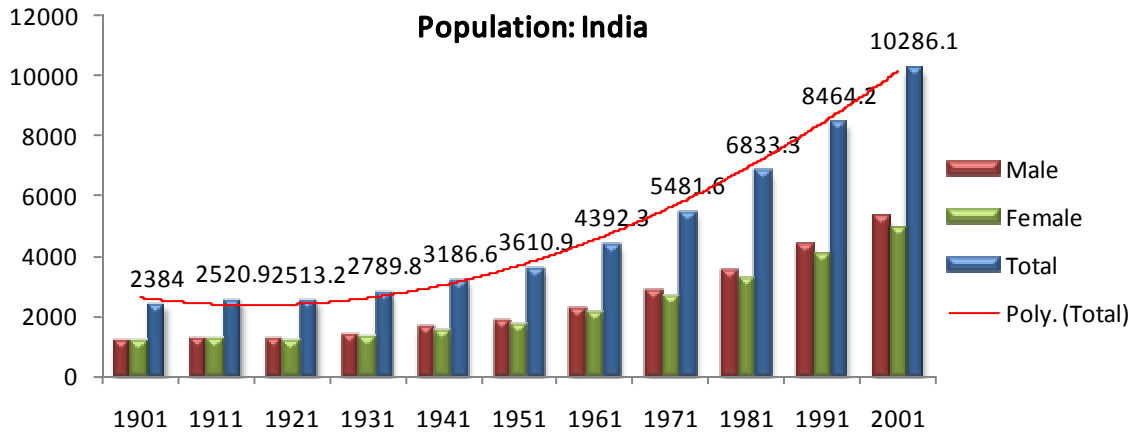
Role of Central Govt. in Health:

1. Policy formulation
2. Maintaining International health relations
3. Administration of central health institutions
4. Regulating Medical education through statutory bodies-MCI/DCI/Councils
5. Medical & Public health research-funding
6. Standards (Drugs/Education)
7. Coordination-Ministries/States/Statutory bodies

8. Central Health Acts
9. Negotiation with International agencies

Population Growth in India-

Year	Total Population in Lacs			Sex Ratio
	Male	Female	Total	
1901	1207.9	1173.6	2384	972
1911	1283.9	1237.1	2520.9	964
1921	1285.5	1227.7	2513.2	955
1931	1429.3	1357.9	2789.8	950
1941	1636.9	1546.9	3186.6	945
1951	1855.3	1755.6	3610.9	946
1961	2262.9	2129.4	4392.3	941
1971	2840.5	2641.1	5481.6	930
1981	3533.7	3299.5	6833.3	934
1991	4393.6	4070.6	8464.2	926
2001	5321.6	4965.5	10286.1	933



Health and Vital statistics:

	India	Rajasthan
CBR	22.8	27.5
CDR	7.4	6.8
Growth Rate	15.4	20.7
IMR	53	63
MMR	254*	388*

Source: SRS bulletin October 2009.

*****Special bulletin on MMR SRS-2004-06

Health Infrastructure:

The recommendations of Health survey and Development Committee (Bhore Committee) asked for expansion of the Health care delivery system in phases with Primary Health Centers as the nodal points of service delivery.

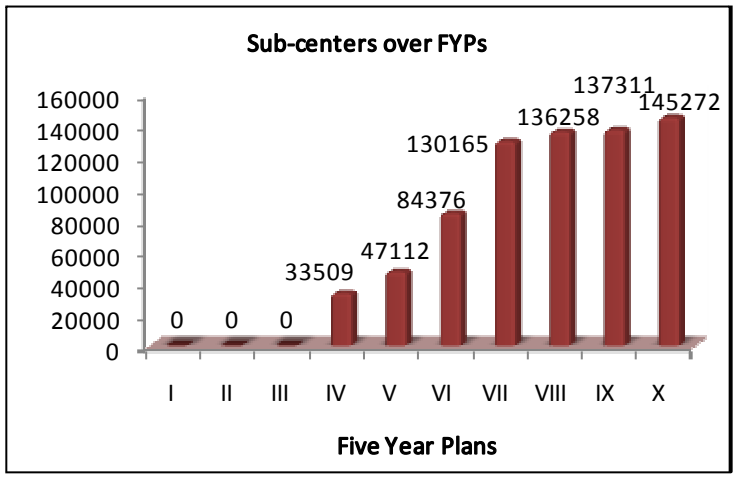
Subsequently a 3 tier structure (SC-PHC-CHC) was adopted for Health care in the Country.

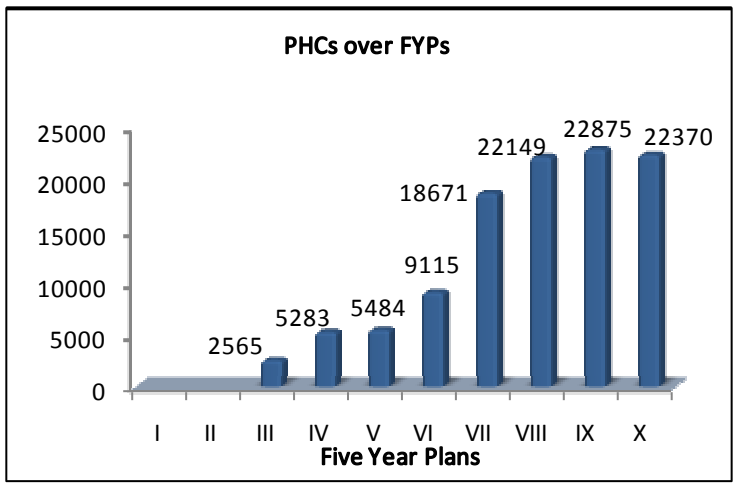
Somehow, the initial response on this account had been very sluggish and for first 3 five year plans we did not have a single Sub-centre, PHCs were not functional till 1961 and there was not a single CHC till 1971

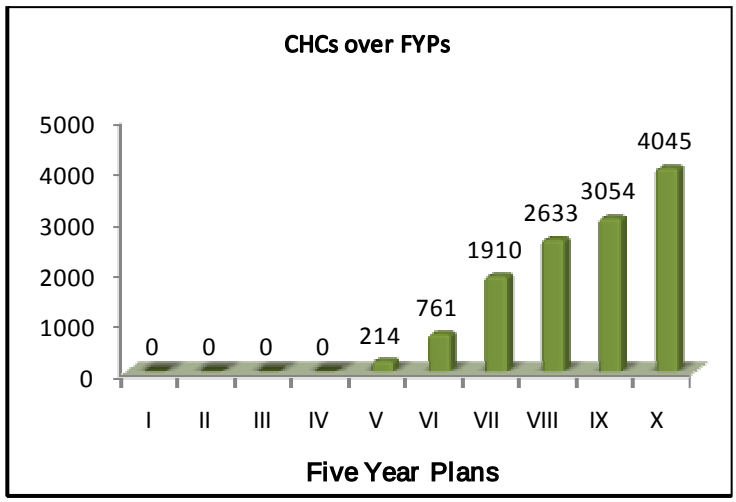
By the end of March 2008 (under XI-FYP) there were 146036 SCs, 23458 PHCs, and 4276 CHCs.

Out of these, 54% of SCs, 84% of PHCs and 91% of CHCs were housed in Govt. buildings by March 2008

Rajasthan (Jan,.2010) has 11448 SC, 1503 PHCs and 368 CHCs along with 33 District Hospitals, 6 satellite hospitals,12 Sub divisional hospitals and 199 city dispensaries







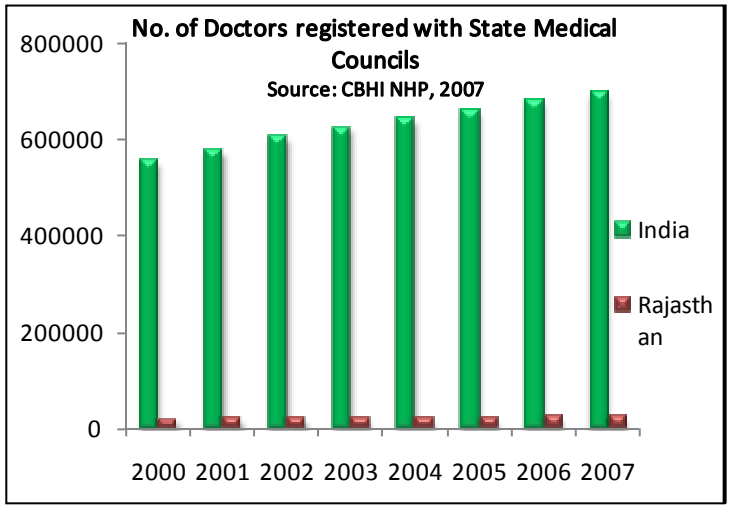
Health Manpower:

The **targeted** doctor population norm of 1:1000 (WHO) means at least 600,000 more doctors are required for the country based on population projections of 2008.

Likewise the total no. of Dentists registered stands at 72497 against the required number of 282130 as on December 2007.(WHO norm 1:7500 pop.)
While the ideal population of nurses should have been 2,188,890 in 2007, only 1,156,372 nurses were available.

There were 550958 ANM, 993256 GNM and 51498 LHV as on March 31, 2008(INC)

The Bulletin of Rural Health Statistics in India shows that while there has been a 66% rise in reported ailments between 1995-96 and 2004-05, the bed density has actually gone down to 0.86 from 0.93 during the same period as the population growth was not matched with bed compliment. This doesn't augur well for the country, considering that the growth of in-patient numbers (6%) will be higher than the growth of out-patient numbers (2.7%) between 2007 and 2017, according to a projection by Crisil research.



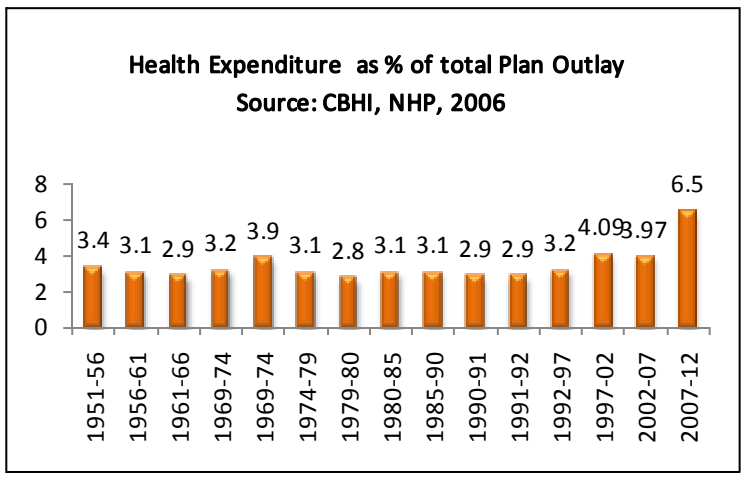
The ideal recommended Bed: Population ratio of 5:1000 (WHO) is a distant dream for majority of countries and the current world average rests at 2.6 beds per 1000 population.

Physicians per 1,000 population	0.60	2005
No. of Nurses per 1,000 population	0.80	2004
No. of Midwives per 1,000 population	0.47	2004
No. of Pharmacists per 1,000 population	0.56	2004

Source: World Health Report 2006

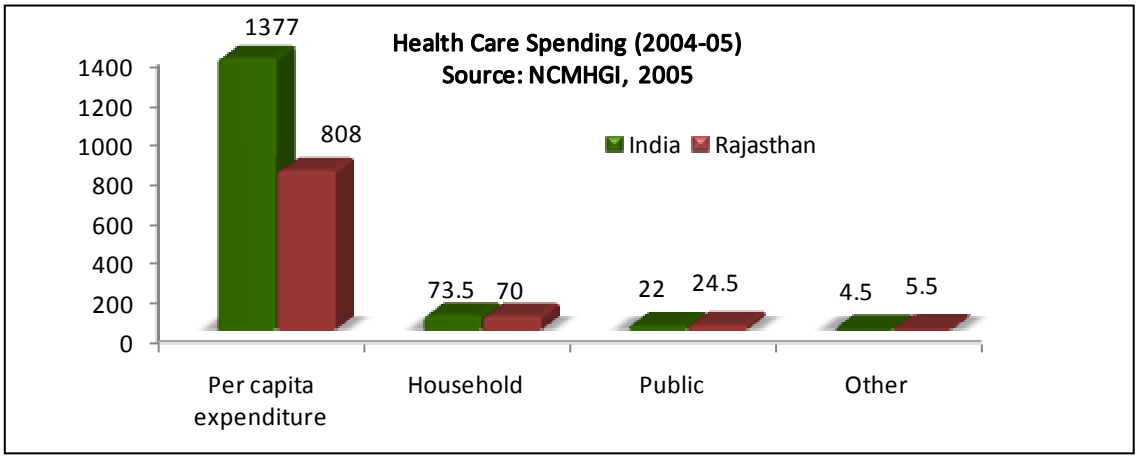
Health Expenditure:

From 3.4% of the total plan expenditure under First Five Year Plan, the Health expenditure has shown just a marginal increase in X-FYP where it was 3.97%(CBHI, 2006).However, the total Govt. expenditure on Health as % of GDP had an increase from 0.22% in 1951-56(First FYP) to 0.9% in 2002-2007(X-FYP).



National Commission on Macro-economics & Health reported per capita Health expenditure as INR 1377 and 808 for India and Rajasthan respectively for year 2004-05.

India spends 5% of GDP on health but the total pulic spending on health is just 0.95% and WHO (2007-08) ranked India at no. 171 out of 175 countries in this regard. With 80% of health care spending in private sector which is largely unorganized and unregulated

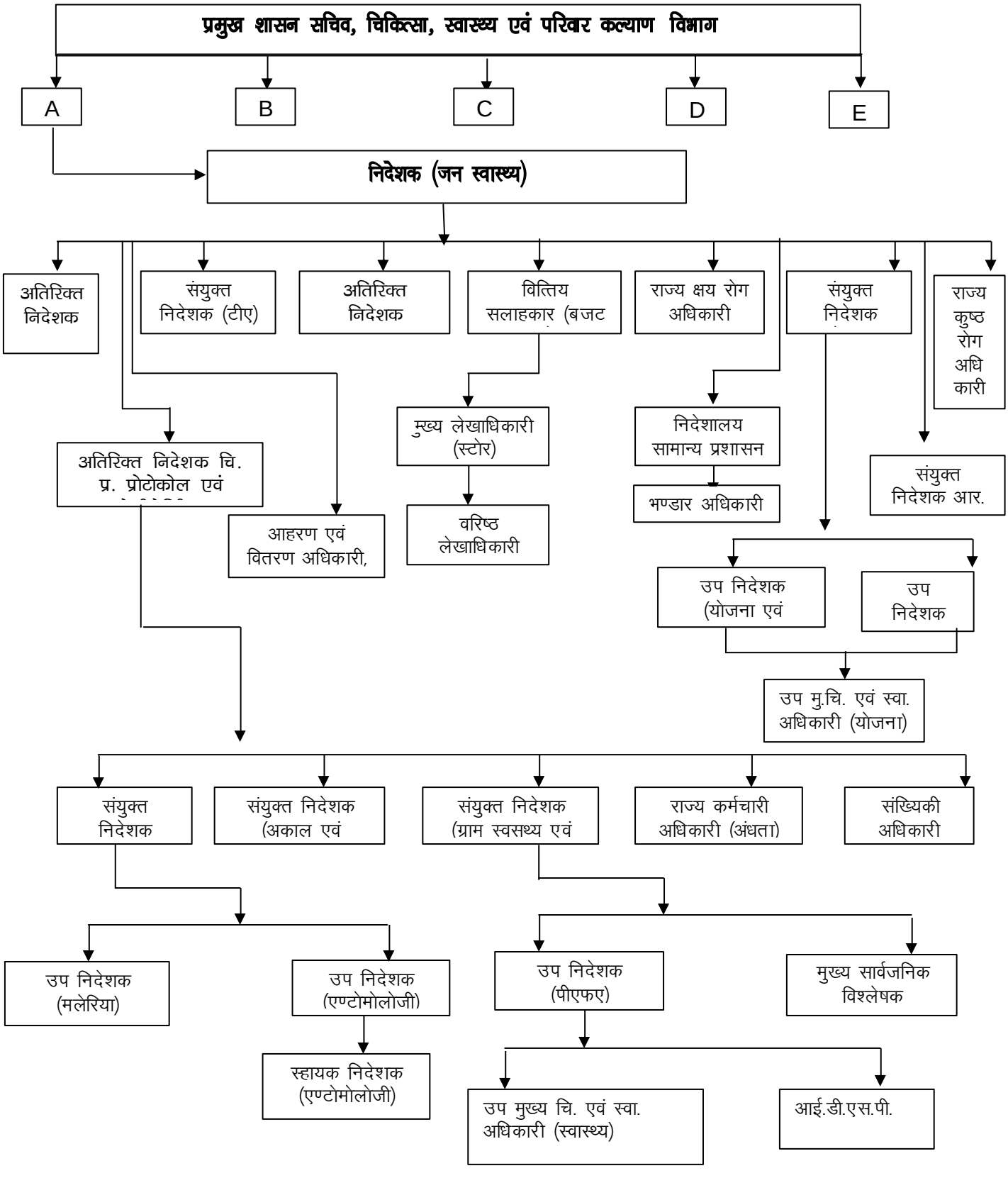


Burden of Disease

Diseases	2005		2006		2007		2008	
	Cases /lac	Deaths /lac	Cases /lac	Deaths /lac	Cases /lac	Deaths /lac	Cases	Deaths
ARI	2349	0.375	2351	0.336	2319	0.616	25541645	4681
Diarrhea	1002	0.196	918	0.286	974	0.319	11231039	2841
Pneumonia	71	0.321	61	0.300	66	0.306	720454	3765
TB	118	5154	126	5803	131	5744	911739	
Malaria	166	0.088	161	0.153	134	0.116	1366517	878
Viral Hepatitis	17	0.066	14	0.062	10	0.048	90440	510
Polio					874	35	559 (568,Nov.'09)	30
Diabetes	31039 932							
CHD	35886 789							
Blindness	11.2/1 000							

Source: CBHI

Organization structure of Health care System: Rajasthan



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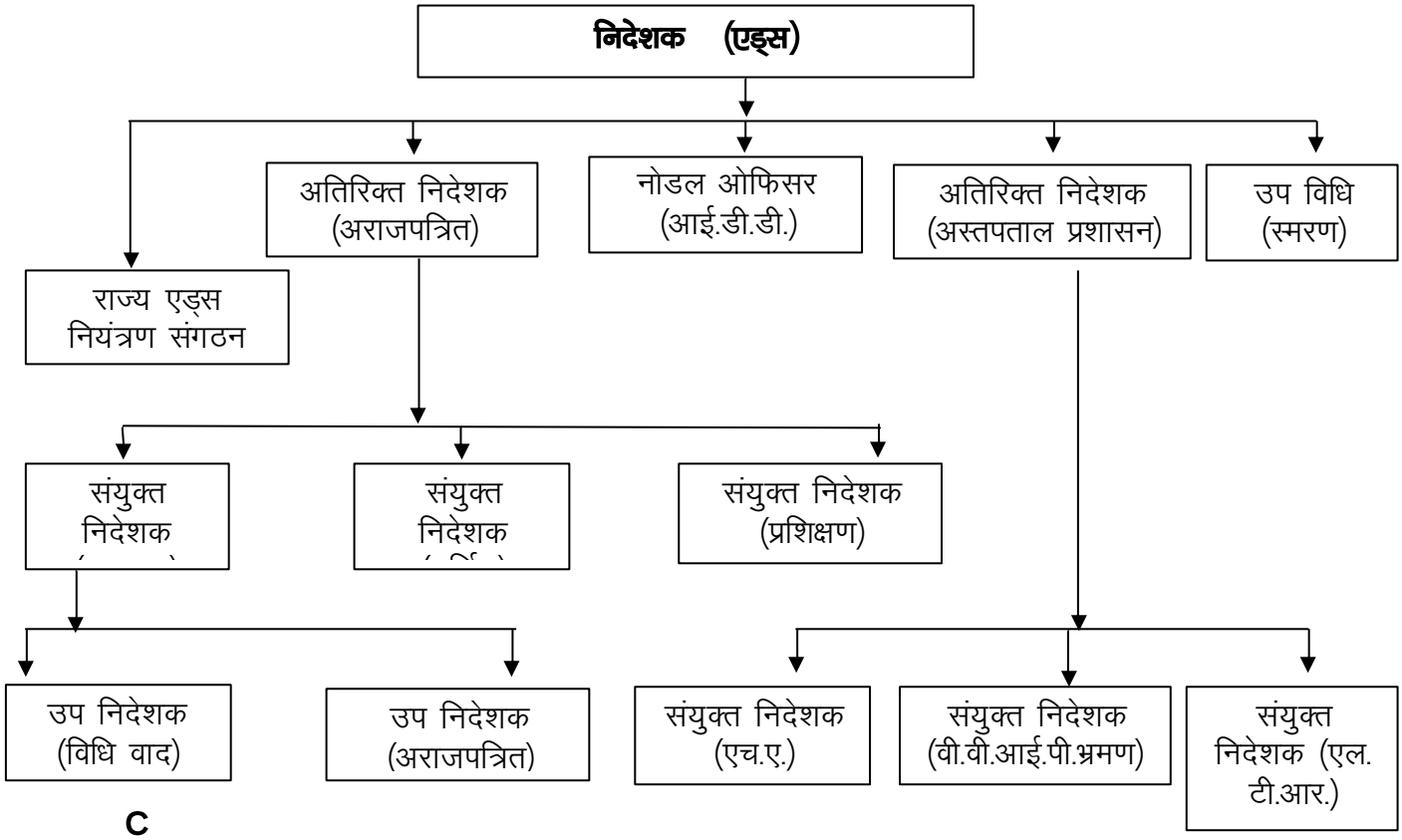
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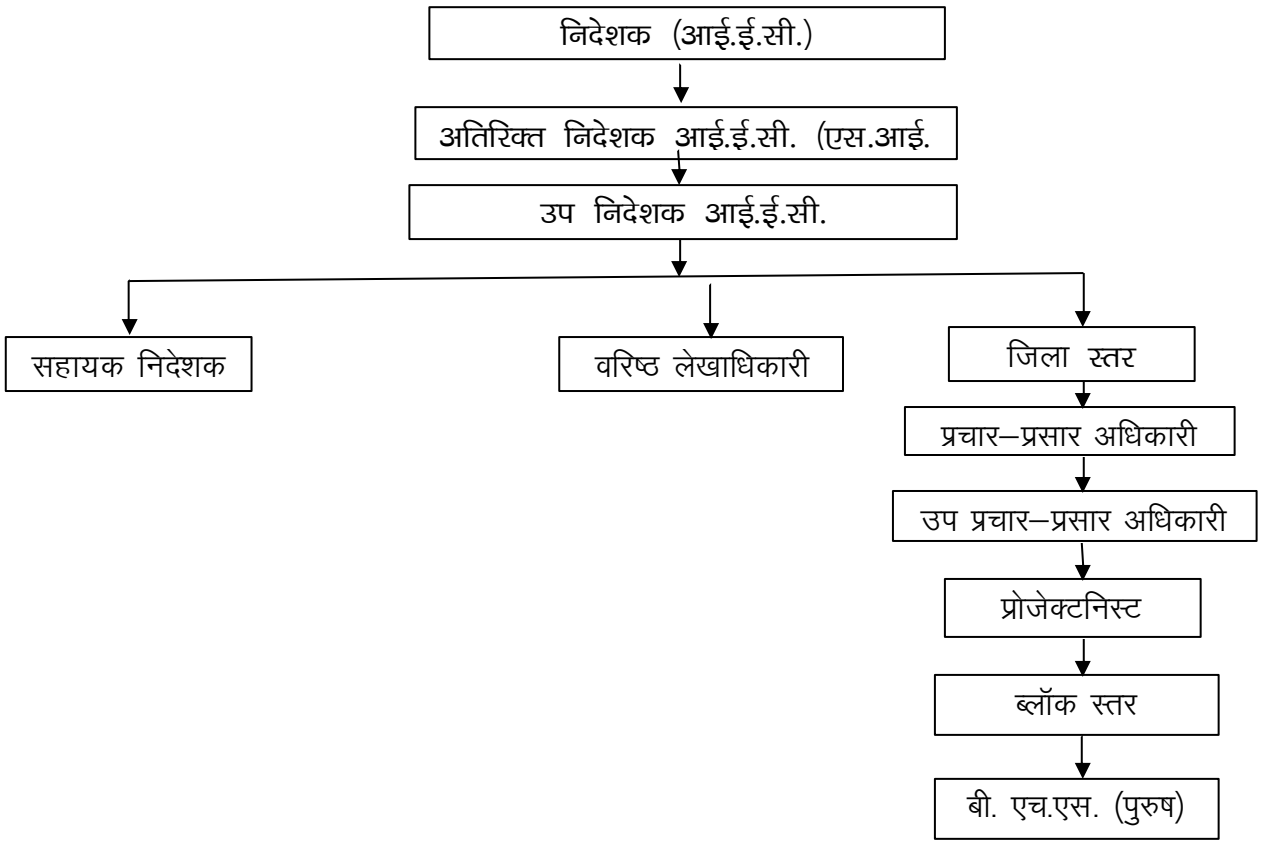
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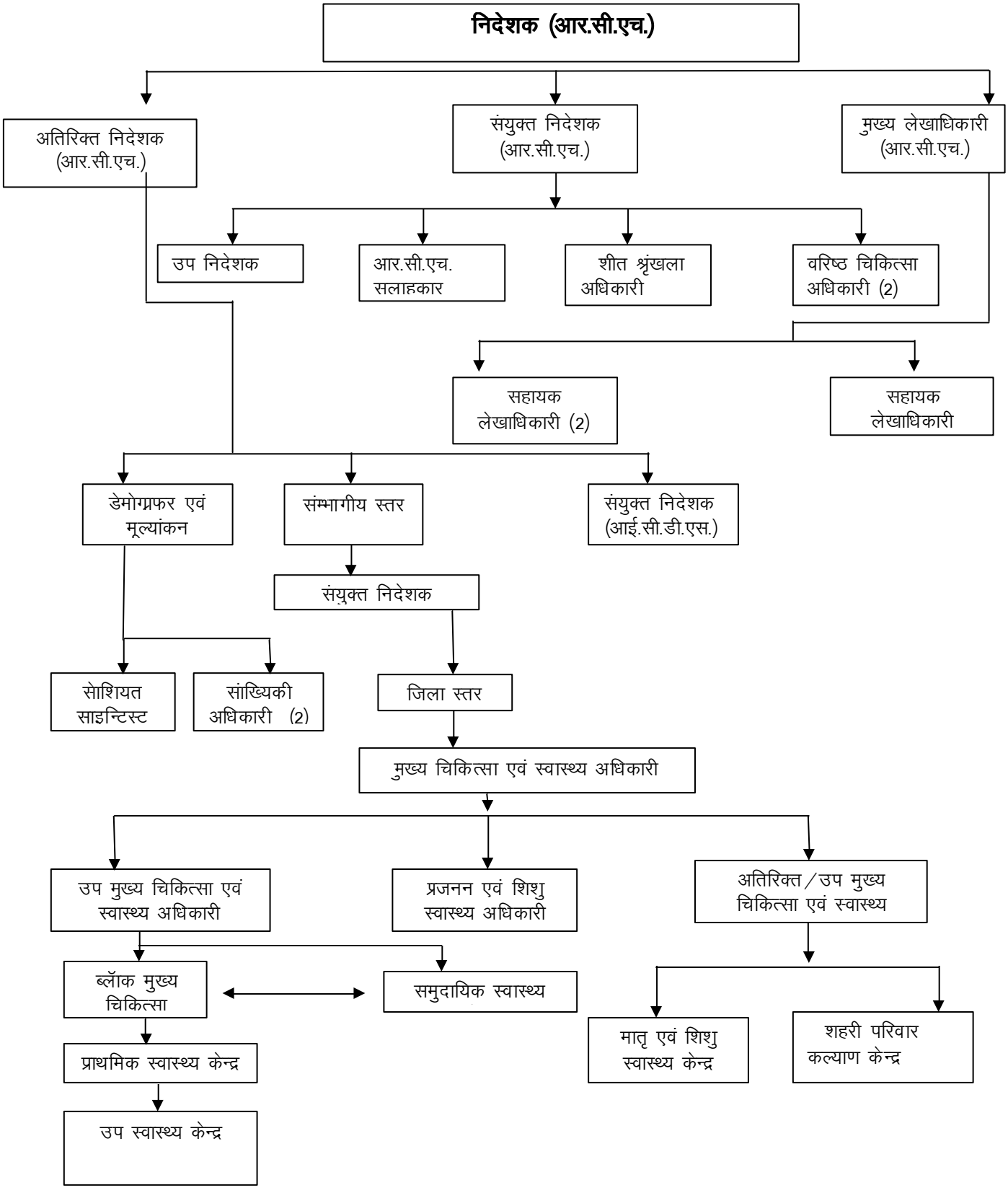
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प्रजनन एवं शिशु स्वास्थ्य अधिकारी
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समुदायिक स्वास्थ्य
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उप स्वास्थ्य केन्द्र
मातृ एवं शिशु स्वास्थ्य केन्द्र
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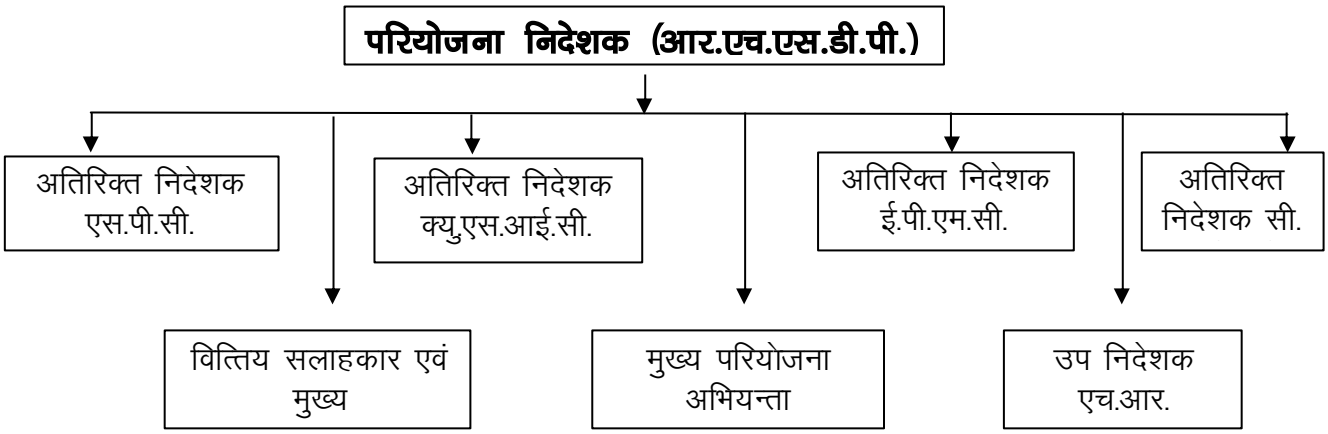


3-Tier health Structure of Health Care Delivery System:

CHC (30 bedded unit, Pop. 80000-120000, covering 4 PHCs, with specialized care)

Staff strength (25)	
MO-	4
Staff Nurse-	7
Dresser-	1
Pharmacist-	1
LT-	1
Radiographer-	1
Ward Boy-	2
Dhobi-	1
Sweepers-	3
Mali-	1
Chowkidar-	1
Aya-	1
Peon-	1

Under IPHS proposed Staff strength (64)	
Specialists	
Block Health officer-	1
Ob. & Gy.*	1
Surgeon*	1
Physician*	1
Pediatrician-*	1
Anesthetist	1
Ophthalmologist	1 (1 for 5CHC)
Dentist	1
Public Health Manager	1
GDMO	6 (2 LMO)
AYUSH	1
AYUSH-GDMO	1
Staff Nurse-	19
PHN-	1
Ophth.Asstt.-	1
ANM-	1
Support staff	

Facilities:

Entrance Zone and OPDs
Emergency Room/Casualty
Treatment room (minor OT, Injection / dressing room)
Wards- male and female
Labor Room and Operation theatre
Blood Storage unit.
Laboratory
X-ray and ECG
Other Services
- Electricity with Back-up
- Water:
- Separate toilets for male & female
- Telephones
- Maintenance and sanitation facility
- Computerization for record and surveillance.

***Minimum required**

PHC (Referral unit for 4-5 SC, pop.-20000-30000, 4-6 beds)

Staff strength (15)	
MO-	1
Staff Nurse-	1
HW (ANM)-	1
HA (M)-	1
HA (F)-	1
HE-	1
UDC-	1
LDC-	1
LT-	1
Class IV-	4
Peon-	1
Driver-	1

Under IPHS proposed Staff strength (24/ 25)	
MO	3 (1 LMO)
AYUSH	1
Pharmacists-	2
Staff Nurse-	5
Accounts Manger-	1
HW (ANM)-	1
HE-	1
HA (M)-	1
HA (F)-	1
LT-	2
Class IV-	4
Peon-	1
Driver-	1-2

SC (Most peripheral unit covering 4-5 villages, Pop.-3000-5000)

Staff strength (2)	
HW (ANM) -	1
HW (M) -	1

Proposed Staff strength (3)	
HW (ANM) -	1
HW (M) -	1
Additional ANM-	1

Voluntary workers
AWW- 1
ASHA- 1
JMC-1

National Health Programs

Major:

National AIDS Control Program
National Cancer Control Program
National Diarrheal Disease Control Program
National Filaria Control Program*
National Family Welfare Program
National Iodine Deficiency Disorders Control Program
National Leprosy Eradication Program
National Malaria Eradication Program*
National Program for Control of Blindness & Visual Impairment
National Reproductive and Child Health Program
National Program for surveillance of Communicable diseases
National Tuberculosis Control Program (Revised)

Minor:

National Mental Health Program
National Japanese Encephalitis control Program*
National Diabetes Control Program
National Kala-azar Control Program*
National Water Supply and Sanitation Program

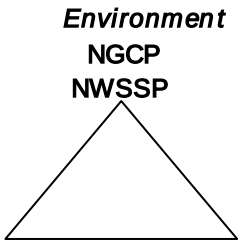
Prologue:

A **Program is a strategy with defined Objectives**; where as the **Policy is a written statement of objectives and expected outcomes.**

In the process of **planning** (***a process of choosing between alternatives to accomplish the desired***) using the input of data/ information the Program is an output with intentions, implementation and introspection as inherent elements.

In context to Health, basically all Programs are addressing to either

1. A Disease
2. A Behavior, or
3. A Development issue



Agent	*Host*
RNTCP	UIP
MAP	HIV/AIDS
NLEP	NFWP
	NPCB

Disease	NMCP-1953 NFCP-1955 NLCP-1955		NTCP-1962 NPIDD		NPCBI-1976 (Trachoma-1968) NCCP-1976 EPI-1978 ⇒	NGEP-1983 NLEP-83 NDDCP- UIP-1985	NACP-1987 NMHP- ⇒	ARI-1992 RNTCP-1993 CSSM-1992 ⇒	NSPCD-1997 RCH-1997
Behavior	NFPP-1953				AIHPPP-1970				
Development	NWSSP				MNP 20-Point Program				
5-Yr. Plan Pd.	I 1951-56	II 1956-61	III 1961-66	IV 1969-74 (66-69 annual plans)	V 1974-79	VI 1980-85 (79-80 Plan Outlay)	VII 1985-90 (90-91& 91-92 Annual Plans	VIII 1992-97	IX 1997-2002
% of total plan outlay	3.3	3.06	2.63		2.45	1.87	3.69 (0.98% of GDP)	1.76	0.9%

Majority of programs address to either Agent or Host and hardly any attention has been paid to environment despite the realization that manipulation of environment helps in identifying and breaking the weakest shackle in the transmission chain that too in a cost effective manner.
Those addressed to environment yielded results (e.g. NGCP), those addressing to agent are still caught up in vortex of paradigm shifts (NMCP to NMEP to MOP to MAP and, NTCP to RNTCP with changing strategies from DOTS to DOTS-plus. Addressing to behavior (NFWP and HIV/AIDS) is a slow process but once successfully modified the dents made shall be permanent.

Program process-

Majority of these "Health" programs are basically "Disease" programs; addressed as "National Health Programs", But, then that is how it is; after all the working definition of "Health" is also based on deducing inferences.

The "second largest" Program (RNTCP) and the "First" (NFPP/ NFWP) address to agent and human behavior respectively; unfortunately the first one has started defying (emergence of MDR-TB) and the second's growth has been stagnant (measured in terms of TFR over last two decades).

The fact here to be appreciated is that despite the "provisions" existing to address a public health "problem", a strong ***Political commitment*** is an equally strong catalyst to start and sustain a program at National level.

The evolution of National Health Policy (1983), subsequent to Alma-Ata Declaration (1978) is an empirical example of the earlier statement and absence of National Rabies Control Program, hitherto, is a point in case.

Health per se had a fragmented approach till 1978 when Global concern dictated in favor of HFA-2000 and, with a little longer latent period at last, a National Health Policy (1983) was formulated.
It is not that nothing was done till 1983 or that the Programs could not achieve any thing. The table below clearly shows what was achieved despite the constrained approach. We have seen Small pox eradicated through the same infrastructure, and Human resource. Somehow, the frequent Paradigm shifts (e.g. Age at which BCG vaccine is to be administered) have made the system cluttered and indifferent.

After formulating the national family welfare program, India has:

1. Reduced crude birth rate (CBR) from 40.8 (1951) to 22.8 (2009, SRS);
2. Halved the infant mortality rate (IMR) from 146 per 1000 live births (1951) to 53 per 1000 live births (2009, SRS);
3. Quadrupled the couple protection rate (CPR) from 10.4 percent (1971) to 56 percent (NFHS III);
4. Reduced crude death rate (CDR) from 25 (1951) to 7.4 (2009, SRS);
5. Added 27 years to life expectancy from 37 years to 64 years;
6. Achieved nearly universal awareness of the need for and methods of family Planning, and
7. Reduced total fertility rate from 6.0 (1951) to 2.7 (NFHS III).

Incidentally, by any scale, these are no mean achievements yet they do not offer any room for complacency if NHP-2002 and NPP-2000 goals are kept in mind.

Program Components:
Each of the programs here shall be dealt under following heads

1. Need
2. Goals & Objectives
3. Strategy
4. Approach
5. Activity
6. Indicators
7. Monitoring & Evaluation
8. Financing

Reproductive and Child Health Program

What is RCH?

Reproductive health refers to a state where people can-

1. Reproduce and regulate their fertility,
2. Women go through pregnancy and childbirth safely,
3. Outcome of pregnancy is successful in terms of maternal and infant survival and well-being, and
4. Couples are able to have sexual relations free of the fear of pregnancy and disease.

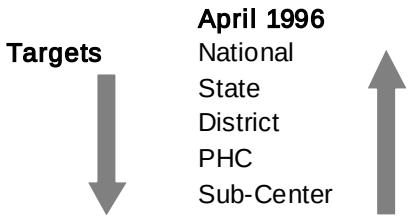
Chronology of events that led to RCH-

NFPP-1951
NFWP-1977
Alma Ata-1978
EPI-1978
NHP-1983
UIP-1985 (the success story of unified approach and micro planning)
CSSM-1992 (the first program officially launched by President of India- an example of national commitment)
ICPD-1994 (international concern for women, gender equity and social justice) at Cairo
Beijing conference-1995
RCH-1997, October
RCH-II (2005-06 -2009-10)

Reproductive & Child Health program is a model developed through experiments in paradigm shifts, as shown below-

Clinic approach
↓
Extension & Education
↓
"Cafeteria"/ "Targets"
↓
"Comprehensive" service delivery approach
↓
Primary health care (1983)
↓
Targeted interventions-Target couples and Eligible couples
Target free approach (1996) adopted in 4th meeting of Central Council of Health & Family Welfare
↓
Quality services & Policy reforms
↓
Community Needs Assessment Approach (1997-98)
↓
Capacity enhancement,

Instead of Targets passed from National epicenter to periphery the shift was towards setting goals through a participatory process involving all stake holders and the approach was bottom up with concern towards quality of care.



The Need:

The RCH Program was conceived in view of the need for-

a. Unified approach
b. Convergence for integration
c. Performance in relation to Goals & Timeframe
d. Shuffling priorities-Paradigm shift
e. Fertility regulation & Replacement goals
f. High Unmet needs
g. High Morbidity/Mortality in women & children

Objectives:

1. Reduction in Birth Rate to stabilize population- Empowering women through informed decisions
2. Integrating efforts of related programs to bring in meaningful convergence
3. Meeting unmet needs through institutional strengthening & Quality of Care through-
    a. Choice of methods
    b. Information provided to clients
    c. Technical competence of providers
    d. Interpersonal relationship between Clients & service providers
    e. Mechanism to ensure continuity of Care
    f. Constellation of service appropriate to need of users

Program components and activities:

1. **CSSM interventions**-Child / Mother
    a) Child Survival activities

        i) **Care of New borne**
            (1) Eye, Cord, Bath & Feed
            (2) Special care & Referral conditions
        ii) Immunization
        iii) **Vitamin-A** (9 dose prophylaxis)
        iv) **Diarrhea-ORT & ARI**
            (1) Standard case definition & management
        v) Support Activities-
            (1) Cold chain

(2) Supplies
(3) Surveillance

b) **Safe Motherhood interventions**

i) **Essential Obstetric care-**

(1) **Early registration** of pregnancy (12-16 weeks)
(2) **ANC** (3 visits)
(3) **TT** (2 or Booster)
(4) **IFA (**100 Tab.)
(5) **Delivery by Trained Birth attendants (TBA)** observing 5Cs
(Term TBA, now stands replaced by SBA- (Skilled Birth Attendant)).
(6) **Institutional, if complicated**
(7) **Referral for emergencies-**conditions, time-frame& place
(8) **PNC** (3 visits)
(9) **Spacing 3** yrs.
(10) **STI/RTI-Mgt.** As per STD control component under NACP
(11) **Adolescent Reproductive health-**
(12) Counseling/IEC based on Life cycle approach

ii) Emergency Obstetric care
iii) Strengthening Referrals
iv) Training of TBA

2. RTI/STDs (including HIV/AIDS)
3. Adolescent Reproductive Health
4. FP Services
5. Modified Mgt. Information Sub-System
6. IEC & Counseling
7. Referral
8. Community Needs Assessment Approach (CNNA)

Approach:

The strategic approach in RCH program is based on-

1. Integration of all related components/ interventions/ programs
2. Differential strategy based on
    a. Crude Birth Rate
    b. Female Literacy rate, based on which the districts have been put under
        i. Category-A (low CBR, high Literacy) (58)
        ii. Category-B (moderate CBR, moderate literacy)(184)
        iii. Category-C (High CBR, Low literacy)(265)

The approach has two components-

1. Policy reforms package in relation to-
    a. Monitoring & Evaluation
    b. Institutional strengthening
    c. Service delivery
2. Capacity enhancement through-
    a. Infrastructure
    b. NGO support
    c. Village workers
    d. Women Health committees

Activities under RCH:

1. **Universal interventions without any differentiation-**
   a. CS & SM interventions
   b. Operationalization of CNAA
   c. Institutional development
   d. Modified Management Information sub-system
   e. IEC & Counseling on –Health, Sexuality & Gender
   f. Urban & Tribal area RCH package
   g. District sub-projects for capacity enhancement
2. **Additional services in selected States & Districts-**
   a. Improving Institutional Delivery & Emergency care – Equipment / IUD / Drug kits
   b. Screening & Treatment of RTI/STI in-
      i. 3 FRUs - "A", (FRU=First Referral Unit)
      ii. 2 FRUs - "B",
      iii. 1 FRU of "C"
   c. Emergency Obstetric Care –
      i. 2 FRUs of "B",
      ii. 3 FRUs of "C"
   d. Essential Obstetric. Care-
      i. Drugs & PHCs in "B" & "C" and
      ii. Contractual PHN/Staff nurse in "C"
   e. Additional HWF in –30% S/C of "C" of 8 States
   f. Rental to Contractual PHNs/Staff Nurse
   g. Referral Transport facility-25%S/C of "C" Districts of all States
   h. Service strengthening-inputs for-
      i. Mobility,
      ii. Supervision,
      iii. Micro-planning (50 Districts in 8 States)
   i. Dai training-142 Districts with < 30% safe delivery
   j. RCH Camps in remote/under-utilized PHCs
   k. Border Cluster project-46 Districts in 16 States to have addl. Inputs

CNAA (Community Needs Assessment Approach) & RCH:

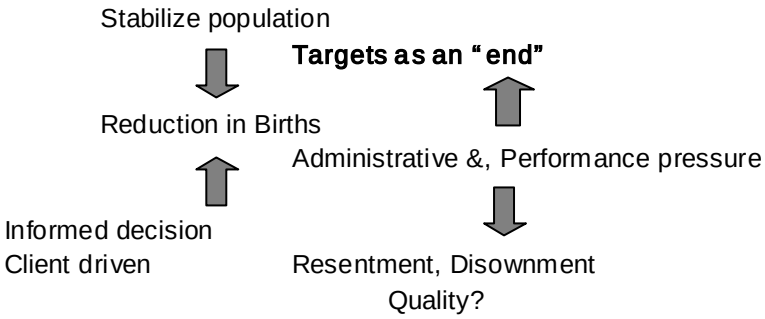
The difference between "perception" and "Feeling" of a need made a huge difference to Maternal & Child Health in general and Family Welfare Program in particular. This was realized during ICPD (1994) that people should be left to freely and responsibly decide, based on informed choices, about the number of children and spacing between two births.

Earlier to the international initiative, The Committee on Population in National Development Council (NDC) in 1993 recommended that there is a need for –

1. Decentralized area specific planning based on Local Needs
2. Creation of a District level Data base on:
   a. Quality,
   b. Coverage,
   c. Impact indicators; for monitoring & Evaluation.

The rational of the CNAA approach can be summarized as-

Family Planning / Welfare Objective-



Some how the TFA (Target Free Approach) was sending a wrong message among field functionaries and that led to baptizing it as CNAA with key words like **Quality** & **Client Satisfaction.**

The purpose of CNAA**-**

1. Setting Priorities
2. Identify Target and High Risk groups
3. Estimation of Service needs and matching it with Resources
4. Develop a realistic action Plan

Key issues in CNAA-

1. Micro-planning
2. Community involvement
3. Client's perspective
4. Quality of Care

Process of CNAA-

The process focuses on Participatory Planning based on:

1. Felt Needs
2. Actual workload assessment
3. Assess Capacity of Providers
4. Involve people for better Utilization

The process stresses on "Speak" to People", "Get "through Records and "Take up" surveys to make a Community diagnosis.

The process steps are-

1. Develop teams involving local people- (support team & consultative team)
2. Organize meetings for decision on service delivery
3. Evaluate need for each Health & Family Welfare service
4. Share it with people
5. Develop an Action Plan
6. Sub-Center Action plan: Steps
    i. Interview people- house to house
    ii. Involve AWW/MSS/Link persons
    iii. Validate information-cross check
    iv. Up-date ECR (Eligible Couple Register)
    v. Compare vital information
    vi. Develop Action Plan

7. PHC Action plan: Steps
    i. Consolidate S/C plans
    ii. MO/IC – Calculate requirements-
        a. Routine
        b. Additional relevant items
8. CHC Action plan: Steps
    i. Check list of services provided
    ii. Assess / calculate matching requirements
9. District Action plan: Steps-Consolidation
10. State Action plan: Steps -Compilation

Problems

Focused around people's participation to empower them in decision-making, process of CNAA is slow for the following reasons-

1. Medical fraternity had been too assertive,
2. Program carries a vertical structure,
3. Inter sectoral coordination is missing,
4. The stress is on infrastructure rather than on functions,
5. Information requirements meet with the indifferent attitude of providers,
6. States with their own reservation have been slow in reacting and matching with the pace that GOI
7. Regular monitoring at State level is missing
8. Medical Officers are reluctant to discuss with field staff and PRIs (Panchayat Raj Institutions)
9. Providers still decide the "best" for clients (Informed choices v/s Client segmentation)
10. Performance measurement tools are missing
11. Multiple entries in 3 different records
13. Unnecessary data collection

RCH-II (2005-06 to 2009-10)

Goals and Objectives

Indicator	Tenth Plan Goals (2002-07)	RCH Phase ii Goals(2005-10)	NPP 2000 (By 2010)	MDG
IMR	<45/1000	<30/1000	<30/1000	-
U-5 MR	-	-	-	Reduce by 2/3 from 1990 levels
MMR	200/100000	<100/100000	<100/100000	Reduce by ¾ by 2015
TFR	2.3	2.1	2.1	-

The overall goal of RCH program is to reduce infant and maternal morbidity and mortality in the state. These goals will be achieved through improvement in quality, enhancing accessibility and availability, and coverage with the reproductive and child health services, including family welfare. The program emphasizes empowerment of women and communities for enhancing health service utilization to achieve reproductive goals and population stabilization.

Indicators	Goal of Rajasthan up to 2011-12
Infant Mortality Rate (IMR)	32
Maternal Mortality Ratio (MMR)	148
Total Fertility Rate (TFR)	2.1
Crude Birth Rate (CBR)	21
Crude Death Rate (CDR)	7

Issues raised during RCH I

a. "One size fits all' approach
b. state/district level requirements not accounted
c. adequate program management skills missing amongst professionals
d. Planning, monitoring, budgeting and resource allocation did not match program objectives
e. Frequent turnover (transfer and retirement)
f. result/outcome orientation missing
g. Human Resource planning neglected
h. Financial/accounting/disbursement and utilization bottlenecks
i. generic BCC
j. focused and thematic approach missing
k. Low utilization of public health facilities
l. Complaints against insensitive providers
m. Hidden cost incurred by users
n. Limited choices for clients
o. No convergence between related sectors
p. Fragmented approach
q. Duplication
r. Loss of opportunities to achieve effectiveness

Key issues and strategies for RCH II

1. **Flexibility: States' needs and capacities**
    a. Planning will be based on the analysis of state level requirements as assessed from district level requirements
    b. Different approach based on state specific scenarios
    c. Encourage and gather evidence for decentralized planning at the state level
    d. Plans to be prepared by states based on the overall guidelines provided by the national framework
    e. Special attention to states facing the biggest socio demographic challenges
2. **Strengthening management capacity**
    a. Program management structures with provision for on contract professionals
    b. Capacity building in program management
    c. Monitoring systems to be introduced
    d. Structures to provide for functional specification in planning etc.
    e. Review and adoption of HR planning, transfer, promotion policy
    f. Infusion of qualified finance professionals and overhauling of the traditional accounting system to make it faster yet easier to monitor
3. **Integrated Behavior Change Communication (BCC) strategies**
    a. Emphasis placed on development of a BCC strategy
    b. Overall national priorities and desired behavior change to guide the framing of the strategy
    c. Based on the national BCC strategy – states to adapt/adopt it to develop state specific objectives and strategies
    d. Emphasis on viewing BCC as a driver to change and adopting this to impact the drivers impacting on the outcomes
    e. Trained human resources and partnerships with NGO/CBO needed
    f. Linkages of the present IEC structures would be reckoned
    g. Tracking IEC input and output linkages for optimal utilization of the IEC resources
    h. Emphasis on increasing the health/life skill issues in the syllabus of elementary and secondary education

i. Accessing all available channels for dissemination of 'Health Values', Hygiene, HIV/AIDS, 'No to Early Marriage', 'No to Gender Violence', 'No to Female Feticide'

4. Improved client responsiveness to public health facilities

a. Reviews of responsiveness and service quality
b. Taking into account both the user's and provider's perspective
c. Strategies for responsiveness
d. Option for demand generated interventions
e. Monitoring service quality
f. Systematic efforts to improve quality through training, BCC, evaluation and feedback
g. Working on a private partnership protocol
h. Convergence and converting single doctor sub-optimal PHCs to at least two doctor FRUs.

5. Convergence with other critical sectors

a. Inter-relations between sectors have been considered
b. Build in co-ordination at state levels and below
c. Coordination with National AIDS Control Program (NACP)
d. Coordination with Integrated Child Development Services (ICDS)

Result Framework:

Outcome indicators	Desegregated by	Baseline 2003-04 (%)	Objectives set to be achieved				Data collection and reporting		
			2005	2006 (%)	2007	2008 (%)	Frequency of reporting	Data tools	Responsibility for data collection
% of eligible couples using modern contraceptive method	Permanent Methods	34		35		36	Annual	• MIS • HH Surveys • Independent Evaluation	M&E Division, MOHFW; IIPS RCHOs
	Spacing Methods	11		12		16	Annual		
% of eligible couples using any modern contraceptive method	Overall	45		47		52	Annual		
	SC/ST	41				45	Mid term & end line		
	EAG States	33		35		40	Annual		
% of deliveries conducted by skilled providers	Overall	48		55		60	Annual		
	SC/ST	35		40		45	Mid term & end line		
	EAG States	32		35		45	Annual		
% of 12-23 months children fully immunized	Female	44		60		75	Mid term & end line		
	Male	45		60		75	Mid term & end line		
	Overall	45		60		75	Annual		
	SC/ST	39		50		75	Mid term & end line		
	EAG States	28		45		60	Annual		
% of mothers & newborns visited within 2 weeks of delivery by a trained worker	overall	<10		20		40	Annual		
Polio free status achieved		10 states have polio		Over 30 states polio free		All states polio free	Annual		NPSP

Other focus areas

a. Targeting of services
   - Define essential services for the poor and the vulnerable
   - Review physical and financial performance against such priorities
   - Resources to be used mainly to finance essential services that address the needs of the poor
   - Need-based/performance-based financing

b. Strengthening service delivery
   - Provide quality, accessible and client sensitive services
   - Enabling contracting of staff, mobility support and contingency
   - Support to service providers and clear mandates on supervision
   - Focus on essential services and improve utilization

c. Infrastructure and maintenance
   - The assessment of potential utilization is the key determinant for creation of infrastructure
   - Complementary factors such as power, water, approach roads and communication to be strengthened through convergence and networking with other sectors
   - Strategy for infrastructure developed.

d. Supply of drugs and equipment
   - In consonance with essential drugs policy
   - Estimation bases developed to assess requirements
   - Logistics management strategy developed

e. Health care providers
   - Appraisal of options of the role, scope and potential for partnership with the private sector and NGOs
   - Enhance the private-public partnership mechanism through win-win situations
   - These strategies outlined above would lead to the achievement of the vision in the long-term

f. Improved transparency and efficiency in procurement of goods and services
   - Strengthening the implementation of good manufacturing practices to ensure supply of quality pharmaceuticals
   - Ensuring better competition and price by undertaking periodic surveys to get more reliable information about the market
   - Strengthening logistic systems to deliver quality goods and services in a timely manner to the end users
   - Promoting transparency in procurement and disclosing information on procurement actions

Activities under RCH II in Rajasthan

1. Strengthening Project Management Structure at state and district levels
   a. Re-organizing of Medical Directorate.
   b. Renovation of Medical Directorate and NRHM/RCH-II cell.
   c. Setting up, of the PMU at state & district levels.
   d. Induction of newly appointed professionals done on program management and interventions.
   e. Support for communication, equipments and mobility to DPMUs.

2. Strengthening Infrastructure at various levels of health service delivery
    a. Upgrading of PHCs as BEmOcs.
    b. Provision of blood storage at 26 identified CEmOcs of IPD districts to make them fully functional.
    c. Support for equipment and labor tables at 25% PHCs.(10000.00 Rs. Per Institution)
    d. Support for minor repair and renovation of public facilities at 50% PHCs. (25000.00 Rs. Per Institution)
    e. Facility survey of all PHC and CHCs.
3. Human resource development and capacity building
    a. Development of annual training calendar.
    b. Strengthening of ANMTCs.
    c. Support medical colleges for Anesthesia trainings.
    d. Library at SIHFW & Medical Directorate.
    e. Orientation of AYUSH Doctors on National Programs.
4. Improving quality of care and Strengthening Referral System
    a. Study on referral system by RHSDP
    b. 7 days Mobility support to PHC MOs
    c. Installation of new telephone connection at all PHC/CHCs.
    d. Work shops for developing standards and protocols for quality of care.
5. Strengthening and improvement of logistics and supply systems
    a. Feasibility study to setting up of the drugs and logistics warehousing has been done under European Commission SIP program. A committee to finalize the modalities behind the setting up of Drug Corporation has been set up at the state level.
    b. Support for the repair of workshop for cold chain equipment has been provided for Jaipur.
    c. Support for hiring 12 new refrigerator mechanics has been provided to district where such positions are vacant.
6. Strengthening Health Management information system (HMIS), monitoring and evaluation
    a. Support for CNNA format, ECS has been provided from state level.
    b. Integration of RCH-II/NRHM reporting format in existing HMIS software.
    c. Baseline and concurrent evaluation.
7. Behavior Change Communication for increasing demand for RCH and contraceptive services
    a. Intensive IEC for RCH-II and NRHM interventions.
    b. Provision for hiring of IEC van in all districts.
    c. Implementation of Integrated Media Plan.
    d. IEC for “Panchamrit program done by printing of booklet, Banners, cards.
8. Specific Interventions
    a. **Maternal Health:**
        i. RCH camps target:
        ii. Dai training target:
        iii. Night delivery facility at all PHCs and CHCs.
        iv. Hiring of contractual staff (PHN & LT) at CEmOcs.
        v. Provision of 1321 additional ANMS at 10 desert and tribal districts.
        vi. STD/RTI drugs for PHCs.
        vii. Jannani Suraksha Yojna
    b. **Child Health:**
        i. IMNCI launched in 9 districts.
        ii. Mal nutrition corner at all 237 blocks.
        iii. Purchase of ORS packets.
    c. **Adolescent Health**
        i. AFHS training at 25% PHCs

d. **Family Planning**
   i. Improving quality of fix camps.
   ii. Compensation scheme for sterilization.
   iii. Blood donation camps.
   iv. NSV mega camps

9. Strengthening Networking and Partnership with the civil society
   a. Collaboration with IMA & FOGSI to build partnership to improve access and quality of health care service in services.
   b. Accreditation of Private nursing home for JSY.
   c. MNGO scheme in all districts.
   d. Annual consultation with stakeholders on NRHM.
   e. Social marketing of contraceptives and other health services.

10. Innovative schemes and pilot projects
   a. Pilot Project on Population stabilization initiated at Jhalawar & Tonk.
   b. PARINCHE project for five districts.
   c. A help line proposed at medical directorate for improving communication between field level functionaries, districts and state level officers.
   d. Campaign on Age at Marriage.
   e. Medical Mobile unit for all districts.
   f. VCTC at 16 CHCs.

11. Improving and strengthening RCH Services in Tribal population
   a. Six districts, namely, Baran, Banswara, Chittorgarh Dungarpur, Sirohi and Udaipur will be included as non-primitive tribal group districts under the project in addition to the tribal population in the adjoining blocks of Jhalawar and Kota district.
   b. Process for developing PIP for six urban districts is under process.

12. Establishing and strengthening RCH services in Urban Area
   The Program will address the urban slum population in Jaipur, Jodhpur, Kota, Bikaner, Pali, Udaipur, Ganganagar, Hanumangarh, Bhilwara and Tonk cities.PIP for 8 urban slums is under process.

National Family Welfare Program (NFWP):

India is the second most populous country in the world. India has 17 % of world's population and has less than 3% of earth's land area. While the global population has increased 3 times, India has increased its population 5 times during the last century. India's population is expected to exceed that of China before 2030 to become the most populous country in the world.

1952, India was the first country to launch a national program emphasizing Family planning, with the objective of "reducing the birth rate to the extent necessary to stabilize the population at a level consistent with the requirement of National economy" and it was put in the concurrent list. Health Policy, 1983 stated that replacement levels of total fertility rate (TFR) should be achieved by the year 2000.

On 11 May, 2000 Indian population crossed 1 billion (100 crores) mark which meant 16 percent of the World's population on 2.4 percent of the globe's land area.

Under this back drop for the first time a National Population Policy was formulated in year 2000 (The earlier one of 1976 (April, 16) and 1977(June) were simply the statements on population policy put before the Parliament).

The Program during first two 5-year plan periods (1951-56 & 1956-61) maintained a "clinic approach" under which facilities for providing services were created. The second 5-year Plan period saw "Target "approach to Family Planning that focused on Sterilization approach

The figures of 1961 census, however asked for a change in approach which was replaced by "Extension and Education" approach in the 3rd 5-year plan (1961-66) period. During the same period a separate department of Family Welfare was created.

The 4th plan (1969-74) accorded a high priority to program in terms of integration of Family Planning services with MCH services and increased acceptance of contraceptive methods and proposed to reduce CBR from 35/ 1000 to 32/ 1000 by end of plan period. 16.5 million couples (16.5%) were protected from conceiving at the end of plan period. Also during this period Medical termination of pregnancy bill was passed, Post Partum scheme started and 364 new PHC were opened with marginal improvements in indicators.

The 5th Five year plan (1974-79) aimed to reduce CBR to 30/ 1000 by 1978-79. The record performance in sterilization area under cover of "targets" and "coercion" during 1975-77, proved detrimental. The NFPP was replaced by NFWP. Statement on National population policy was made with salient feature like raise of age of marriage for men and woman from 15 to 18 years for females and 18 to 21 for males., Freezing of Peoples representation in legislatures and parliament on the basis of 1971 census till 2001 and more central assistance to States on family planning.

The VI five- year plan (1980-85) stressed on long term goal of Net Reproduction Rate (NRR) of 1 by achieving a reduction in average family size from 4.4 to 2.3, reduction in CBR from 33 (in 1978) to 21/1000, reducing death rate from 14 to 9 and IMR from 127 to below 60 and increasing Couple Protection Rate (CPR) from 22% to 60%.

All the goals remained elusive and what was envisaged for 5th plan could partly be achieved by end of year 1990.

During the 7th five-year plan (1985-90) Family Welfare continued on voluntary basis and stressed on promotion of spacing methods, community participation and promotion of MCH care.

The achievements were a little closer to what was thought of in 5th plan.

1. CBR reduced from 41.7 (1951-61) to 30.2 (1990-SRS),
2. TFR (Total Fertility Rate) dropped from 5.97(1950-55) to 3.8 (1990-SRS),
3. IMR reduced from146 (1970-71) to 80(1990-SRS),
4. CPR increased from 10.4% (1970-71) to 43.3% (March,1990)

The 8th five-year plan (1992-97) introduced many new schemes and revamped the ongoing ones in Family Welfare. Some of the new schemes were-

1. Area Development Projects to upgrade infrastructure and develop trained manpower were continued
2. India Population Project-VIII & IX started (IPP-VIII to improve Health &FW services in urban areas of Delhi, Kolkata, Hyderabad and Bangalore; while IPP-IX to operate in States of Rajasthan, Assam and Karnataka)
3. Project on "Innovations in Family Planning services" was taken up in UP with assistance from USAID with a specific objective to reduce TFR from 5.4 to 4.0 and increasing CPR from 35% to 50% over 10 years.
4. Differential planning scheme-90 districts with CBR over 39/1000(1991 census) were identified for enhanced financial allocation amounting to 50 lacs per district per year for upgrading infrastructure (OT, Labor Room, Six bedded observation ward and Residential quarters for Paramedical workers in 5 PHCs of each district per year) over 1992-93 to 1995-96.
5. Increasing involvement of NGOs in Family Welfare promotion for which 4 new schemes were started.
6. UIP strengthened and extended as CSSM Project since 1992-93
7. Target Free Approach(TFA) adopted in Family Welfare in 1996-97

The targets of VIII plan of National CBR of 26/1000 were achieved by all States except Assam, Bihar, Haryana, MP, Orissa, Rajasthan, and UP.

Under the 8th Five year plan greater stress has been laid on the involvement of NGOs to supplement and complement the Government efforts.
9th five-year plan period (1997-2002) stressed on reduction in population growth.
The priority objectives laid were-

1. To meet all felt needs for contraception
2. To reduce IMR and Maternal Morbidity & Mortality for reducing fertility top desired levels

The Strategies identified were-

1. To assess the needs for RCH at PHC level and undertake area specific micro planning
2. To provide need based demand driven high quality integrated Reproductive and Child Health services.

The expected levels of achievement by the terminal year of Ninth Plan (2002) are given below

Indicator	If current trend continues	If acceleration envisaged in Approach Paper to the Ninth Five Year Plan is achieved.
CBR	24/1000	23/1000
IMR	56/1000	50/1000
TFR	2.9	2.6
CPR	51%	60%
NNMR	35/1000	
MMR	3/1000	

The efforts towards Family welfare have resulted in a decrease in CBR from 36.8 in 1970 to 25.8 in year 2000 though the death rate decline has been relatively steeper.

Projected population as on 1st March 2001-2026 (in million)

	2001	2006	2011	2016	2021	2026
Rajasthan	57	62	68	73	78	82
India	1029	1112	1193	1269	1340	1400

Empowered Action Groups-

In order to facilitate the preparation of area-specific programs, with special emphasis on eight states that have been lagging behind in containing population growth(contributes 45% of the population of the country) to manageable limits, the Government of India has constituted an Empowered Action Group in the Ministry of Health and Family Welfare w.e.f. 20th March,2001. The members of the group consist of-

- Chairman -Minister for Health and Family Welfare,
- Vice Chairman- Minister of State for H&FW, and are
- Members- Secretaries of these 8 states,
- Secretaries of different Central Govt. Depts.
- Advisor (Health) Planning Commission,
- Other Central Govt. officials
- Convener- Joint Secretary (P) D/O Family Welfare

Role of the EAG

The EAG will seek to facilitate the change process by:

1. Ensuring appropriate policy development at the Centre,
2. Provisioning for technical assistance to the member States,
3. Addressing issues of coordination between member states and departments, and
4. Deploying financial resources, as appropriate and feasible.
5. The Empowered Action Group will meet during the inter-session period at least twice a year, first after the budget session of Parliament, during May-June, and then after the monsoon session during October-November

Objectives-

1. Universal access to quality family Planning services so that the small-family norm becomes a reality
2. Total coverage of registration of births, deaths and marriages
3. Full access to information on birth limitation methods and freedom of choice, especially to women, for planning their families
4. Reduction of Infant Mortality Rate to below 30 per thousand live births, incidence of low birth weight and maternal mortality rate
5. Immunization against vaccine preventable diseases
6. Elimination of incidence of girls being married below the age of 18
7. Increase in the percentage of deliveries conducted by trained persons to 100 per cent
8. Contain Sexually Transmitted diseases, especially AIDS
9. Universalization of ‘primary’ education and reduction in the dropout rates at primary and secondary levels to below 20 per cent for boys and girls

10. To introduce information technologies and management information systems, at district and sub-district levels, to monitor availability and access to contraceptives, drugs and vaccines as well as to services, in the near and far flung areas
11. To improve the existing systems for logistics
12. To implement the paradigm shift in the management of programs for population stabilization by incorporating diverse health care providers.
13. Accrediting private medical practitioners and assigning to them defined satellite populations for whom they will provide basic health services;
14. Reviving the system of licensed medical practitioner; who can provide specific clinical services, after appropriate certification;
15. Involving the non-medical fraternity;
16. Creating a network in these states of all manner of health facilities, identified by a common logo, to provide reproductive and child health services free to any client;
17. Forming a consortium of the voluntary sector, the non-government sector and private corporate sector to aid government in the provision and outreach of basic reproductive and child health care and basic education;
18. Mainstreaming Indian Systems of Medicine;
19. To position appropriate health care providers at every CHC/PHC/Sub-Centers in these states, to target 24 hour service delivery at the primary health centers in these states;
20. To pilot convergence of service delivery at village levels, through self help groups, with the help of the voluntary sector and the non-government organizations;
21. To finalize a targeted campaign for information, education and communication in these states that will involve the community, civil society, opinion leaders and political representatives, from village levels upwards, for dissemination of advocacy, information and communication;
22. To energize the existing system of referral transportation, training of dais, and quality of reproductive health care through a public private partnership;
23. To put in place intensive monitoring systems, inclusive of concurrent evaluation and reliable, detailed household and facility surveys, through professional agencies;
24. To ensure implementation of district planning through the community needs assessment reporting from each of the districts;
25. To align program and project delivery with advances in current technologies in reproductive research;
26. To pioneer projects for extending wider coverage and outreach of basic health care services through the active participation of non-government organizations, the voluntary sector and the private corporate sector, particularly in the area of referral transportation and improving quality of care;
27. To explore the possibility of expanding the scope of social marketing of contraceptives in a manner that makes them easily accessible even while raising awareness level.

The efforts towards Family welfare have resulted in a decrease in CBR from 36.8 in 1970 to 25.8 in year 2000 though the death rate decline has been relatively steeper.

Some of the steps imitated during X five year plan-

1. IEC in Family Welfare
2. Red Triangle
3. New Initiatives-
    a. Professional agencies for creating audio-visual and advertising campaigns.
    b. Separate IEC Bureaus for better planning and evolve local specific media strategies.

c. Decentralized strategy-
   i. IEC at State level
   ii. IEC at District Level
   iii. Non Government IEC efforts

d. Population education
   i. Proj*ect on School education* (implemented with the help of the National Council of Education Research and Training (NCERT) in 30 out of a total of 32 States/ U.T.)
   ii. *Project on post-literacy & continuing Education* is being implemented by Directorate Of Adult Education (National Literacy Mission) through State/Regional Resource Centers in 430 districts of 26 States/UTs.
   iii. *Project on Higher Education* is being implemented since 1986 through 17 Population Education Research Centers (PERCs),
   iv. *Project on Vocational Training* is being implemented through Directorate General of Employment and Training (DGET), M/o Labor in 600 Industrial Technical Institutes (ITI) all over the country in its second phase. The first phase covered about 1000 ITIs.

e. Training and development in Family Welfare-
   i. Village Health Guides (VHG) scheme:
   ii. Basic training of ANM / MPHFW (F):
   iii. Training of Multipurpose Health Worker (Male)/MPHW (M)
   iv. Health and Family Welfare Training Centers

A big achievement was made in Family Welfare when the first Population Policy was announced in 2000 with specific objectives and Goals to be achieved in a set timeframe. The Policy focuses on *reduction in TFR for Population stabilization.*

The 10th Plan (2002-2007) focus was on reaching a TFR of 2.1 by 2016 from the current levels (2003) of 3.2

The estimates of population requiring various family welfare services as on 2001 were:

Total eligible couples (wife in the reproductive age group of 15-44)	177 millions
Total no. of pregnant women	29.5 millions
Total no. of new borne	26.8 millions
Total no. of children 0-6 Years as per Census 2001	158 millions

Family Planning Insurance scheme:
Compensation: (w.e.f-07.09.07)

In Govt. facilities-

Category	Intervention	Acceptor	Motivator	Drugs	Surgeon	Anesthetist	Staff nurse	OT Asstt.	Refreshment	Camp mgt.
High focus states	Vasectomy (all)	1100	200	50	100	-	15	15	10	10
	Tubectomy (all)	600	150	100	75	25	15	15	10	10
Non high focus states	Vasectomy (all)	1100	200	50	100	-	15	15	10	10
	Tubectomy (BPL, SC/ST only)	600	150	100	75	25	15	15	10	10
	Tubectomy (APL only)	250	150	100	75	25	15	15	10	10

In Private facilities-

Category	Type of operation	Facility	Motivator	Total
High Focus States	Vasectomy (All)	1300	200	1500
	Tubectomy (All)	1350	150	1500
Non High focus states	Vasectomy (All)	1300	200	1500
	Tubectomy (BPL+SC/ST)	1350	150	1500

Compensation in case of adverse event (w.e.f. January 1st, 2009)

Section		Coverage	Limits (Rs. in Lakhs)	To be paid to whom
I	IA	Death following sterilization in hospital or within 7 days from the date of discharge from the hospital	2	Spouse and/or dependant children
	IB	Death following sterilization within 8-30 days from the date of discharge from the hospital	0.5	Spouse and/or dependant children
	IC	Failure of sterilization	0.3	Beneficiary
	ID	Cost of treatment upto 60 days arising of complication from the date of discharge	Actual not exceeding 0.25	Beneficiary
II		Indemnity Insurance per Doctor/facility but not more than 4 cases in a year	Upto 2 per claim	
Total liability of the insurance Company shall not exceed Rs. 9 crores in a year under each section				

Jansankhya Sthirata Kosh

The **"Jansankhya Sthirata Kosh"** (JSK) (National Population Stabilisation Fund) has been registered as an autonomous Society established under the Societies Registration Act of 1860. JSK has to promote and undertake activities aimed at achieving population stabilisation at a level consistent with the needs of sustainable economic growth, social development and environment protection, by 2045. The Union Health Minister heads the General Body of JSK and the Ministries of Health and Family Welfare, Women and Child Development, Department of School Education & Literacy, Rural Development, Planning Commission are represented by their Secretaries on the General Body of JSK. All State Governments are members of JSK. Besides this the General Body has demographers, representatives of Industry & Trade, NGOs, medical and para-medical associations, general citizens as its members. This enables JSK run as a civil society movement drawing on the strength of its partners. JSK has started a Call Centre service to give information on reproductive health and family planning in English and Hindi.

Innovative Strategy under JSK

a. "***Prerna***" provides an opportunity for couples who have fulfilled specific **responsible parenthood** criteria to become entitled to receive a reward. The ingredients to qualify are :-

1. Girl's marriage after 19 years of age **(Reward of Rs.5000/)** and giving birth to the first child after the mother was 21 years old **(Reward of Rs.7000/ if it's a girl child & Rs 5000/ if it's a boy).**
2. Keeping a 36 month gap between first and second child and one parent getting sterilized after the second child is born**(Reward of Rs.7000/ if it's a girl child & Rs 5000/ if it's a boy)**
    - Couple must belong to any of the 46 districts identified for 2008-09 Prerna awards by JSK.
    - Must belong to BPL category.
    - Preference will be given to younger couples (age of wife not exceeding 30 years).
    - Only those couples who have completed registration of marriage and registration of the birth of each child with the competent authority (Registrar of Marriages / Appropriate Govt. Officer registering births) would qualify for the Award.
    - The award shall be given in form of Kisan Vikas Patra in the name of Couple and will be given at a public function

b. "***Santushti"*** strategy private gynecologists are being encouraged to perform 100 tubectomy (laparoscopic sterilization operation) / NSV for which the doctors will be paid according to compensation rates already notified by the Government with an additionality for fast track quality service. An MOU is signed between the district CMHO and private facilities. Funding is provided by JSK through the Collector and CHMO to save time and paperwork and encourage the private sector to join hands. To date 25 MOU's have been signed in Satna and Jabalpur district of Madhya Pradesh

JSK vs. Family Welfare

JSK is a unique organization. Its goal is to promote initiatives which leverage the strength of different economic and social sectors and reach out to needy population groups through innovative strategies. It is a combination of government and civil society working hand in hand to promote innovations by drawing on the strength of joint partnerships.

All the events that JSK has organized are evidence of partnership forged already which indicates JSK's uniqueness.

- Observation of World Population Day
- Prerna Awards at Dhaulpur and Jodhpur in Rajasthan and Nabarangpur in Orissa- Direct contact with village people who have now become JSK's Role Models for responsible Parenthood practices.

- Working with the Private Sector Medical Specialists (Gyneacologists and NSV Surgeons) to enhance services for contraception.
- Induction of professional people, NGOs, CII, FICCI, IASP, IPHA, IAP & SM, FOGSI, TNAI, IMA and ASSOCHAM in the Governing Board of JSK.

JSK's initiatives like **GIS Maps**, **Call Centre**, **Virtual Resource Center**, **Prerna**, **Santushti**, large scale sensitisation workshops for adolescents from remote villages.

JSK Strategies

a. Prerna
b. Santhushti
c. Call Center
d. Virtual Resource Center
e. Involvement of Gynaecologists in IUD(380A) and Material Development and display for IEC/BCC

National AIDS Control Program:
HIV/ AIDS

- **A** Acquired must do something to acquire
- **I** Immune ability to fight disease
- **D** Deficiency
- **S** Syndrome cluster of symptoms characteristic of disease

First case: 1986
National AIDS control program: 1987
NAC0: 1992

HIV/ AIDS prevalence criteria

1. High- > 1% in Ante-natal women
2. Moderate- < 1% in Ante-natal, >5% in STD/other high risk behavior
3. Low- < 1% in Ante-natal & < 5% in STD/other high risk behavior

Some facts:

1. **One disease**
2. **Two Viruses**
3. **Three transmission modes-**
   a. Sexual
   b. Vertical
   c. IV Drug/Blood
4. **Four interventions**
   a. Communication
   b. Counseling
   c. Condoms
   d. Care of PLWA
5. **Five owe responsibility**
   a. Individual
   b. Family
   c. Community
   d. Care providers
   e. Media

Avoid transmission

1. Condom use
2. Sterile needle use
3. Blood safety
4. Single partner
5. Universal Precautions

Signs:
Major:

1. Weight loss: > 10% of body weight
2. Chronic diarrhea > I month

Transmission modes

Avoiding Transmission

No transmission

3. Fever > 1 month (intermittent or constant)

Minor:

1. Persistent cough > 1 month
2. General pruritic dermatitis
3. Recurrent herpes zoster
4. Oropharyngeal candidiasis
5. Chronic progressive and disseminated
6. herpes simplex infection
7. Generalised lymphadenopathy

Symptoms:

Swollen glands
Mouth ulcers
Sore throat, cough
Symptoms of opportunistic infections
Skin rashes, pruritus, and recurrent herpes
Prolonged unexplained fatigue
Joint pains, muscle atrophy,
Impaired cognitive functions, vision problems

Diagnosis

1. ELISA/Rapid Simple Tests
2. Western Blot

Criteria for confirmation:

A +ve ELISA antibody test
A +ve Western Blot Test
Absolute CD4 cell count <200
Abnormal p24 antigen
T(thymus derived) Lymphocyte count is abnormal

HIV/ AIDS control strategy

- Program management
- Surveillance & Research
- IEC & Social mobilization through NGOs.
- Control of STDs.
- Condom programming
- Blood safety
- Impact reduction

NACO policies

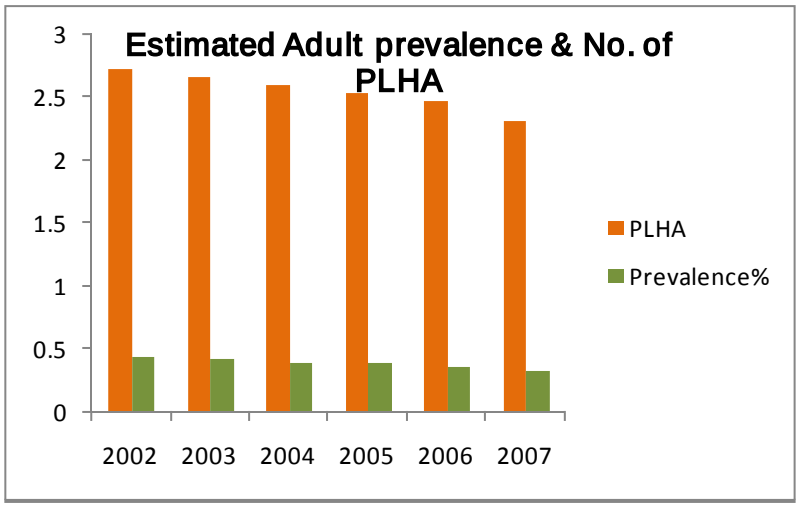
- **National AIDS control Policy**
- **Policy on HIV testing**
- **National Blood policy**
- **ART guidelines**

NACP-III (2006-2111)

Current epidemiological situation in India:

The HIV/AIDS situation is monitored through sentinel surveillance since 1992. Sentinel surveillance started with 192 sites and by end of 2007 there were 1134 sites (646 Ante-natal clinics and 488 high risk sites).There were 2.31 million people living with HIV/ AIDS by Dec. 2007, with adult prevalence of 0.34% .

The first phase of National AIDS Control Programme was initially from 1992 to 1997 and was extended to 1999.



NACP-II commenced from April 1999 with the twin objectives of

A. Reducing the spread of HIV infection and strengthening the capacity of Central and State Governments to respond to HIV/AIDS on a long term basis.
B. Targeted interventions for high risk groups and measures to prevent HIV transmission among the general population. Anti-Retro Viral Therapy was provided to AIDS patients at selected centres.

The programme implementation has been completely decentralized to states and UTs. Each state and UT has registered a State AIDS Control Society (SACS) responsible for implementing the programme at the State/ UT level. Mumbai, Chennai and Ahmedabad have formed Municipal AIDS Control Societies to effectively implement the programme.

Important policy initiatives taken during NACP-II include

a. Adoption of National AIDS Prevention and Control Policy (2002);
b. National Blood Policy; Greater Involvement of People with HIV/AIDS (GIPA);
c. Launch of the National Adolescent Education Programme;
d. Provision of anti-retroviral treatment (ART);
e. Formation of an inter-ministerial group for mainstreaming; and
f. Setting up of the National Council on AIDS, chaired by the Prime Minister.

National AIDS Control Programme – Phase III

The overall goal of NACP-III launched in June 2007 is to halt and reverse the epidemic in India over the next 5 years. Considering that more than 99% of the population in the country is free from infection, NACP-III will place the highest priority on preventive efforts while, at the same time, seeking to integrate prevention with care, support and treatment. This will be achieved through **a four-pronged** strategy:

1. Prevention of new infections in high risk groups and general population through:
   a. Saturation of coverage of high risk groups with targeted interventions (TIs)
   b. Scaled up interventions in the general population
2. Providing greater care, support and treatment to larger number of PLHA.
3. Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.
4. Strengthening the nationwide Strategic Information Management System.

The specific objective is to reduce new infection as estimated in the first year of the programme by:

a. Sixty per cent (60%) in high prevalence states so as to obtain the reversal of the epidemic;

b. Forty per cent (40%) in the vulnerable states so as to stabilize the epidemic.

S.No.	Activity/Component	Baseline Sept 1999	June 2007	March 2009
1	Establishment of Sentinel sites for HIV trends			
2	Knowledge of HIV/AIDS and at least 2 methods of prevention	50-80% Urban, 13-64% Rural	43-83% (U) 25-86% (R)	
3	Consistent condom use among female sex workers	50.3%	73.4%	
4	Coverage of schools & colleges for awareness	0	112000 schools	97279 schools
5	Condom vending machines installed by NACO	0	11025	19525
6	Condoms distributed		231.07 crores (2006-07)	221.31 crores (2008-09)
7	Modernization of blood banks	960	1086	1092
8	Voluntary blood donation (%of requirement)	20%	59.1%	61.7%
9	Establishhment of ICTC	0	4312	4987

10	HIV test conducted	0	10 million	10.02million
11	Centers providing PPTCT services	0	2418	3452
12	Centers providing HIV-TB collaborative services	0	2684	4987
13	Government STI clinics	504	845	886
14	Anti retrovial theraphy ccentrres	0	127	211
15	Patient on ART	0	85915	217781
16	Children on ART	0	6300	13961
17	Community care centres	0	101	254
18	PLHA networks	0	90	259
19	Drop-in centres	0	84	204
20	Coverage of high-risk population across the country through targeted intervention projects	300	764	1271

Strategy:

1. Prevent infections through saturation of coverage high-risk groups with targeted interventions (TIs) and scaled up interventions in the general population.
2. Provide greater care, support and treatment to larger number of PLHA.
3. Strengthen the infrastructure, systems and human resources in prevention, care, support and treatment Programs at district, state and national levels.
4. Strengthen the nationwide Strategic Information Management System.
5. The specific objective is to reduce the rate of incidence by 60 per cent in the first year of the Program in high prevalence states to obtain the reversal of the epidemic, and by 40 percent in the vulnerable states to stabilise the epidemic.

A. Targeted Interventions

Currently, 1,271 Targeted Intervention projects are operational in the e country under various State AIDS Control Societies and around 200 TIs are managed by other partners. These TIs cover 55 5% of FSW, 73% of IDU and 77% of MSM & Transgender populations. Saturation of all high risk groups through 2,100 TI projects and development of ownership by community to ensure the services accessibility to all is the target aimed at during NACP-III.

NACO has institutionalized the training and capacity building process with the establishment of the State Training and Resource Centres (STRC). STRCs function with the objectives of:

a. Ensuring need based training of TIs as per NACP III's technical and operational guidelines;
b. Enhancing the capacity of NGOs and civil society organizations in proposal development for NACP funded targeted intervention projects; and
c. Undertaking operational research and evaluation of TIs. STRCs have been established in 14 states and 6 more are being established

A new intervention that has been taken up in NACP-III for addressing the HIV risk among Injecting Drug Users is provision of Oral Substitution Therapy (OST), which has been seen to be an effective strategy worldwide.

As per NACP III, truckers' interventions are to be focused on high priority locations i.e. major trans-shipment locations (TSLs) with 5,000 or more long distance truckers halt on a monthly

basis. At present, there are 52 truckers interventions, of which 17 are in high-priority locations, being implemented by NGOs.

B. The **Link Worker Scheme** (LWS):

Under NACP-III has been designed specifically to address population with high-risk behaviors (including High Risk Groups and Bridge Populations). LWS is a medium term, meso-level strategy, whose scope is limited to five years. The services established through LWS will be linked to local health governance system at three levels. This will again ensure mainstreaming of the HIV response project and, therefore, the project sustainability can be assured beyond five years. They work in each cluster of villages around a 5,000+ population. They are supported in their work by village-level volunteers selected from the available groups in the community. In every district, the LWS is being implemented through one or two District Resource Persons, one Monitoring & Evaluation Officer, four Supervisors and 40 Link Workers. The scheme is supported by UNDP, UNICEF, USG and GFATM.

C. Preventive interventions for the general population

Prevention has always been the main stay of addressing the HIV/AIDS epidemic. Under NACP-III, it is proposed to integrate and scale-up service delivery to sub-district and community levels through existing infrastructure in the public and private sectors. The following is the package of preventive services provided under NACP-III:

i.	Creating awareness about symptoms, spread, prevention and services available through a strong IEC campaign
ii.	Condom promotion
iii.	Promotion of voluntary blood donation and access to safe blood
iv.	Integrated Counseling and Testing (ICT)
v.	Prevention of Parent To Child Transmission
vi.	Management of STI and RTI
vii.	Post Exposure Prophylaxis (PEP)
viii.	Promotion of safe practices and infection control
ix.	Intersectoral coordination and mainstreaming

Under NACP-III, **Voluntary Counseling and Testing Centres** (VCTC) & Prevention of Parent to Child Transmission Centres (PPTCT) have been remodeled together as ICTC **(Integrated Counseling and Testing Centre)**. The number of integrated counseling and testing centres increased from 982 (2004), 1,476 (2005), 4,027 (2006), 4,567 (2007), 4,987 (March 2009). The number of persons tested in these centres increased from 17.5 lakhs in 2004 to 27.8 lakhs in 2005, 40.3 lakhs in 2006, 73.7 lakhs in 2007 and 102 lakhs in 2008-09.

ICTCs also provide PPTCT services to pregnant women. The number of pregnant women counseled and tested was 1.8 lakhs in 2004, 13.7 lakhs in 2005, 21 lakhs in 2006, 32.3 lakhs in 2007 and 46.31 lakhs in 2008. In 2008, 21,483 pregnant women were found to be HIV positive. Women who are HIV positive are given a single dose of Nevirapine prophylaxis at the time of labor and newborn is also given a single dose of Nevirapine within 72 hours of birth. In 2008, a total of 10,494 mother-baby pairs were given prophylaxis dose of Nevirapine.

NACP-III aims to accomplish the following targets to expand the outreach of ICTC services:

a. All Community Health Centres to have HIV counseling and testing services
b. 24hr Primary Health Centres and Private hospitals are also being involved

c. Mobile ICTCs in hard to access areas in collaboration with NRHM
d. Internal and External Quality assurance mechanisms
e. Target of 10-15 tests per day per centre

D. **Sexually Transmitted Infections (STI) Services**

As STI increase the risk of HIV transmission significantly, their care has been given high importance in NACP-III. NACP-III envisages that about 15 million episodes with STI/RTI will be treated through the programme. The STI /RTI services are being delivered through designated STI/RTI clinics, TI STI clinics, and a network of STI/RTI private preferred providers and NRHM at sub-district facility. The Regional STI Reference Research and Training Centres are providing high quality laboratory support to generate scientific evidence for providing good quality STI/RTI services through monitoring drug resistance to gonococci and implementing Syphilis EQAS so as to review the syndromic protocol on a periodic basis.

STI Services provided under NACP-III

S.No.	Name of Centre	No. of Centers	Location
1.	Designated STI clinics	886	Medical Colleges, District hospitals, selected area hospitals and large CHCs under SACS/NACO.
2.	Targeted Intervention Clinics	1271	In the each district to cater the high risk population
3.	Community based STI/RTI services delivery through network of "Private Preferred Providers" "Janani" Scheme in Bihar	8515	STI/RTI services to be provided to the HRG and the clients of HRG through the network of Private providers (Allopath and non allopath) in 100 high priority districts.
4.	NRHM facilities	26,415 PHC/CHC	STI/RTI services delivered at sub district level through NRHM facilities.
5.	Regional STI Reference, research and training centers	7	In medical colleges -Safdarjung & Maulana Azad Medical College in Delhi, Osmania Medical College in Hyderabad, B.J. Medical College in Ahmedabad, Institute of Serology and Calcutta Medical College in Kolkata, Institute of Venereology in Chennai & Government Medical College in Nagpur.

STI/RTI episodes managed under NACP III (2008-2009)

S.No.	Name of the health care facility	Number of cases (in lakhs)
1.	Designated STI/RTI Clinics	25.7
2.	TI STI clinics	9.1
3.	PPP Scheme	1.0
4.	NRHM facilities	31.0
	Total	**66.7**

During 2008-09, a Public Private Partnership scheme was launched in 91 priority districts in 14 zones in 16 states involving 7 agencies. This scheme was implemented as a pilot wherein the agencies identified 8,515 private practitioners (including 2,233 allopaths and 6,282 non-allopaths) who were

high volume STI/RTI service providers in and around hot zones in the selected districts. These networked providers were trained and provided with colour-coded STD drugs to administer the syndromic treatment and provided on-site supervision. Demand generation activities were also carried out alongside. As of 31st March, 2009, 1,975 (88%) allopaths and 5,528 (88%) nonallopaths had been trained; 1,06,684 STI/RTI cases treated; 1,49,880 clients counseled; and 15,226 clients referred.

E. Mainstreaming HIV for multi-sectoral response:

1. **Constitution of the State Councils on AIDS (SCA):**
2. **Mainstreaming with civil society organizations:**
3. **Greater Involvement of People Living with HIV (GIPA) under NACP-III:**

NACP III has outlined steps in establishing systems, structures and various activities to meaningfully involve people living with HIV (PLHIV) in programme design and implementation to reduce stigma and discrimination associated with the infected and affected persons. This will also enhance their access to prevention and quality treatment, care, insurance and legal services. Support from NACO has enabled the Indian Network of Positive People to establish and strengthen up to 22 state level networks and 221 district level networks of people living with HIV. These networks aim to mobilize the communities to ensure community access to various services, like ART Centres, Community Care Centres, and Drop-in centers (DIC). At present, a total of 204 DICs are operational across the country out of which 127 are in the 'A' category districts and 27 in the 'B' category districts. NACO is working towards establishing DIC in all A and B category districts

F. **Condom Promotion**

The NACP-III envisages significant expansion in the condom use through social marketing for which partnerships with private sector and social marketing organizations were planned.

a. **Scaling up condom social marketing:**

NACO supported the social marketing programmes in various states during 2008-09. These programmes were initially extended for a six month period during which a total of 856 lakh condoms, against the target of 750 lakh condoms, were marketed and over 2.7 lakh outlets, against the target of 2.4 lakh outlets, were covered with socially marketed condoms. With the focus on expanding the retail outlet and coverage of non-traditional outlets, 71% of the outlets were the non-traditional outlets.

Retail Condom off take (In lakh pieces)

	2006-07	2007-08	2008-09
Social market	6395	6393	8353
Commercial	3837	4386	6313
Free	12875	7750	7465
Total	23107	18529	22131

During 2008-09, socially marketed condom off-take of 83.53 Crore pieces (Table 6) and outlet reach of 12 lakhs were achieved.

b. **Scaling up Female Condom Programme**:

Based on the pre-programme assessment of the Female Condom Programme, NACO scaled up the Female Condom Programme in Andhra Pradesh, Tamil Nadu, Maharashtra and West Bengal to saturate all female sex worker Targeted Interventions. The peer-led

programme aims to build capacity of two lakh female sex workers. During 2008-09, 15 lakh female condoms were procured for the programme.

c. Installation of Condom Vending Machines:

During the year 2008-09, four metro cities and two large towns in Uttar Pradesh were targeted for the installation of condom vending machines. Against 10,025 targeted number of CVMs, 8,500 CVMs have already been installed. During 2008-09, 7,50,000 condoms were sold through these CVMs.

G. **Blood Safety:**

The Blood Safety Programme under NACP-III aims to ensure provision of safe and quality blood to far-flung remote areas of the country in the shortest possible time through a well-coordinated National Blood Transfusion Service. The specific objective is to ensure reduction in the transfusion associated.HIV transmission to 0.5 per cent. This is sought to be achieved by:

1. Ensuring that regular (repeat) voluntary non-remunerated blood donors constitute the main source of blood supply through phased increase in donor recruitment and retention;
2. Establishing blood storage centres in the primary health care system for availability of blood in far-flung remote areas;
3. Vigorously promoting appropriate use of blood, blood components and blood products among the clinicians; and
4. Developing long-term policy for capacity building to achieve efficient and self sufficient blood transfusion services.

a. **Blood collection:**

Access to safe blood is ensured by a network of 1,092 blood banks including 104 Blood Component Separation Units (BCSU) and 10 Model Blood Banks. NACO supported the installation of blood component separation units and also funded modernization of all major blood banks at state and district levels, besides the procurement of equipments, test kits and reagents as well as the recurring expenditure of government blood banks and those run by charitable organizations that were modernized.

Based on population standards, the requirement of blood for the country is estimated to be 100 lakh units annually, whereas the available supply was 74 lakh units in 2008-09. During this period, 61.7% of blood was collected through Voluntary Blood Donation programme.

b. **Strengthening of Blood bank facilities through:**

i. District level Blood Banks
ii. Blood Component Separation Units
iii. Blood Storage Centres
iv. Blood Refrigerated Vans

H. Other activities for Blood safety initiated under NACP-III are-

a. Blood Safety Training Programme:
b. Monitoring of blood banks
c. Newer initiatives
   i. Centre of Excellence in Transfusion Medicine:
   ii. Plasma Fractionation Centre:
   iii. National Blood Transfusion Authority:

I. **Care, Support and Treatment for People Living with HIV/AIDS (PLHA)-**

The Care, support and treatment programme under NACP III includes comprehensive management of PLHA with respect to treatment and prevention of Opportunistic infections, antiretroviral therapy (ART), psychosocial support, home based care, positive prevention and impact mitigation.

Any person who has a confirmed HIV infection is subjected to further evaluation for determining whether he requires ART or not by performing CD4 count and other baseline investigations. All those eligible as per technical guidelines are started on ART.

The **target for National ART program** is to:

1. Free ART to 300000 adult, and 40000 pediatric PLHA by 2012 through 250 ART and 650 Link ART centers.

2. Achieve and maintain high levels of adherence and minimize numbers lost to follow up

3. Involve intersectoral partners, NGOs and Private partners

4. Provide comprehensive care, support and treatment through 350 Community Care Centers by 2012.

During 2008-09, the following activities were undertaken to improve the quality of care offered to PLHAs:

i)	Revision of technical and operational guidelines on ART, Opportunistic Infections, Community Care Centres and Pediatrics
ii)	Preparation of training modules for doctors, counselors and nurses.
iii)	Appointment of Regional coordinators for care, support and treatment to monitor quality of services
iv)	**Revision of Manpower at ART Centres.** The human resources at ART centres have been linked to the number of patients at the centre so that all patients get proper time for counseling and patient's satisfaction is increased.
v)	**Strengthening the capacity of laboratories for CD4 testing.** At the end of March 2009, 145 CD4 machines were installed in the country to take care of 197 centres, by way of a sample transport mechanism for centres without CD4 machines. The sample is transported by the lab technician who also brings back the report after testing at the Nodal Centre.
vi)	**Technical Resource Groups** have been constituted on ART, Pediatric issues, Lab. services and CCCs for discussion and recommendations on various technical and operational issues relating to the programme.
vii)	**Supply Chain Management for ARV Drugs.** All efforts are made to ensure continuity of drug supply to ART centres and in case of unexpected in number of patients at any particular centre, re-location of drugs is done in order to ensure that there are no stock outs.
viii)	**Conceptualization and operationalization of the Link ART Centres.** The concept of Link ART centres was developed considering the large distances PHLAs had to cover to reach ART centres. These Link ART Centres are
	being developed at ICTC or CCC, whereby stabilized patients will get their drugs within easy reach and need to travel to the main ART centre only once in six months. A total of 300 Link ART Centres have been sanctioned so far.
ix)	**Collaboration with intersectoral partners, NGOs & CII.** NACO is strengthening the public private partnership by involving corporate sector, intersectoral partners and NGOs in ART roll out. Presently, eight ART centres are running in collaboration with different NGOs/Industries.

x)	**Community Care Centres.** In order to improve the quality of counseling and also reduce the inconvenience caused to PLHAs while being investigated at ART centres, all ART centres will be linked to a Community Care Centre, where patients can be admitted during the period of investigation and adherence counseling can be reinforced. At the end of March 2009, a total of 254 CCCs were operational. It is planned to have a total of 350 CCC across the country by 2012. Each CCC will be linked to the closest ART Centre.

J. **Institutional Strengthening and Capacity Building through**

a. strategic planning skills,
b. disseminating best practices for TIs,
c. establishing and managing a network of technical expertise through Technical Resource Groups (TRGs) in STI/HIV/AIDS,
d. conducting OR and
e. R&D activities

K. **Strategic Information Management**

Key activities being undertaken are -

a. Establishing a Research Wing/ Division at NACO with strong linkages developed with research/academic institutions at regional/ state level;
b. Strengthening operations research and evaluation studies on the design, strategies, implementation and testing of HIV intervention programmes and measure their impact related to risk/vulnerability reduction, behavior change, stigma reduction, HIV prevalence rate,
c. Building capacity for monitoring and evaluating community based interventions, school based adolescent education programmes and support groups of positive people;
d. Conducting two types of Behavioral Surveillance Survey, namely,
    i. annual risk assessment at the district level and
    ii. Methodologically rigorous Integrated Biological and Behavioral Surveillance (IBSS) at district level, once in three years.

L. **Monitoring and Evaluation**

Following activities were undertaken:

a. Development of an integrated M&E Plan for NACP-III
b. Strengthening systems for better M&E
c. Improving Component Specific M&E
    i. ART Centers
    ii. Integrated Counseling and Testing Centres
    iii. STI/RTI Reporting
    iv. Community Care Centers

M. **Improving CMIS and overall Reporting**

Through a comprehensive software for SIMS with advanced features like on and off-line reporting, client tracking, GIS features and basic statistical analysis. A process for development of smart card is re-initiated for tracking of patients on ART.

N. HIV Sentinel Surveillance

Scale-up of Sentinel Sites: HIV Surveillance in India was started from 1985. Subsequently, NACO established in 1992, sentinel surveillance for HIV/AIDS in India. The number of sentinel sites were increased from 176 in 1998 to 1,215 in 2008 The population groups monitored under HSS include pregnant women attending antenatal clinics (ANC), patients attending Sexually Transmitted Diseases Clinics (STD), Female Sex Workers (FSW), Men who have Sex with Men (MSM), Injecting Drug Users (IDU), High Risk Migrants/ Single Male Migrants and Long distance Truckers.

The objectives of HIV Sentinel Surveillance are to:

a. determine the level of HIV infection among general population as well as high risk groups in different states;

b. understand the trends of HIV epidemic among general population as well as high risk groups in different states;

c. understand the geographical spread of HIV infection and to identify emerging pockets of HIV epidemic;

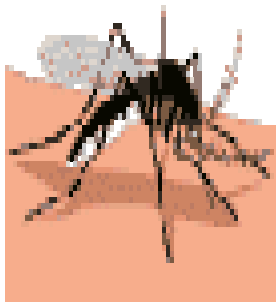
d. provide information for planning the programme in different states and districts, for prioritization of programme resources and evaluation of programme impact; and

e. estimate HIV Prevalence and HIV burden in the country besides HIV incidence, Mortality due to AIDS and ART needs.

Methodology of HIV Sentinel Surveillance

S. No	Item	Surveillance among General Population	Surveillance among High Risk Groups (HRG)	Surveillance among Special Groups
1	Population Group	Pregnant women attending ANC Clinics of 15 – 49 years age group.	Female Sex Workers, Men who have Sex with Men, Injecting Drug Users, Eunuchs, Migrants, Truckers of 15–49 years age group.	Patients attending STD Clinics of 15 – 49 years age group.
2	Sample size	400 through consecutive sampling	250 through consecutive sampling at service points or satellite points.	250 through consecutive sampling
3	Method of sample collection	Routine method of blood collection at ANC Clinics (Intra-Venous Samples)	Dried Blood Spot (DBS) method at HRG sites (Drops of blood collected through finger prick)	Routine method of blood collection at STD Clinics (Intra-Venous Samples)
4	Testing Strategy	Unlinked Anonymous	Unlinked Anonymous with Informed Consent	Unlinked Anonymous
5	Testing Protocol	2-test protocol	2-test protocol	2-test protocol

National Anti Malaria Program:



(Now merged into National Vector Borne Disease Control Program, since Dec. 2, 2004)

Chronology of developments in Malaria-

April 1953: Case load- **75 million**

National Malaria Control Program (NMCP) launched

Focus on twice an year indoor residual spray (1 Gm. per Sq. meter) in areas with annual spleen rate of >10%

1958: Case load- reduced to **2 Million** cases

National Malaria Eradication Program (NMEP) launched

NMEP had phased approach-

1. Preparatory
2. Attack
3. Consolidation
4. Maintenance

1971: Urban Malaria Scheme (**UMS**)

1. To reduce/ control transmission
2. Extensive use of Anti-larval measures
3. Operational in 131 large cities

1976: **Resurgence** with peak in 1976 (1961-50000 cases, 1976-6.47 million cases)

Reasons:

1. Priority shifts
2. Sole reliance on DDT-Insecticide resistance
3. Rising costs of Insecticides
4. Chloroquine resistance in falciparum

1977: Modified Plan of Operation (**MPO**) and Plasmodium falciparum containment Program (**PfCP**)

1. Objective-
   a. Prevent Malaria deaths
   b. Reduce Malaria morbidity
   c. Consolidate gains
   d. Maintain production-agricultural and industrial
2. Activities-
   a. Reclassification of area based on API
      i. Area with API >2
         a) Spraying-
            - DDT 2 rounds (1.0 Gms./Sq.meter)
            - Malathion 3 rounds (2.0 Gms./Sq.meter)
            - Synthetic pyrethroids 2 rounds (0.25 Gms./ Sq.meter
         b) Entomological assessment
         c) Surveillance-Active &Passive
         d) Treatment of Cases
      ii. Areas with API <2
         a) Spraying-Focal around Pf cases
         b) Surveillance
         c) Treatment
         d) Monthly Follow-up of all smear positive4 cases for one year
   b. Drug Distribution Centers (DDC) and Fever Treatment Depots (FTD)

i. DDC only for dispensing anti-malarial drugs
ii. FTD for collecting slides and dispensing drugs (1/ 1000 pop. or part thereof with a stock of 200 Chloroquine tablets)

c. Pf containment (Oct. 1997) (SIDA assisted)
d. Research & Re-organization
e. IEC

3. Records to be maintained and forwarded-
   a. MF-1 (Family Health Register)
   b. MF-2 (Reporting of Blood smears by MPW/HA/Surveillance workers)
   c. MF-3 (Tour record of HA) & MF-3A (MPW)
   d. MF-4 & MF-5 (Monthly report of PHC)
   e. MF-6 (Monthly report-progress & assessment of spraying)
   f. MF-7 (Details of positives & remedial actions)
   g. MF-8 (blood smears received and examined –Sub center wise)
   h. MF-9 (Epidemiological evaluation master register-Sub center, village & month wise)
   i. MF-10 (Passive agencies including FTDs report)
   j. MF-11
   k. MF-12 (Tour report of District Medical Officer)
   l. MF-13-(Monthly report of work by CMHO)
   m. MF-14 (Particulars of PHCs visited)
   n. Mf-15 (Zonal officer's activity report for the month)
   o. MF-16 (For reporting by DDC/FTD and Malaria clinics)

1979: Centrally sponsored category-II scheme on 50:50 basis
(Poor States who do not spend their 50% do not get central assistance of 50%- **those who need most get the least**)

1985: 2 million cases
1991: Peak in Pf cases
1994: Epidemic proportions in Eastern India and Western Rajasthan

1994: 100% centrally sponsored program for N-E States, covers-
1. Operational cost
2. Equipments cost
3. Cash assistance

1995: Malaria Action Plan

Sep. 1997:

Enhanced Malaria Control Project (EMCP)- 8 States (AP, Chattisgarh, Gujarat, MP, Jharkhand, Maharashtra, Orissa, and Rajasthan).

Program is in operation in **1045 PHCs of 100 districts** of these States with rural population of **62.2 million** along with **19 cities/ towns** in these States and in States of Karnataka, WB and Tamil Nadu. (Cost-891 Crores for 1997-2002)

Criteria for selection of PHCs in EMCP area-
1. API > 2 in last 3 years (>5- High risk)
2. SFR > 30% of total cases (0.9% -High Risk)
3. PHCs with 25% or more tribal population
4. PHCs reporting mortality because of malaria

The main focus areas under EMCP are-
   a. Early diagnosis and prompt presumptive treatment (EDPT)
      i. Active & passive surveillance, slide examination and rendering radical treatment within 48 hours.
         a) One microscopic Center/30000 pop.

b) RDK for emergency and difficult areas.
c) DDC per village/MLV on 2000 High Risk area

ii. Selective/ Integrated vector control and personal protection (IVM) Graded reduction in IRS, Village as a unit for IRS, Selective use of Synthetic Pyrethroids.

b. Integrated Vector Management-
   i. Anti adult measures
      a) Indoor Residual Spray(IRS)
      b) Space Spray
      c) Genetic Control
   ii. Anti-larval Measures
      a) Environmental control
      b) Chemical and Biological Control
   iii. Personal Prophylaxis
      a) Mosquito-net
      b) Screening and repellent
c. IEC
d. Capacity building, and
e. Epidemic containment plan and Rapid action
f. Surveillance
g. Rapid diagnostic kits
h. Inclusion of alternative insecticides like synthetic pyrethroids & biological control methods

April 1999: **National Anti Malaria Program** (NAMP)
2004: **NVBDCP**

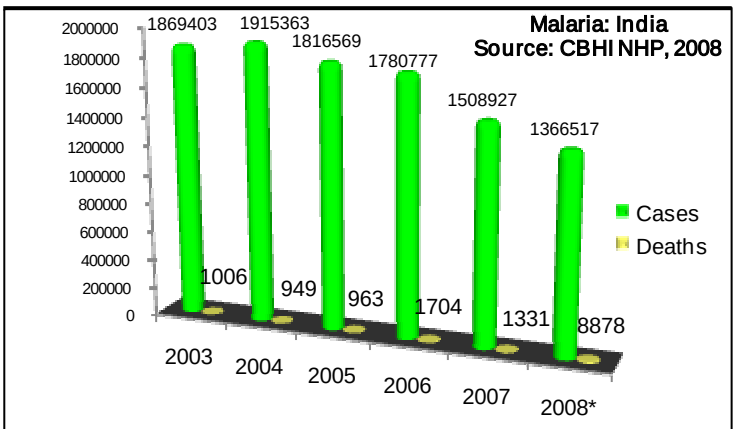
Malaria situation:

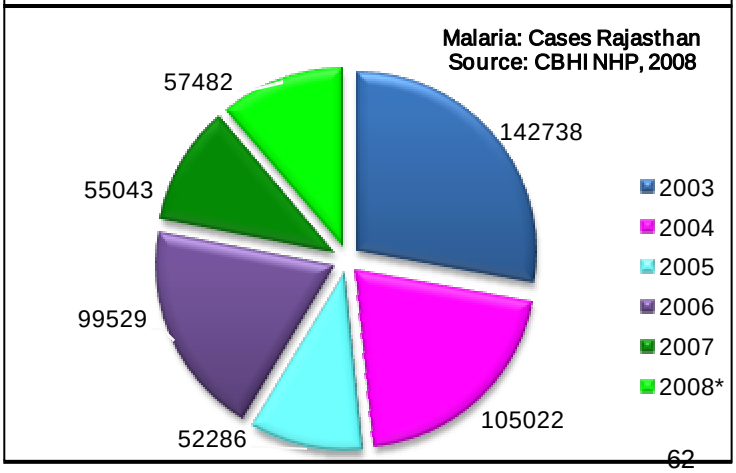
Data for the year 2006 reveals the largest numbers of cases in the country were reported by Orissa, followed by Jharkhand, West Bengal, Assam, Chhattisgarh, Rajasthan, Gujarat & Uttar Pradesh and the largest numbers of deaths were reported by Assam followed by Orissa, West Bengal, Arunachal Pradesh, Meghalaya, Maharashtra, Mizoram, Gujarat & Karnataka.

1.79 million Cases of malaria (including 0.84 million P.falciparum cases) and 1707 deaths were reported from the country in 2006.

In 2008, 1524939 cases were detected out of which 755582 were Pf cases and 595 deaths (Source: NVBDCP).

In 2009 till May 319581 cases, 184591 Pf cases and 178 deaths were reported across the country.





Rajasthan had reported 6020 positive cases, 258 Pf cases and zero Death for 2009(till May 2009)

Main factors for Malaria spread:

1. Irrigation practices – IG canal in Raj.-Pf cases on rise
2. Wet cultivation – rice
3. Labor migration—asymptomatic carriers
4. Dams -----Pf introduction
5. Deforestation—Vivax introduction, epidemics of Pf
6. Plantation--- Pf introduction

Measuring Malaria:

1. **Human indices-**
   a. Annual Parasite Index (API) Annual Blood Examination Rate (ABER)
   b. Annual Falciparum Index (AFI)
   c. Slide positivity rate (SPR)
   d. Slide Falciparum Rate (SFR)

$$API = \frac{\text{Confirmed case in one year}}{\text{Population under surveillance}} \times 1000$$

$$ABER = \frac{\text{No. of slides examined}}{\text{Population}} \times 1000$$

2. **Vector Indices-**
   a. Human Blood Index (HBI)-proportion of freshly fed female anopheles with human blood in stomach.
   b. Sporozoite rate-percentage of female anopheles with Sporozoites in salivary glands
   c. Mosquito density—no. Of mosquitoes per man hour catch
   d. Man-biting rate-average anopheline bites per person per day

High-risk area Identification -Criteria:

Rural area-

1. Recorded Malaria deaths due to P.falciparum in last 3 yrs.
2. Slide Positivity Rate (SPR)
   a. Doubling of SPR during last 3 years, provided the SPR in 2nd & 3rd year is 4% or more
   b. NO doubling trend of SPR but average SPR is 5% or more in last 3 years.
3. P.falciparum proportion is 30% or more and SPR is 3% or more in any of the last 3 years.
4. Areas with focus of Chloroquine resistant P.falciparum-more than 25% cases in a sample of 30 are of R-II & R-III level
5. Tropical aggregation of labor population in project areas
6. New settlements in endemic areas

Urban area-

1. SPR > 5% or
2. Ratio of clinical Malaria cases to total fever cases being more than 1/3 , during a calendar year in a population of 50000

Malaria control strategies:

1. **Early case Detection and Prompt Treatment (EDPT)**
   a. EDPT is the main strategy of malaria control – radical treatment is necessary for all the cases of malaria to prevent transmission of malaria.
   b. Chloroquine is the main anti-malaria drug for uncomplicated malaria.
   c. Drug Distribution Centres (DDCs) and Fever Treatment Depots (FTDs) have been established in the rural areas for providing easy access to anti-malarial drugs to the community.
   d. Alternative drugs for chloroquine resistant malaria are recommended as per the drug policy of malaria.

2. **Vector Control**

   a. **Chemical Control**
      i. Use of Indoor Residual Spray (IRS) with insecticides recommended under the programnme
      ii. Use of chemical larvicides like Abate in potable water
      iii. Aerosol space spray during day time
      iv. Malathion fogging during outbreaks
   b. **Biological Control**
      i. Use of larvivorous fish in pond, ornamental tanks, fountains etc.
      ii. Use of biocides.
   c. **Personal Prophylatic Measures that individuals/communities can take up**
      i. Use of mosquito repellent creams, liquids, coils, mats etc.
      ii. Screening of the houses with wire mesh
      iii. Use of bednets treated with insecticide
      iv. Wearing clothes that cover maximum surface area of the body
3. **Community Participation**
   a. Sensitizing and involving the community for detection of *Anopheles* breeding places and their elimination
   b. Involving NGOs in Program strategies
4. **Environmental Management & Source Reduction Methods**
   a. Source reduction i.e. filling of the breeding places
   b. Proper covering of stored water

The basic premise of Malaria control is-

1. **Management of cases**
2. **Interrupting transmission**

The management issues that punctuate control are-

a. All kind of irrational prescriptions from General practitioners who attend to 60-70% of fever cases
b. Competence of Laboratory technicians, work load, Delay in slide reporting and offering radical Treatment
c. Drug resistance

Management of cases:

a. Diagnosis- Blood slide (Thick & Thin)
b. Treatment
   1. Presumptive
   2. Radical

National Drug Policy on Malaria (2008)
Drug schedule for treatment of malaria under NVBDCP.

1**. Chloroquine**

Chloroquine base	Day 1	10 mg/kg	(600 mg adult dose)
Chloroquine base	Day 2	10 mg/kg	(600 mg adult dose)
Chloroquine base	Day 3	5 mg/kg	(300 mg adult dose)

Dosage as per age groups

Age in years	Day 1	Day 2	Day -3
	Tab. chloroquine	Tab. Chloroquine	Tab. Chloroquine
<1	3	3	4
1-4	1	1	3
5-8	2	2	1
9-14	3	3	13
15 & above	4	4	2

2. Primaquine (*contraindicated in infants and pregnant women)*
Dosage as per age groups

(a) *P. falciparum* **Age in years**		**Primaquine On Day 1**	
	mg base	**No. of Tablets (2.5 mg base)**	**No. of Tablets (7.5 mg base)**
<1	Nil	Nil	Nil
1-4	7.5	3	1
5-8	15	6	2
9-14	30	12	4
15 & above	45	18	6

(b) *P. vivax*	Primaquine Daily dose for 14 days*		
Age in year	mg base	No. of Tablets (2.5 mg base)	No. of Tablets (7.5 mg base)
< 1	Nil	Nil	Nil
1-4	2.5	1	⅓
5-8	5.0	2	⅔
9-14	10.0	4	1⅓
15 & Above	15.0	6	2

Primaquine for 14 days should be given as per prescribed guidelines only

3. Artesunate + Sulpha-pyrimethamine (ACT) combination Age wise Dose Schedule for AS+SP

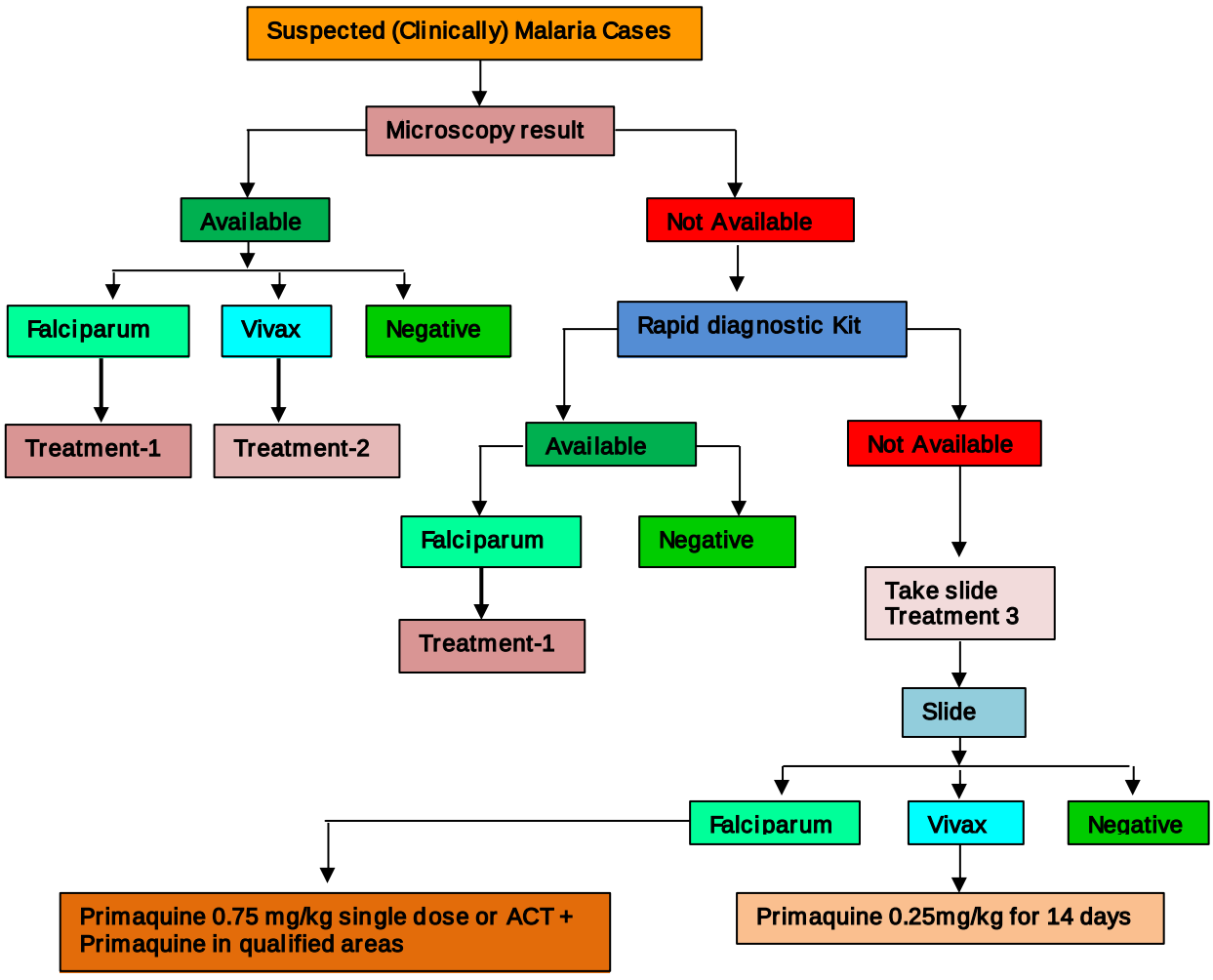
Age		1st Day (number of tabs)*	2nd Day (number of tabs)	3rd Day (numbers of tabs)
<1 Year	AS SP	3 4	3 Nil	3 Nil
1-4 Years	AS SP	1 1	1 Nil	1 Nil
5-8 Years	AS SP	2 1 3	2 Nil	2 Nil
9-14 Years	AS SP	3 2	3 Nil	3 Nil
15 +	AS SP	4 3	4 Nil	4 Nil

ACT should be given only to confirmed *P. falciparum* cases, found positive by microscopy or Rapid Diagnostic Test (RDT). ACT tablets are not to be used in pregnant women.
Primaquine is contra indicated in pregnant woman and infants.
Strength of each Artesunate tablet: contains 50 mg & each Sulpha Pyrimethamine (SP) tablet contain 500mg sulphadoxine/sulphalene and 25mg pyrimethamine
Artemisinin group of drugs is not recommended in pregnancy
ACT: consists of an artemisinin derivative combined with a long acting antimalarial (amodiaquine, lumefantrine, mefloquine or sulfadoxine-pyrimethamine). Tha ACT used in the national program in India is artesunate+sulfadoxine-pyrimethamine (SP). Presently, Artemether+Lumefantrine fixed dose combination and blister pack of artesunate+mefloquine are also available in the country.

Chemoprophylaxis

Chemoprophylaxis should be administered only in selective groups in high *P.falciparum* endemic areas.

Flow chart for the treatment of an uncomplicated malaria case (2008)



Treatment 1	**Chloroquine + Primaquine** (25mg/kg over 3 days + 0.75mg/kg single dose) **or Artesunate + Sulpha Pyrimethamine + Primaquine (in areas qualified for ACT)** 4 mg/kg for 3 days + 25/1.25mg/kg single dose + 0.75mg/kg single dose
Treatment 2	**Chloroquine + Primaquine** (25mg/kg over 3 days + 0.25mg/kg for 14 days)
Treatment 3	**Chloroquine** (25mg/kg over 3 days)

Note: Primaquine is contraindicated in pregnant women, G6PD deficiency, and infants; ACT is contraindicated in pregnant women

* For clinically suspected malaria cases, signs and symptoms may be referred

Districts identified for use of ACT Combination (AS+SP) for treatment of Pf malaria in Rajasthan:

4 Districts and 11 PHCs

Dungarpur (4 PHCs): Bicchiwara, Damri, Simalwara, Dungarpur
Banswara (4 PHCs): Kushalgarh, Chota Dungra, Banswara, Talwara
Baran (2 PHCs): Kishanganj, Shahbad
Udaipur (1 PHC): Kotra

Revised National Tuberculosis Control Program (RNTCP)

Issues in Tuberculosis:

1. Case finding-Access to/ Availability of, sputum microscopy
2. Treatment-continuity, regularity & compliance
3. Drug resistance-MDR-TB (Every one who breathes should be concerned)
4. Dual Epidemic-HIV/AIDS & Tuberculosis.

Chronology of developments in Tuberculosis

1955-58: ICMR conducted survey to assess burden of disease in India

1956-61: Tuberculosis Research Center at Chennai (1956)
National Tuberculosis Institute established at Bangalore (1959)
District Tuberculosis Program (1961)

1962: National Tuberculosis Control Program (NTCP) established

1973-74: NTI initiated longitudinal surveys at Bangalore, Delhi, and Chingelput (not representative of the country scenario).

1975: Tuberculosis included in 20-point Program

1991: Surajkund Conclave for review of NTCP; recommended

1. Strengthening of Laboratory services
2. Ensure regular drug supply-"create a Drug Bank"
3. Create a task force to monitor program implementation

1992: Situational review by Government of India and World Bank

1. Achievements not as desired
2. Suggested a revised approach as RNTCP.

1993: Pilot phase of Revised National Tuberculosis Control Program (RNTCP) started with DOTS (**D**irectly **O**bserved **T**reatment with ***S***hort course Chemotherapy) as the main interventional stay. By 1998 coverage was only 2% of population

1998: Stop TB initiative

1999: RNTCP becomes the second largest program in the World

2000: Stop TB movement (Amsterdam Declaration)- Targets
By 2005, 70% people with TB will be diagnosed and 85% cured.
By 2010, Global burden will be 50%
By 2050, global TB incidence will be <1/ million populations

2001: ⅓ of the country's population covered

2002: 50% population under RNTCP

2003: More than 900,000 cases were placed on treatment- *largest cohort of cases, more than any other country in the world*

2004, Feb.: 819 Million (76%) population (16 States /Union territories under RNTCP)

National Tuberculosis Control Program (NTCP) comprised:

1. Domiciliary treatment
2. Use of a standard drug regimen of 12-18 months duration
3. Treatment free of cost
4. Priority to newly diagnosed patients, over previously treated patients
5. Treatment organization fully decentralized
6. Efficient defaulter system/mostly self-administered regimen
7. Timely follow up

In India BCG vaccination policy was revised and it was recommended to be given at an early age preferably before the end of the first year after birth by integrating under UIP. NTCP was not measuring up to the expectations. The NTP was evaluated by three agencies, ICMR, Institute of Communication, Operations Research and Community Involvement (ICORCI) and WHO. Started in 1962, National Tuberculosis Control Program had certain short term and a few long-term objectives.

The long-term objectives were addresses to reducing the transmission to a level where Tuberculosis ceases to be a public health problem (Control), measured through prevalence which was to drop to 1% in population below 14 years from the then existing level of 30%.
In 1992, review of national program concluded that it suffered from-

1. Managerial weakness,
2. Inadequate funding,
3. Over-reliance on x-ray,
4. Non-standard treatment regimen,
5. Low rates of treatment completion, And
6. Lack of systematic information on treatment outcomes.

NTP, however, created an extensive infrastructure for tuberculosis control, with a network of 632 District (March 2006) TB Centers, 330 TB Clinics and more than 47,600 TB beds; wherein 1.29million patients were treated in 2005.

In 2006, 1.39 milllion and in 2007, 1.48 million patients have been enrolled for treatment. In 2008, 1.51 million were placed on treatment.

Treatment success rates have ttripled from 25% to 86% and TB death rates have been cut 7 folds from 29% to 4% in comparison to the pre RNTCP era.

Evolution of RNTCP

As a result, a Revised National Tuberculosis Control Program (RNTCP) was designed in 1993 using the infrastructure created under NTP and the achievements it made. RNTCP furthered the cause by creating a management unit (TB unit), for 5-lac population, manned by-A Senior Treatment Supervisor (STS), A Senior TB Laboratory Supervisor (STLS) and a Medical Officer.
The other areas attended by program are-

1. State of art binocular microscope (78000 Laboratory Microscopy centers
2. Good quality reagents
3. New recording reporting formats
4. Vehicle/ POL
5. Intensive modular training
6. Supervision
7. Cross checking the work of Lab. Technician

RNTCP-Goals

1. To cure at least 85% of new smear positive cases of Tuberculosis
2. To detect at least 70% of sputum positive cases after reaching 85% cure rate

Strengths of RNTCP-

1. Phased expansion
    a. Does not dilute efforts

   b. Helps capacity building towards sustainability
   c. Allows evaluation & correction
   d. Ensures smooth service delivery within resources
2. System's Accountability (Direct observation of drug administration)
3. New Reporting/ Recording system
4. "Recruitment effect"-cured patient are best motivators for case detection

Strategy-

The main stay of RNTCP is based on *D*irectly *O*bserved *T*reatment with *S*hort course Chemotherapy (DOTS)
DOTS is a comprehensive, systematic strategy for effective Tuberculosis control on a mass scale

The strategy components are-

1. Political & Administrative commitment.
2. Good Quality diagnosis
3. Good Quality drugs
4. Right treatment administered rightly
5. Systematic Monitoring and Accountability

The DOTS was developed in India only by TRC, Chennai in and now is being practiced by 60% of Countries (127 out of 211 by year 1999) and makes RNTCP the second largest program in the world (after China)

The DOTS Strategy interventions are-

1. Case detection primarily by microscopic examination of sputum of *patients presenting to a health facility* (Note the paradigm shift- Active case finding, the forte of NTCP, is no more pursued in RNTCP)
2. Adequate Drug supply- Patient wise boxes to ensure regular availability.
3. Short Course chemotherapy given under direct supervision.
4. Systematic Monitoring and Accountability for every patient diagnosed &registered for DOTS
5. Political will & Advocacy
6. *System is made Accountable rather than Patient for Drug compliance*

DOTS Operational scheme under RNTCP-

Under the DOTS regimen of chemotherapy in India, following schedule is used

The figures outside the bracket refer to number of months while those after the bracket indicate number of doses per week.
The Normal dose for each of the drug is-
Isoniazid (H) - 600 mg.
Rifampicin (R) -450 mg. (additional 150 mg if patient weighs more than 60 Kg)
Pyrazinamide (Z) -1500 mg.
Ethambutol (E) -1200 mg.
Streptomycin (S) -750 mg. (reduced to 500 mg. if age is more than 50 years

Treatment Regimen			Sputum examination for Pulmonary Tuberculosis			
Category	Type of Patient	Regimen Intensive phase	Pre-treatment sputum	Test at months	If Result is	Then
Category-I	New sputum smear positive	2 (HRZE)3	+ve	2	-ve	Start Continuation phase, test again at 4 & 6 months
					+ve	Continue intensive phase for one more month
	Seriously ill sputum -ve Seriously ill extra pulmonary		-ve	2	-ve	Start Continuation phase, test again at 6 months
					+ve	Continue intensive phase for one more month, test again at3, 4 & 7 months
Category-II	Sputum smear +ve relapse	2 (HRZES)3	+ve	3	-ve	Start Continuation phase, test again at 5 & 6 months
	Sputum smear +ve failure	1 (HRZE)3			+ve	Continue intensive phase for one more month, test again at4, 6 & 9 months
	Sputum smear +ve treatment after default	5 (HRE)3				
Category-III	Sputum smear –ve not seriously ill,	2 (HRZ)3	-ve	2	-ve	Start Continuation phase, test again at 6 months
	Extra pulmonary not seriously ill	4 (HR)3			+ve	Re-register and start category-II treatment

To simplify for remembrance-

Category	Intensive phase	Continuation phase
I	2 (HRZE) 3	4 (HR) 3
II	2 (HRZES) 3 + 1 (HRZE) 3	5 (HRE) 3
III	2 (HRZ) 3	4 (HR) 3

Year	1998	1999	2000	2001	2002	2003	2004	2005	March 2006
Population Covered *	18	130	287	450	530	775	947	1080	1114**
* cumulative, in millions; ** Entire country									

Second Phase of RNTCP

In the first phase of RNTCP (1998-2005), the Program's focus was on ensuring expansion of quality DOTS services to the entire country.

The RNTCP has now entered its second phase in which the Program aims to firstly consolidate the gains made to date, to widen services both in terms of activities and access, and to sustain the achievements for decades to come in order to achieve ultimate objective of TB control in the country.

All components of new Stop TB Strategy are incorporated in the second phase of RNTCP. These are:

a. Pursue quality DOTS expansion and enhancement, by improving the case finding and cure through an effective patient-centred approach to reach all patients, especially the poor.
b. Address TB-HIV, MDR-TB and other challenges, by scaling up TB-HIV joint activities, DOTS Plus, and other relevant approaches.
c. Contribute to health system strengthening, by collaborating with other health Programs and general services
d. Involve all health care providers, public, nongovernmental and private, by scaling up approaches based on a public-private mix (PPM),
e. Engage people with TB, and affected communities to demand, and contribute to effective care.
f. Enable and promote research for the development of new drugs, diagnostic and vaccines. Operational Research will also be needed to improve Program performance.

RNTCP performance (Oct. Dec. 2008)

Suspects examined:	1.65 million
Sputum +ve :	207144
Registered for Treatment:	351593
New smear positive case detection rate:	67%

Multi Drug Resistant Tuberculosis:

As per the estimates from the State representative drug resistance surveillance (DRS) survey in Gujarat and various district level DRS studies, the prevalence of MDR-TB in new smear positive pulmonary TB (PTB) cases is ≤ 3% and 12 to 17% amongst smear positive previously treated PTB cases. Review of studies with representative samples do not indicate any increase in India of the prevalence of drug resistance over the years.

Although isolated reports, both published and unpublished, indicate the existence of XDR-TB in the country, it is not possible as yet to estimate its magnitude and distribution from the available data.

Definitions

MDR-TB is defined as resistance to isoniazid and rifampicin, with or without resistance to other anti-TB drugs.

XDR-TB is defined as resistance to at least Isoniazid and Rifampicin (i.e. MDR-TB) plus resistance to any of the fluoroquinolones and any one of the second-line injectable drugs (amikacin, kanamycin, or capreomycin).

Prevention of MDR-TB and XDR-TB

The use of inadequate regimens and the absence, or inappropriate application, of directly observed treatment can lead to the development of drug resistance and potentially to an increase in drug resistance levels amongst the community. The implementation of a good quality DOTS programme will prevent the emergence of MDR and XDR-TB in the community. Therefore the highest priority is to further improve the quality and reach of DOTS services in the country. For this, all health care providers managing TB patients need to be linked to RNTCP and operational challenges in implementing DOTS needs to be addressed. The proportion of TB patients being treated outside the DOTS strategy needs to be minimized. The International Standards of TB Care need to be used by RNTCP and professional medical associations as a tool to improve TB care in the country. The fluoroquinolone group of drugs are not as yet recognized, nor recommended, as first line anti-TB drugs, and their use should be restricted only to the treatment of confirmed MDR-TB cases.

Management of MDR-TB

National guidelines and plans for scaling up management of MDR-TB have been developed under RNTCP. In the interim, while RNTCP DOTS-Plus services are being expanded across the country, all health care providers in the public and private sector managing MDR TB cases, need to adhere to the following:

a. MDR-TB management to be preferably undertaken only at selected health institutions with experience, expertise and availability of required diagnostic and treatment facilities
b. Diagnosis of MDR-TB
    i. Drug resistance may be suspected based on history of prior treatment (e.g. smear positive case after repeated treatment courses, Cat II failure etc.) and/or close exposure to a possible source case confirmed to have drug-resistant TB
    ii. For patients in whom drug resistance is suspected, diagnosis of MDR-TB should be done through culture and drug susceptibility testing from a quality-assured laboratory.
    iii. Interpretation of DST Results
    iv. Drug susceptibility test results of the 1st line anti-TB drugs pyrazinamide, streptomycin, and ethambutol should be interpreted with caution due to the poor reproducibility of these results even under optimal laboratory conditions.
    v. Drug Susceptibility Test (DST) results of 2nd line anti-TB drugs* should be interpreted with great caution due to limited capacity of laboratories, absence of quality-assurance, and lack of standardized methodology.
c. Treatment regimen
    i. All relevant investigations to be performed prior to treatment initiation
    ii. Preferably the standardized regimen as recommended in the national DOTS-Plus guidelines should be used [6(9) Km Ofx Eto Cs Z E / 18 Ofx Eto Cs E] †
    iii. If results of 2nd line DST from an accredited laboratory are available, an individualized regimen may be used in such patients after obtaining a detailed history of previous anti-TB treatment
d. Duration of treatment
    i. At least six months of Intensive Phase (IP) should be given, extended up to 9 months in patients who have a positive culture result taken at 4th month of treatment
    ii. Minimum 18 months of Continuation Phase (CP) should be given following the Intensive Phase
e. Follow-up schedule
    i. Smear examination should be conducted monthly during IP and at least quarterly during CP
    ii. Culture examination should be done at least at 4, 6, 12, 18 and 24 months of treatment
    iii. Relevant additional investigations should be performed as indicated
f. Treatment adherence and support
    i. All patients initiated on treatment and their family members should be intensively counseled prior to treatment initiation and during all follow-up visits
    ii. To reduce the risk of development of resistance to second-line anti-TB drugs and promote optimal treatment outcomes, all efforts should be made to administer treatment under direct observation (DOT) over the entire course of treatment

iii. If DOT is not possible, attempts to ensure treatment adherence should be made by
    1. Checking empty blister packs; and
    2. Follow up visits at least every month

g. Documentation of treatment
    i. Health care facilities/practitioners managing MDR-TB patients should maintain a systematic record of treatment regimen, doses, duration, side-effects, investigation results and treatment outcome for all patients initiated on second-line treatment.

h. Public health responsibilities of health care providers
    i. Health care facilities/practitioners managing confirmed MDR-TB patients should inform their respective District TB Officer regarding treatment initiation and outcome of all MDR-TB cases
    ii. Prior to treatment initiation and on all follow up visits the patient and family members should be counseled on all aspects of MDR-TB
    iii. All house hold contacts of the MDR-TB patients should be screened for active TB disease

i. Infection control measures
    i. All large health care facilities need to have an infection control (including airborne infection) plan and a team for implementation of measures to prevent nosocomial transmission of TB and other air-borne infections

j. Statements to the press/media on MDR-TB and XDR-TB should be made with extreme caution and after requisite verification and authentication

* Fluoroquinolones (Ciprofloxacin, Ofloxacin, Levofloxacin, Moxifloxacin, Gatifloxacin, Sparfloxacin, Pefloxacin); Kanamycin, Amikacin, Capreomycin, Ethionamide, Prothionamide, Cycloserine and PAS
† Km = Kanamycin; Ofx=Ofloxacin; Eto=Ethinamide; Cs=Cycloserine; Z=Pyrazinamide; E=Etambutol

Impact of the program:

- TB mortality in the country has reduced from over 42/100,000 population in 1990 to 28/100,000 population in 2006 as per the WHO global TB report 2008.
- Ther prevalence of TB in the country has reduced from 568/100,000 population in 1990 to 299/100,000 by the year 2006 as per the WHO global TB report 2008.
- Repeat population surveys conducted by TRC indicate an annual decline and prevelane of disease by 12%

The program is currently undertaking repeat zonal ARTI survey (2008-10) and disease prevelance survey at 7 sites (2007-09) to assess the impact of the program and TB control and additional monitor the progress towards MDG's

Advocacy, Communocation and Social Mobilisation (ACSM):

- An effective ACSM strategy is in place, in order to maintain hifgh visibility of TB and RNTCP amongst policy makers, opinion leaders and community.
- Four National level ACSM capacity building training workshops held with the support of National Institute of Health and Family Welfare for the key functionaries in the field (State TB officers, IEC officers and Communication facilitators).
- Mass Media Agency developed new TV and radio spot and also conducted Capacity Building in the few selectewd States.

National Leprosy Eradication Program:

In India first records of 'Leprosy Like' disease appear in the sixth century B.C. First described in 'Susruth Samhita' and treatment with 'Choulmoogra oil' was known at that time. Leprosy was referred to as 'Kusht' in the Vedic writing.

In India **'The Lepers Act 1898' was enacted, which discriminated against the Leprosy patients** and segregated them socially. Union Government & all the States & UTs have since repealed this act.
In 1991, WHO and its member States committed themselves to eliminate Leprosy as a public health problem by the year 2000, which means to *bring down the Leprosy cases below one case per 10,000 population.*

Leprosy is a **major public health problem in 24 countries and 90% of the global leprosy problem is in 11 countries**. Namely India, Brazil (b) Indonesia, Myanmar, Nepal. Ethiopia, Mozambique, D.R. Congo, Niger, Gunea.

Globally

At the **beginning of 2001**, the total number of leprosy patients in the world was **less than 600000.** About 720 000 new cases were detected during 2000. (Source: WHO Weekly Epidemiological Record 4 January 2002 No77). The proportion of single skin lesions among new cases was 9% and the proportion of new cases with grade 2 disabilities was 4%.

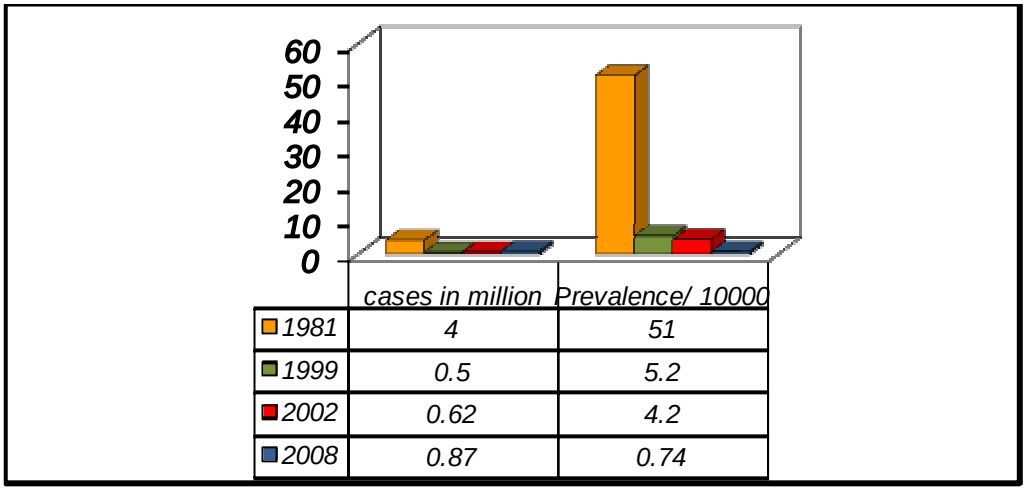
Magnitude of leprosy in India

60% of globally recorded patients are in India.
Total patient load in 1981 was 4 Million. (Prevalence Rate (PR) -51/10,000)
Total recorded patient load by March 1999 -0.5 Million, {MB-56%} (Prevalence Rate 5.2/10,000)
Prevalence rate decreased to 4.1/10000 by March 2002
Prevalence rate decreased to .74/10000 by April 2008
5 States / UTs viz. Bihar, Chhattisgarh, Jharkhand, West Bengal and Chandigarh have PR between 1 and 2 per 10,000 populations.
Dadra & Nagar Haveli has PR of 2.34/10,000.
These 6 states/UTs contribute 33% of country's recorded caseload and 35% of the country's new case detected during the year 2007-08
29 states and UT has achieved PR less than 1 per 10000 population

This load decreased to .87 lakh in 2007- 2008 (PR-0.74) of which

1. MB cases-47.2%
2. Female- 34.5%
3. Child- 9.4%
4. Visible Deformity- 2.5%
5. ST cases -13%
6. SC Cases -18.9%

Till March 2002, 10.8 million cases ere discharged through MDT (MDT's geographic coverage has already reached 100% since 1999)



Trend of leprosy Prevalence (PR) and Annual New Case Detection Rate (ANCDR) in India:

The status on April 2008 is that there are 6 States/UT viz. Bihar, Chhattisgarh, Jharkhand, West Bengal, Chandigarh and Dadra & Nagar Haveli **with PR between 1 and 3 per 10,000 population. These 6 States with 20.8% of country's population now contribute 33% of the country's recorded case load.**

Status of PR and NCDR in 6 States/ UTs

S. No.	State	Population	% of country's population	No. of cases on record	% of country's case load	PR/ 10,000	No. of new cases detected	% of country's new case	ANCDR/ 100,000
1	2	3	4	5	6	7	8	9	10
1	D& N Haveli	303029	0.03	57	0.07	1.88	150	0.11	49.50
2	Chhattisgarh	23336171	1.98	5465	6.27	2.34	7808	5.67	33.46
3	Jharkhand	31101898	2.64	3460	3.97	1.11	6799	4.94	21.86
4	Bihar	98516843	8.37	10262	11.76	1.04	19041	13.83	19.33
5	Chandigarh	1137712	0.14	140	0.16	1.23	190	0.14	16.70
6	West Bengal	89899615	7.64	9358	10.73	1.04	13551	9.84	15.07
	Total	244295268		28742	-	1.18	47539	-	19.46
	Percentage	-	20.77	-	32.95	-	-	34.53	-

Leprosy Control in India-

The Government of India started **National Leprosy Control Program in 1955** with objective of controlling Leprosy with help of Dapsone.
Main features of NLCP were-

1. **Input oriented-**
    a. No primary prevention
    b. Non-availability of potent drugs
    c. Lack of Community co-operation

2. **Performance oriented** (since 1976)
    a. Targets
        i. New cases
        ii. Discharged cases

3. **Operational limitations**
    a. Self administered mono-drug
    b. Rural focus
    c. Decline in Incidence

The program was re-designated as **National Leprosy Eradication Program (NLEP) in 1983** as a 100% **centrally sponsored scheme**, after MDT became available for effective treatment of Leprosy. The NLEP had a **Goal** of eradicating Leprosy by year 2000 and mid term Goal of bring down the case load to < 1/ 10000

The **issues of concern before NLEP** were-

1. Multi Drug therapy
2. Case detection
3. Disease classification
4. Clinical examination
5. Bacteriological examination
6. Diagnosis and D/D
7. Disease activity status
8. Surveillance
9. Case holding
10. Defaulter retrieval action
11. Discharge criteria
12. Relapse
13. Reports

Objectives-

1. Render all case non-infectious in shortest time by
    a. Early detection & treatment
    b. Interrupting transmission
2. Prevent deformities
3. Eradicate Leprosy
4. MDT throughout
5. Prevalence-<1/10000 by 2002

Strategy-

1. Interruption of transmission by early detection and treatment using MDT
2. Case holding & Surveillance
3. Social & Economic rehabilitation

Organizational structure for NLEP implementation-

National Leprosy Eradication Commission
⇩
National Leprosy Eradication Board
⇩
MOHFW
⇩
DGHS
⇩
Leprosy Division
⇩
State Leprosy Officer
⇩

LCU	Leprosy Trg.	SSAUs	DLUs	LPRU/RSU	ULC	THW	SET centers	MLT
778	49	39	285	13/75	907	290	6097	350

Each LCU has
⇩
MO-1/4.5 lac population besides Physiotherapists (1), Lab. Tech. (2), Non-med. Supervisors (4), PMWs (20), Health educator (1)

(LCU-Leprosy Control Unit; SSAU-Sample Survey cum Assessment Unit; DLU-District Leprosy Unit; LPRU-Leprosy Rehabilitation Unit; RSU-Reconstructive Surgery Unit; ULC-Urban Leprosy Centers; THW-Temporary Hospitalization Wards; SET-Survey Education and Treatment centers; MLT-Mobile Leprosy Treatment Units.)

Approach-

1. Prevalence based categorization
    a. Endemic->5/1000
    b. Moderate endemic-3-5/1000
    c. Low endemic-<2/1000
2. Plan of Action-
    a. Preparatory phase
    b. Intensive phase
    c. Maintenance phase

Program implementation-

Primary prevention (Not possible in Leprosy)

Secondary prevention

Case finding
Diagnostic services
Clinical Exam.
Bacteriological exam

Tertiary prevention

Disability limitation
Constructive/ corrective surgery
Rehabilitation
Social
Vocational

Case finding in Leprosy

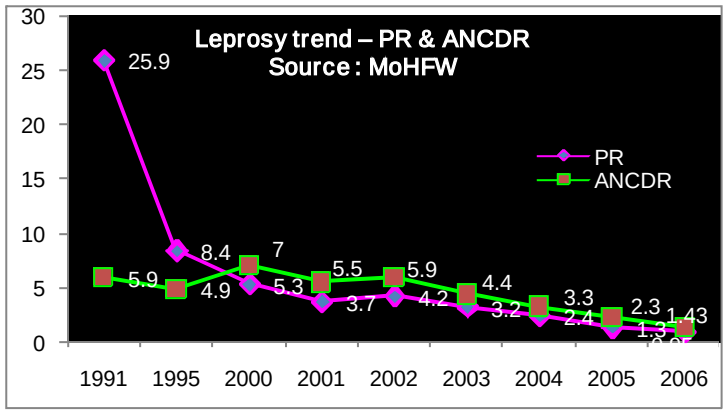
1. **Active-**
   a. Sample surveys (in areas with PR >1/1000)
   b. Mass Surveys (>10/1000)
   c. Contact surveys (<1/1000)
   d. Rapid surveys
2. **Passive-**
   a. Voluntary reporting
   b. Referral & Notification

Organizing case finding-some considerations

1. Prevalence
2. Pop. Density
3. Geography
4. Communication network
5. Health care delivery system

Case holding-Facilitators

1. **Regularity of drug intake**
   a. Location & timing of clinic
   b. Clinical & Bacteriological reviews
   c. Physiotherapy
   d. Care of plantar ulcers
   e. Provision of suitable foot wears
   f. Timely & appropriate referral
   g. Comprehensive care
   h. Timely termination of treatment
   i. Rehabilitation
   j. Supervision of workers
2. **Promoting Compliance-**
   a. Home Visits, Family pressure
   b. Urine sample monitoring
   c. Drug dispensing



Issues in treatment with Multi Drug Therapy (MDT)

1. **Prioritize** (based on resources)
   a. Multibaciliary
   b. Paucibacilliary resistant to Dapsone
   c. Other Paucibacilliary
2. **Delivery**
   a. Adequate, Efficient, Flexible
   b. Referral
   c. Integration with primary care

Treatment in Multibaciliary – (12 months course)

1. All skin smear +ve
2. All clinically active BB, BL, LL cases

3. All active BT cases with 10 0r >lesions
    a. Supervised once a month –
        i. Clofazamine 300 mg
        ii. Rifampicin 600 mg
    b. Unsupervised daily -
        i. Clofazamine 50 mg
        ii. Dapsone 100 mg

Treatment in Paucibacilliary

1. **Single skin lesion, no nerve thickening**
    a. Single dose-Rifampicin 600 mg +
        i. Ofloxacin 400 mg +
        ii. Minocyclin 100 mg
2. **Single nerve lesion or 2-9 lesion-(6 months)**
    a. Supervised once a month
        i. Rifampicin 600 mg
        ii. Dapsone plus
    b. Unsupervised daily-
        i. Dapsone 100mg

Treatment Failure reasons-

1. Ignorance
2. Toxicity
3. Skin discoloration
4. Attitude of Health staff
5. Social prejudice
6. Symptoms do not subside as quickly as expected
7. Distance
8. Clinic hours

The elimination strategy based on MDT has proved to be effective and is working well. However, several challenges need to be overcome to ensure that leprosy services are fully integrated and sustained. These include to:

a. Further simplify and shorten the current MDT regimen;
b. Abolish classification for treatment purposes;
c. Identify areas and communities not yet covered by leprosy services;
d. Actively change the negative image of leprosy to be more positive;
e. Focus more on analysis of detection trends than on prevalence; and
f. Develop an integrated community-based strategy for rehabilitation.

Newer approaches-

Modified Leprosy Eradication Program (1997)-

Realizing that though the National average performance has been satisfactory, there were States with poor performance which was revealed during a mid term appraisal in April 1997

In order to address these challenges mentioned above and referring to the appraisal report, a few areas were identified for intensive efforts. These are-

1. Training
2. Intensified IEC
3. Detection and immediate MDT

These three activities have been merged in the **Modified Leprosy Eradication Program** wherein States and Districts *according to endemicity levels* have been categorized and accordingly action plan developed for-

1. 8 States with prevalence rate less than 5/ 10000 with
   a. Active case finding
   b. Promoting self reporting (Voluntary reporting by cases-VRC)
   c. IEC & Training
2. 14 States with prevalence rate 1-5/10000
   a. VRC
   b. Staff training &IEC
   c. Detection of paucibacilliary cases
3. 13 States with prevalence rate less than 1/ 10000
   a. Intensified IEC
   b. Detection of paucibacilliary cases

National Program for prevention of Visual Impairment and Control of Blindness (1976):

Started as National Trachoma Control Program in 1963 as the first organized attempt to control blindness, the program was renamed as National Program for prevention of Visual Impairment and Control of Blindness in 1976.

The National surveys (1973-75) have estimated 12.5 million people to be suffering form economic blindness with a visual acuity of <6/60. (2.2 million became economically blind each year). Children almost makeup for 25% of total blind in the country

Extent of the problem:

As per WHO criteria 40-45 million people are blind worldwide. Where as a further 135 million people have low vision. In India nearly 12 million people are blind, the major proportion of which remain in rural, remote and underserved areas. According to WHO estimation, by the year 2020 the number of people who are blind and visually impaired will be twice the current level unless aggressive and innovative approaches are taken. India is committed to reduce this burden of blindness by adopting the strategies advocated for vision 2020-' THE RIGHT TO SIGHT."

Prevalence Rate

As per survey conducted by Indian Council of Medical Research during 1974 the prevalence rate of blindness in India was 1.38%. During 1986-89 conducted by GOI/WHO, the prevalence rate was 1.49%. During 1999-01 survey in 15 districts of the country indicated that 8.5% of 50+ population are blind.

Rapid survey oon avoidable Blindness conducted under NPCP during 2006-07 showed reduction in the prevalence rate of blindness from 1.1% (2001-02) to 1%(2006-07).

With a **Goal** of reducing the Blindness prevalence **from 1.4% to 0.3%** by 2020; a ***centrally sponsored*** program was started with following objectives-

Major causes for Blindness-

Of the total,

Cataract:	80.1 %
Refractive errors:	7.35%,
aphakia:	4.6%
Glaucoma:	1.7%,
Corneal opacities:	1.55%
Trachoma:	3.9%
Other causes:	4.25%

Objectives:

1. To bring down the prevalence rate of cataract blindness from 1.49% to 0.8% by the year 2007.
2. To provide high quality of eye care to the affected population.
3. To expand coverage of eye care to the affected population.
4. To expand coverage of eye care services to the under-served areas.
5. To reduce the backlog of blindness by identifying and providing services to the affected population.
6. To develop institutional capacity for eye care services by providing support for equipment and material and training personnel

11th Plan Objectives (2007-12)

- To reduce the backlog of blindness through identification and ttratment of blindness.
- To develop Comprehensive Eye care facilities in every District.
- To develop Human Resources for providing eye care services.
- To improve quality of service delivery.
- To secure participation of Voluntary Organisations/Private Practitioners in eye care.
- To enhance Community awareness on eye care.

11th Plan Strategies (2007-12)

- Decentalise implementation of the scheme through District Healtrh Societies (NPCB)
- Reduction in the backlog of the blind persons by active screening of the population above 50years, organizing screening eye camps and transporting operable cases to eye care facilities.
- Involvement of voluntary organisations in various eye care activities.
- Participation of community and Panchayati Raj Institutions in organizing services in rural areas.
- Development of eye care services and improvement in quality of eye care by training of personnel, supply of hightech opthalmic equipments, strengthening follow up services and regular monitoring of services.
- Screening of school age group children for identification of treatment of refractive errors with special attention in under served ares.
- Public awareness about prevention and timely treatment of eye ailments.
- Special focus on illetrate women ofn rural areas. Foer this purpose there should be convergence with various ongoing schemes for development of women and children.
- To make eye care comprehensive, besides cataract surgery, provision of assistance for other eye diaseases like diabetic retinopathy, glaucoma management , laser techniques, corneal transplantation, vitreoretinal surgery, treatment of childhood blindness ect.

Program Strategy-

1. Strengthening Service delivery
    a. Improving physical, technical and managerial capabilities of all Health institutions and selected NGOs
    b. Setting norms for service delivery
    c. Emphasis on vision restoration through quality surgery, after care, follow up, provision of IOL
    d. Camp approach to cover Rural and tribal areas on priority
2. Developing Human resource for eye care
    a. Training of Ophthalmic personnel, besides teachers, volunteers and functionaries of Primary health care system
3. Promoting outreach activities
4. Increasing Public awareness
5. Developing institutional capacity
    a. Management training
    b. Developing collaborative mechanism
    c. Introducing monitoring and feedback mechanisms

Strategies:

1. Decentralized implementation of the scheme through District Blindness Control Societies.
2. Reduction in backlog of blind persons by active screening of population above 50 years of age. Organizing screening eye camps and transporting operable cases to eye care facilities.
3. Involvement of voluntary Organization in various eye care activities.
4. Participation of community and panchayat Raj institutions in organizing services in rural areas.
5. Development of eye care services and improvement in quality of eye care by training of personnel, supply of high-tech equipments, strengthening follow up and monitoring services.
6. Screening of school going children for identification and treatment of refractive errors with special attention in underserved areas.
7. Public awareness about prevention and timely treatment of eye ailments.
8. Specific focus on illiterate women in rural areas. For this purpose there should be convergence with various ongoing schemes for development of women and children.
9. To make eye care comprehensive, besides cataract surgery other interlobular surgical operations for treatment of Glaucoma. Diabetic Retinopathy may also be provided free of cost to poor patients through Govt. and NGOs.

Activities:

1. Strengthening of eye care infrastructures in the state.
2. Improvement of quality of eye care services by training of eye care personnel.
3. Provision of modern equipments instruments and other commodity assistance by GOI.
4. Provision of vehicle.
5. Increased no of cataract surgery.
6. Abolition of reach out camps.
7. Introduction of cataract surgery with IOL implantation.
8. Involvement of NGOs. Component activities under NPCB:
9. Cataract surgery.
10. School eye screening.
11. Eye donation and Eye Banking.
12. Training and capacity building of ASHAs to orient them towards Blindness control program as well as create a core group of field functionaries who will initiate and create awareness on blindness control program at the village level.
    a. IEC and EYE health education at all levels to be undertaken. and referral for eye care

Implementing agencies-

District Blindness Control Society (DBCS) **Composition of DBCS-**

Chairman	: District Collector
Vice chairman	: Chief Medical & Health Officer
Members	: Medical Superintendent. Of District hospital
	District Education Officer
	Representatives of NGOs
	President of IMA
	Ophthalmic surgeon of Mobile surgical unit
	An eminent practicing Ophthalmologist
Member secretary	: District Blindness Control Coordinator

Functions of DBCS

1. Plan, Implement and Monitor activities related to Blindness control
2. Draw list of voluntary agencies/ private hospitals/ NGOs & involve in Blindness control
3. Coordination with Health & other departments
4. Raise funds and monitor use of funds

Indicators:

1. Cataract operation in bi-lateral Blind
2. Cataract surgery in Female.
3. Cataract surgery in SC ST population.
4. Cataract surgery in different facilities
5. Cataract surgery in different age groups.
6. Initiatives that will be integrated into the Blindness Control Program:
7. Free surgery for cataract cases in rural areas.
8. Free transportation for patients of unreached areas.
9. Free medicine for all types of eye ailments.
10. Free spectacles for post operative care.
11. Free spectacles for poor school students.
12. All backlog cataract cases would be treated.
13. All schools would be covered for SES.
14. All children would be given Vitamin-A supplementation and immunization coverage.
15. Modern and advanced treatment would be available in all Medical College Hospitals and DHHs,
16. Two Eye Banks to be established.
17. Establishment of one RIO (Regional Institute of Ophthalmology) in one of the medical colleges.

Achievements:

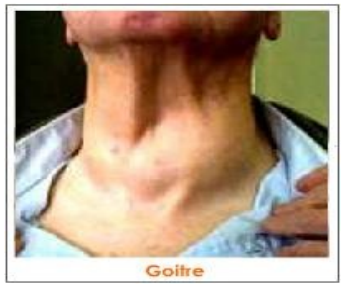
Performance of Cataract Surgery**:**

Year	Target	Achievement	% Surgery with IOL
2002-03	4000000	3857133	77
2003-04	4000000	4200138	83
2004-05	4200000	4513667	88
2005-06	4513000	4905619	90
2006-07	4500000	5040089	93
2007-08	5000000	5404406	94
2008-09**	6000000	192805	--

International partners: World Bank and DANIDA

All this requires is enforcement; education and strengthening iodized salt supply through Public Distribution System and incentive to salt manufacturers. The **"Sun" logo** on iodized salt packs has already helped in distinguishing it from plain salt.

National Iodine Deficiency Disorders Control Program:


Goitre

Launched as **National Goiter Control Program in 1962**, the program simply focused on iodized salt.
The operational and logistics punctuations prevailed. Prevalence of goiter did not change. The problem was **reassessed by ICMR** and findings indicated that -

i. Goiter is just not restricted to Goiter- belt in Sub-Himalayan region but is prevalent in other areas also (Gujarat, Maharashtra, Punjab, MP, Kerala, Assam and AP).
ii. Iodine deficiency is not restricted to endemic Goiter and/ or Cretinism but has wider implications in form of deaf mutism, mental retardation and impaired cognitive functions.
iii. 200 million are exposed to risk of IDD (61 M with Goiter, 2.2 M have cretinism, 6.6 M mild neurological disorder)

The program was re-baptized as **National Iodine Deficiency Disorders Control Program, in 1992.**

Problem Statement-
World's single most significant cause of preventable brain damage and mental retardation.
261 million suffering from brain damage (10 million cretins)
130 countries, 13% of world's population.9 million persons affected.2.2 billion people live in ID areas
167 million at risk of IDD Goiter- 54.4 million, IDD mental/motor handicaps - 8.8 million
1984-86: ICMR multi centric study(14 districts in 9 States, Goiter prevalence 21.1%, Endemic cretinism : 0.7%)
India : 241 of 617 Districts are Goiter endemic
140 million people are estimated to be living in goiter endemic regions
In 1983 Mrs. Indira Gandhi asked-What is Iodine Deficiency?, Why should I be interested in National Goitre Control Programme (NGCP)? and how is it going to contribute towards Prime Minister's 20 point programme?
51% HH consuming iodized salt (State of World's Children, 2009-UNICEF)
Surveys in 310 districts of 28 States and 5 Union territories by DGHS, ICMR and State Health departments has revealed that out of 324 districts surveyed, 263 districts have IDD prevalence of > 10%, 200 million people are at a risk of IDD and 71 million people are suffering from Goiter and other iodine deficiency related disorders

Chronology of developments in Iodine deficiency:
1962: NGCP launched
1984: Policy of Universal salt Iodization (USI)
: Private sector to produce iodized salt
1992: NGCP renamed as NIDDCP
1995: Independent survey evaluation of USI in MP, New Delhi and Sikkim
1997: sale and storage of common salt banned
1998-99: NFHS II (71% using iodized salt)
13th Sept 2000: ban on sale of common salt lifted by the GoI, States continued the ban

Spectrum of IDD

Fetus:	Abortion, Still Birth, Congenital Anomalies, Prenatal mortality, Infant mortality, Neurological cretinism (mental deficiency, deaf mutism, squint)
Neonate:	Neonatal Goiter, Neonat Hypothyroidism
Child and adolescent:	Juvenile Hypothyroidism, Impaired Mental function, Growth retardation
Adult:	Goiter, Hypothyroidism, Impaired mental function

Classification of goiter

Grade 0: No palpable or visible goiter
Grade 1: A mass in the neck with enlarged thyroid, palpable but not visible
Grade 2: Swelling in the neck that is palpable as well as visible

Program goal-

Bring down IDD prevalence to < 10% by 2000
To decrease overall IDD prevalence (goiter) to <5% in the school children 6-12 years.

Program Objective

1. Surveys to assess the magnitude of the Iodine Deficiency Disorders
2. Supply of iodated salt in place of common salt
3. Resurvey after every 5 years to assess the extent of IDD and the impact of iodated salt
4. Laboratory monitoring of iodated salt and urinary iodine excretion
5. Health education and publicity

Program components-

1. Survey to identify Goiter endemic areas
2. Fortify all edible salt with iodine in a phased manner by end of 8th 5-year plan
3. Production and supply of Iodized salt to all endemic areas
4. IEC
5. Re survey of endemic areas after 5 years of iodized salt supply to ascertain impact
6. Laboratory monitoring of iodized salt and urinary excretion of iodine

Implementation plan:

- Creating Demand for iodized salt in Community
- Improving Monitoring of quality of iodized salt
- Increasing outlets and access to low cost adequately iodized salt
- Improving iodized salt production
- Advocacy with Policy Makers and Programme Managers

Implementing partners-

a. Ministry of **Railways** (subsidized *transport* of Iodized salt)
b. Ministry of **Industry** (controlling *production* of iodized salt through Salt Commissioner's office)
c. Ministry of **Health** (*Supervision, monitoring & evaluation* besides implementation of *PFA Act*)
d. **Civil supplies** department in States (*Procurement, transportation and supply* of iodized salt to population in endemic areas)

Support from International agencies-

UNICEF is the main partner in IDD control program, in 13 States for monitoring and extensive IEC

Achievements:

a. Salt manufacturing license issued to 930 units, 550 of them are producing iodized salt with a capacity of 13 million MT
b. Production of iodized salt recorded at 49.83 million MT in 2005-06
c. 26 States have totally banned non-iodized salt, and 2 have banned it partially
d. 29 States and UTs have established IDD cells
e. Intensive IEC campaigns using all kind of media has started in all States

f. Standards for iodized salt have been laid down as 30 ppm at production and 15 ppm at consumption level
g. A National reference laboratory set up at Bio-Chemistry division of NICD for training
h. Ban on sale of non iodised salt w.e.f May 2006, under PFA Act 1954

Of the 11091 samples of salt examined in 2002-03, 87.3% samples were not satisfactory. The reasons offered are-

Poor supervision and control over salt manufacturers

Poor PFA Act enforcement by States

Industrial salt being sold to domestic consumers for economic reasons

Plain salt is economical

PIP & District Action Plan (DAP) under NRHM

Planning terse can be put as "an act or process of choosing between alternatives to accomplish preset goals".

Plan denotes a blue print of action.
The planning process involves a number of steps which are essential to identify, look into alternatives, and decide priorities and evaluation of impact.

The entire planning process is punctuated and complimented by constraints & considerations related to Finances, Manpower, Legal issues and expectations of people, which put together forms the Planning Environment.

Planning helps in assessing and forecasting demands and requirements, assessing resources available and matching resources with requirements in view of competing priorities

The planning prerequisites are-

1. Base line of standards and performance
2. Additional resources
3. Reallocation of resources.

Planning steps-

1. Situational analysis
2. Deciding objectives
3. Defining strategies
4. Laying an Operational Plan
5. Implementation
6. Evaluation-
    a. criteria,
    b. frequency and
    c. process

Further, specific to Health care, the planning process is cyclical & repetitive involving the following steps-

1. Measurement or assessment of burden of illness
2. Identification of cause of illness
3. Measurement of effectiveness of different community interventions
4. Assessment of efficiency of interventions in terms of resources used
5. Implementation of interventions
6. Monitoring of activities
7. Reassessment of burden of Disease to see if there is any change

Planning as such need to be tailor made in view of the varied geo geographical situation , burden of diseases, the infrastructure and manpower available and the resources based on these. Under this context it was envisaged under NRHM to develop District specific plans taking a cognizance of morbidity, mortality, resources, infrastructure and objectives in consonance to the overall goals of NRHM and National Health Policy.

Why district action plans?

1. Mechanism to partner with community
2. Planning based on local evidence and needs
3. Area specific strategies to achieve NRHM goals
4. Cost effective and practical solutions
5. Move from budget based plans to outcome oriented plans
6. Requirement of GOI – no funds if no plans

Why emphasis on participatory planning?

The very basis of District Action Plan is to have all the stake holders involved into the planning process so that everyone in rank and file feels involved and has a feel of ownership. The participatory planning shall help in:

1. Promote community ownership
2. Greater ownership of health functionaries
3. Harness benefits of community action
4. Bring accountability of health functionaries to community members
5. Draw together elements that are determinants of health
6. Share resources and opportunities with partnering departments – convergent action

District Plan Components

1. Introduction: - The Setting:
2. Situational Analysis
3. Goals and Objectives
4. Strategies
5. Activities
6. Work Plan/Schedule
7. Monitoring and Evaluation
8. Budget

What a district plan ought to have

1. Background
2. Planning Process
3. Priorities as per the background and planning process
4. Annual Plan for each of the Health Institutions based on facility surveys
5. Community Action Plan
6. Financing of Health Care Management
7. Structure to deliver the program
8. Partnerships for convergent action
9. Capacity Building Plan
10. Human Resource Plan
11. Procurement and Logistics Plan
12. Non-governmental Partnerships
13. Community Monitoring and evaluation Framework
14. Action Plan for Demand generation
15. Sector specific plan for maternal health, child health, adolescent health, disease control, Geriatric care disease, Surveillance, family welfare
16. Program Management Structure
17. Budget

The entire planning process has to be dealt under different heads wherein the activities will go simultaneously. For a better understanding the levels of planning have been identified as-

The Levels of Planning-

1. Goals
2. Objectives
3. Strategies
4. Activities/ Processes
5. Inputs indicators
6. Impact indicators
7. Outcome indicators
8. Output indicators
9. Process indicators

Steps for planning

1. Objectives (what is being planned?)
2. Approach or strategies for reaching the objectives (how shall the objectives be achieved?)
3. Activities required to achieve the objectives (which? enlistment)
4. The obstacles that may hamper the activities (why?)
5. Resources to be used (who?)
6. Cost of activities (money?)
7. Detailed scheduling

What is being planned?

1. Looking at the situation
    a. Information from the community
    b. Information from records
        i. Morbidity and mortality profile
        ii. Health care institutions (PPP)
        iii. ICDS
        iv. Social and cultural background
        v. PRI structure
        vi. Geographical area

District planning-situation analysis

1. Identify the problems
2. Identify the causes
3. Do resource analysis to handle the causes---man, money, material &time
4. Map the problem geographically, groups& vulnerability and the resources
5. Identify the strategies to improve.

District planning

a. **Preparatory Activities -**Orient District Collectors and CMO & train District Planning teams.
b. **Desk Review**
    1. Compare District with State average and NRHM objectives
    2. Mapping- facilities / services /staffing, infrastructure, population served /Patient load & utilization (PHCs &CHCs)
    3. Review performance of National Programs in the last year
    4. Map performance of ANM/ MPW
    5. Mapping of TBA- AWW-ANM- LHV

6. Listing of NGOs –reach and focus of work
7. CBOs in the district – block and activity- wise
8. Last year's budget and expenditure analysis

c. Community Assessment

1. Resource Mapping
2. Understanding health problems
3. Assess BOD
4. Health expenditure
5. Problems- referral/ transport/FP
6. Role of PRI
7. Understanding health seeking behavior and practices – Pregnancy/illnesses
8. Understanding Community Participation and Ownership: Meeting VHSC
9. Perception and the role of PRI
10. Additional Information
11. Studies
12. NGO's- activities/achievement and willingness
13. Other CBO's / SHG's federation

d. Recognizing important problems

1. Health problems
    a. Malaria
    b. Malnutrition
2. Health service problems
    a. Insufficient drugs
    b. Lack of qualified person
    c. Difficult terrain
3. Community problems
    a. Inadequate water supply
    b. No primary education
    c. Inaccessibility of health care-socio cultural barriers

e. Setting objective

1. Expected outcomes
2. Relevance(related to the problem or policy)
3. Feasibility (it can be achieved)
4. Observable (its achievement can be clearly seen)
5. Measurable (outcome can be stated in number)

f. Reviewing punctuations

1. Types
    a. Manpower
    b. Materials
    c. Money
    d. Minutes
    e. Environment
    f. Technical
    g. Social
2. Analyzing punctuations
    a. Removable
    b. Modifiable
    c. Stubborn

g. Defining strategies

How do we aim to achieve objectives?

h. Choosing Alternatives

a. Technically sound
b. Feasible
   i. Manpower
   ii. Finances
   iii. Manageability of constraints

i. Scheduling the activities

1. Consider the alternative strategies
2. List out the resources
3. Select the best strategy
4. Mobilize the community resources
5. Detail activities
6. Log frame approach

j. Monitoring Efficiency tells you that the input into the work is appropriate in terms of the output. This could be put in terms of money, time, staff, equipment and so on.

k. Evaluation

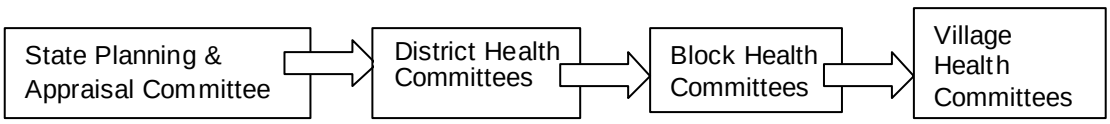
1. Measure of the extent of achievement of specific objectives.
2. Whether or not the specific objectives made any difference to the main goals

The PIP is

1. Essentially a statement of intent
2. A description of implementation with estimation of cost
3. Implementation likely to lead to desired results
4. The MOU between C&S should include plans, budget and log frames

Planning Process

The entire DAP should have a bottom up approach where village is the key focus and all Village plans get converged to Block plans which subsequently are dovetailed into one District Plan. These DAPs then are consolidated into a State Plan.



Additional provisions and norms under NRHM

Village Health Water & Sanitation Committee	10,000
Gram Panchayat Health Committee	10,000
PHC Level Rogi Kalyan Samiti	50,000
Block Untied Fund	50,000
ASHA Workers per 1000 population – Gram Panchayat level revolving advance	5,000
CHC Rogi Kalyan Samiti	1,00,000
DH/SDH Rogi Kalyan Samiti	5,00,000

Additional provisions and norms under NRHM

1 ASHA Sahyogini /1000 population
2 ANMs/Sub Centre
2 Medical Officers/ PHC (1 AYUSH) –Mainstreaming AYUSH
3 Staff Nurses/PHC
7 Specialists/CHC
9 Staff Nurses/CHC
Rs. 20 lakhs for Staff Quarters as per IPHS standards
1 Mobile Medical Unit in each district

Sources of data

1. DLHS
2. NFHS
3. SRS
4. NSSO
5. UNICEF
6. Special surveys by Medical colleges
7. CBHI
8. District data
9. Household surveys
10. Facility surveys
11. Eligible couple register
12. State annual reports
13. Disease surveillance system
14. Routine reports

Institutional Framework for Convergent Action

1. State Health Mission/Society
2. District Health Mission/Society
3. Block Water & Health Sanitation Committee
4. Village Water & Health Sanitation Committee

Partners and Members in above mentioned Societies and Committees are DWCD; PRI/RD; Education; PHED and AYUSH

NRHM Support to Convergence

1. Planning process and Joint Action Plan
2. Sharing of Information
3. Regular Joint Reviews
4. Funds for Gap filling - Untied Funds at various levels

Key Enabling Actions

Constitution of State Health Mission	✓
Constitution of State Planning & Appraisal Committee	
Constitution of District Planning Teams & their training	
Constitution of Block Planning Teams & their training	
Forming of Village Health, Water and Sanitation Committees	✓
Nominating selected functionaries to the State, District and Block Planning Committees/Teams for leading the planning process	
Preparing clear guidelines on core NRHM strategies for planning teams at District and Block	
Communicating fund availability, allocations and the flow of funds to the Districts and other levels as per NRHM guidelines	

Level of planning and the key functionaries:

1. **Village Level**
   a. ASHA
   b. Anganwadi
   c. Panchayat Representative
   d. SHG Leader
   e. PTA/ MTA Secretary
   f. Local CBO Representative
   g. Data Source-Village Health Register
2. **Gram Panchayat Level**
   a. The Gram Panchayat Pradhan
   b. ANM
   c. MPW
   d. Village Health & Sanitation Committee
   e. Village Health Plan
3. **District Level**
   a. NGO Representatives
   b. Few professionals recruited to meet planning and implementation needs.
   c. Zila Parishad Chairman
   d. District Medical Officer
   e. District Magistrate

Conducting situational analysis

1. **District Profile**
   a. Public Health Infrastructure in the District e.g. at Government/rented
   b. Human Resources in the District

Functionality of District Hospitals, CHCs, PHCs &SC

1. District: - Availability of Staff needed for service Guarantees.
2. CHC: - Ob & Gy. Specialists, Pediatrician Anesthetist at identified FRUs. Indicate blocks where more than 20 % posts are vacant.
3. PHC: - Availability of an ANM at SC. Indicate PHCs with more than 10 % vacant.
4. Sub-Centre:- Availability of an ANM at sub-centre.

Status of Logistics

1. Availability of a dedicated District warehouse for health department.
2. Stock outs of any vital supplies in last year.
3. Indenting Systems (from peripheral facilities of districts).

Existence of a functional system for assessing Quality of Vaccine

1. Status of Logistics
   a. Physical Infrastructures
   b. Indicate the trainings conducted for all categories of health personnel's.
   c. Training load.
   d. Personnel's trained each training or topic wise
2. Locally Endemic Diseases in the District.
3. New Interventions under NRHM

Importance of Facility surveys

1. No routine allocation of resources under NRHM.
2. Every health facility will have to develop a baseline and an annual plan.
3. Funds will be released only after outcomes are guaranteed by additional funds
4. Every health facility need will be **specifically** asked for in the annual district action plan and budget.
5. Facility survey should focus on:
   a. Main building
   b. Staff quarters
   c. Equipment
   d. Furniture and fixtures
   e. Cleanliness and sanitation
   f. Human resources
   g. Needs for medicines and supplies

Indicators- Some of the variables which should be measured in the District Action Plan

S. No.	**Objectives to be achieved by the district**	Current year	Next year
1	Universal coverage of all pregnant women with package of quality ANC services as per national guidelines		
2	Increase in deliveries with skilled attendance at birth including institutional deliveries		
3	FRUs (including DHs, CHCs/PHCs) made functional as defined in the National RCH 2 PIP		
4	Universal coverage of all eligible pregnant women under JSY scheme		
5	Increase in percentage of new born babies given colostrums		
6	Increase in prevalence of exclusive breast feeding		
7	Increase in percentage of fully protected children in 12-23 months as per national immunization schedule		
8	Universal coverage with Vitamin A prophylaxis in 9-36 months children		
9	Percentage of severely malnourished children below 6 yrs referred to medical institutions		
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		
11	Number of health institutions in PHCs/CHCs offering ARSH services		
12	Number of health institutions providing services for management of STIs and RTIs		
13	Percentage (as planned) of ASHAs functional in the district (received induction training)		
14	Number of RKS registered /established		
15	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)		

16	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		
17	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		
18	Village health and sanitation committeesConstituted - Grants given		
19	Number of SCs strengthened - Additional ANMs hired - Annual maintenance grants given		
20	No. of PHCs strengthened to provide 24x7 - 3 staff Nurses hired - Annual maintenance grants given		
21	National Blindness Control Program - 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		
22	National Leprosy Eradication Program - 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)		
23	Integrated Disease Surveillance Program - 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	Number of facilities to be covered for facility survey - SHCs - PHCs - CHCs		
26	No. of villages to be covered for HH survey		
27	No. of Community hearings planned		
28	District training plan developed and implemented		
29	District BCCC plan developed and implemented		
30	District procurement and Logistics plan developed		
31	No. of PHC/CHC's where AYUSH physicians posted		

Role of DPM

1. Review of secondary data, consultations with Department officials to prepare common guidelines and resource material
2. Facilitate the planning exercise and support the State Planning cell
3. Orientation of Dist. Officials
4. Development and management of Monitoring System for Dist. Planning
5. Field level support to staff
6. Monitoring and review of the field level activities
7. District & Block Level Plan Appraisal
8. Orientation of District Health Missions and Societies
9. Training of District Planning and Appraisal Core Groups (DCGs)
10. Training of Block Planning and Appraisal Core Groups
11. Training of NGOs in the Districts allocated to them
12. Support to multi-stakeholder consultation workshops at block level
13. Support to NGOs for conducting village level participatory planning
14. Assist health facility surveys
15. Assist consolidation of Block Action Plans (BAPs)
16. Assist appraisal and approval of block action plans by the DCGs
17. Assist in preparation of District Action Plan based on BAPs
18. Assist in approval and state level appraisal of DAPs

Role of Block functionaries

1. Review RCH-I lessons & existing program strategies.
2. Compiling the information, data, reports and evidence from existing records at various levels, as the basis for planning
3. Reviewing the existing management systems and identifying gaps
4. Development of locally relevant strategies and suggesting changes
5. Provide lead to the consultation and participatory planning processes
6. Carry out assessment of strengthening needs of health facilities as per prescribed GoI norms
7. Consolidate Block Action Plans (BAPs)
8. Prepare District Action Plans based on Block level plans

Role of NGOs

1. Orientation of Village Health Water and Sanitation Committees
2. Involvement of women's groups and community based organizations
3. Support to multi-stakeholder consultation workshops at block level
4. Assist health facility surveys
5. Assist consolidation of Block Action Plans (BAPs)
6. Participate in the functioning of Block Core Group/Health Committee for planning, program implementation and monitoring support to the Block Health Plan

Role of PRI's

1. **Village Level**
   a. Select Panchayats for participatory planning.
   b. All Gram Panchayats to be included.
2. **Block Level**
   a. PS and Pradhans to lead planning process in Block core groups.
3. **District Level**
   a. Health and Nutrition Committees of District Panchayats lead the planning process as part of the District Core Groups.

b. Support implementation of Village Health Plans.
c. Organize monthly review meetings.
d. Report progress to Block Health Planning and Appraisal Committees.
e. Draw attention of emerging needs and call for support from the Health, WCD, IPH, RD Departments.

Inter sectoral convergence

In view of the various determinants, Health, terse, requires concerted approach and interaction between various sectors and calls for strong interaction between all related sectors. Even the guiding principles of the health strategy adopted at Alma-Ata, 1978, identified Inter sectoral coordination as key to achieving HFA recognizing the multilateral linkages between Health, Socio-cultural, Political and Economic spheres. The departments and areas involved are WCD, PHED, *transport*, communication, Education, PRI member, Local groups, Youth clubs, Mahila mandals, SHGs, and NGOs

The National Rural Health Mission seeks to adopt a sector wide approach and subsumes key National Programmes such as: The Reproductive & Child Health Programme (RCH-II), the National Disease control programmes (NDCP) and the Integrated Disease Surveillance Programme (IDSP). NRHM will also enable the mainstreaming of Ayurvedic, Yoga, Unani, Siddha and homeopathy system of Health (AYUSH). Given that health is so critically linked with nutrition, water and sanitation, NRHM includes strategies for operational convergence to ensure that there is demonstrable synergy between these sectors.. One of the criteria for appraisal of District Health Plan was ensuring that the entire range of wider determinants of health have been taken care of in the approach to convergent action.

The Anganwadi Worker, ASHA and ANM are proposed to form the core of the Village Health Team and all three will work together to draw the village health plan in consultation with dais, other stakeholders and local opinion leaders. The Anganwadi will be the core institution for activities relating to delivery of health, family welfare and nutrition services at the village level. It will also serve as the institutional set up for ASHA at village level.

What is convergence:

A process - that facilitates different functionaries and community to work together for efficient service delivery

Convergence -

1. Saves time
2. Helps in building rapport
3. Increases efficiency
4. Reduces workload
5. Sharing of ideas
6. Trustworthy

Why convergence:

1. Vertical nature of programs
2. loosing focus on primary health care
3. Need to ensure unity of purpose
4. Provide directionality
5. Promote team work

How ISC helps:

1. More participative
2. Implies commitment
3. Economizes efforts
4. Improves quality of work
5. Avoid duplication and wastage
6. Optimizes output

Types of convergence:

1. Within the department – Intra-sectoral
2. Between the department
3. Inter-sectoral coordination
4. Intra-sectoral coordination:

Constraints in inter-sectoral coordination:

1. At the Knowledge level (program goals and implementation in isolation)
2. At the Attitudinal level(power conflicts and egos related to programs)
3. At the Practice level(unaware about mechanism of operations)

Pre-requisites of effective coordination:

1. leadership style and willingness
2. Health policies and priorities
3. Sharing of a common vision and perspective
4. Defining role & responsibilities of participatory agencies
5. Participatory decision making
6. Developing informal contacts with involved groups
7. Learning more about quality of services
8. Spelling out strategies and procedures
9. Conducting joint monitoring and evaluation
10. Taking remedial measures in solving problems related to coordination

Some of the activities of health department providing scope for inter-sectoral coordination are:

a. Supply of safe water,
b. Excreta disposal and refuse disposal,
c. Waste water disposal,
d. Maternal and child health,
e. Family welfare, immunization against major infectious diseases,
f. Prevention and control of locally endemic diseases, and
g. Health education on prevailing health problems.

Coordination Mechanism

a. **Listing** out the programmes which need joint efforts
b. **Identifying** the areas where coordination is required
c. **Knowing** the categories of health personnel whose activities should be integrated
d. **Locating** the level of health systems where joint efforts are needed
e. **Forming** coordination committee of members of district health team which includes all the middle level supervisors and specialized functionaries
f. **Forming** of operation teams at field level

Interdepartmental convergence -

1. **Convergence with WCD:**

The Department of Women and Children (DWCD) is the repository of national programmes for the holistic development of women and children. It includes: the Integrated Child Development Services (ICDS), to provide supplementary nutrition for pregnant and lactating mothers and children under six, and non-formal preschool education; programmes to ensure social and economic empowerment of

women through collectivization, welfare and support services, training for employment and income generation, and gender sensitization. DWCD and Health Dept.have overlapping goals, and thus complementary programming is essential. Such programming needs to extend to other stakeholders, such as NGOs, academic, research, and training institutions, involved in health, nutrition, and women's empowerment.

Success of convergence in health, nutrition, and empowerment requires convergence of approaches in DWCD and Health Dept.in: behaviour change communication strategies, planning modalities, monitoring and information systems, capacity building and training inputs. Additionally theHealth Dept. must ensure that convergence efforts are backed by a strong service delivery system, responsive to community needs.

The following areas of convergence between Health Dept. and DWCD could be considered:

a. Women and Children's Health: Mobilization of women, adolescents, and children and provision of a package of quality health education and services at the village level
b. Women's empowerment, gender and equity: Involvement of community based women's groups to ensure that social and related determinants of health including gender and equity are addressed. These include prevention of early child marriages, implementation of the PNDT Act, including awareness and action against girl child elimination, leading to distorted sex ratios, domestic violence, and mobilization of resources through collective action for health and other emergencies.

Convergence between the following functions of both departments for nutrition, health and women's empowerment is also necessary. They include:

a. Joint formulation of BCC strategies, materials, and messages,
b. Operational strategies for joint planning at village, block and district levels,
c. Development of joint MIS including common indicators,
d. Identification of functional areas for training of staff including joint training

Issues for convergence between WCD and Health

1. Low birth weight –how to reduce it? cope with it ?
2. How to reduce IMR, high morbidity and undernutrition during infancy
3. How to reduce under five mortality rates& high undernutrition rates in preschool children
4. What can we do to reduce anaemia in Indians
5. Is it possible to ensure universal access to iodised salt by 2010
6. How do we tackle over- nutrition and disease risks

Synergy between ANM, ASHA and AWW

A. Safe Abortion Services
   i. AWW, and ASHA may help in early identification of women who need safe abortion services
   ii. ANM can refer them to the appropriate facility for MTP and contraception
B. Antenatal Care
   i. ANM provides ANC
   ii. AWW provides Food supplements to pregnant women
C. Convergence: on the health & nutrition days
   i. AWW& ASHA can bring all pregnant women to AW to record weight.

ii. ANM can provide ANC (check BP,Hb?& obst exam) to 15-20 pregnant women in the anganwadi.
iii. Synergy in delivery care
iv. Decision regarding place of delivery (domiciliary & health facilities).
v. ANM will identify low risk women who can deliver at home;
vi. AWW and ASHA can monitor for clean delivery
vii. If there are complications during delivery ASHA can help the woman to access emergency care at the right place
viii. PRI can facilitate emergency transport
ix. AWW can weigh all neonates in home deliveries,
x. identify those weighing less than 2 kg and refer them to CHC for care
xi. ASHA and PRI can facilitate emergency referral for neonate

D. Declining sex ratio
   i. Women who have two or more girls can be counseled about the fact that fetal sex determination by ultrasound is possible only in second trimester and second trimester abortions are dangerous to the mother
   ii. The village women / AWW /ASHA can readily identify women in the village who have two or more girl children – these women can be persuaded during antenatal check up to have hospital deliveries; hospital delivery may reduce the female infanticide at birth

E. Low Birth Weight
   i. anganwadi workers to report all births in village,
   ii. weigh all neonates delivered at home soon after birth and
   iii. refer those weighing less than 2.2 kg to a hospital with a pediatrician.

2. Convergence with water and sanitation

The department of public health engineering(PHED) & department of panchayat & rural development implements two mission mode initiatives for improving access, coverage, quality of safe water and sanitation in a sustainable manner through the total sanitation campaign (TSC). Activities under TSC are: construction of individual household latrines, latrines, community sanitary complexes, anganwadi toilets,IEC , school sanitation and hygiene education, and rural sanitary marts and production centers.

TSC and NRHM rely on community led approaches and are expected to be managed by panchayats. Strong intersectoral convergence is necessary at the district and state levels for improved synergy among these three initiatives. The institutional arrangement for the total sanitation campaign (to be universalized) will be the same at district and village levels.

The village health & sanitation committee (VHSC) will be formed in every villages of state as per guidelines of govt. of India. The VHSC will be responsible for planning, monitoring and implementation of NRHM activities at the village and creating a demand for the services.

Involvement of PRIs: Monitoring and supervising the services of health (and related) functionaries providing services to the masses are important and hence involvement of elected representatives is imperative. Under the programme, the PRIs will be involved. PRIs will be sensitized and oriented towards issued relating to women and reproductive health issues, child health issues, family planning and gender.

Panchayati Raj Institutions will be responsible for the selection of ASHA and ASHA will be responsible to the Gram Panchayat. At the village level, the Gram Panchayat will guide the Village

Health and Sanitation Committee. Funds for activities for involvement of PRIs have already been budgeted under the head Behaviour Change Communication.

3. Convergence with Education Department:

Various agencies working on adolescent issues will be converged for improving the knowledge of adolescents in sexual and reproductive health issues. Secondary, Higher and Technical Education dept would be involved in implementing the School Health Programme like formation. They will be involved in ASRH issues. A system of counseling young married adolescents and adults will be worked out through the peer educator and other grass root NGOs, by the health department

Extension workers of education, rural development, agriculture departments in propagating IEC messages pertaining to health and RCH programs Coordination among village-level functionaries - anganwadi workers,

TBAs, Mahila Swasthaya Sangh, Krishi Vigyan Kendra volunteers and school teachers can help in the population to optimally utilise available services reproductive and child health care to the population with whom they work.

ANM, MMPW and AWW can also talk to the families they look after and give them messages pertaining to agriculture, education, water supply, sanitation, how to improve the status of the girl child and women, how to improve female literacy and employment, raise age at marriage, and how to improve nutritional status of women and children.

Potential areas of convergence of services between health and education include:

a. inclusion of educational material relating to health, nutrition and population in the curriculum for formal and non-formal education;
b. involvement of all zilla saksharata samitis in IEC activities pertaining to the RCH programme;
c. involving school teachers and children in Class V and above in school health programmes, growth monitoring , immunisation and related activities in the anganwadi at least once a month as a part of socially useful productive work.

4. Convergence with National Blindness Control Programme:

The National Blindness Control Programme and NRHM will develop a strategic plan to address the refractory errors and eye related problems of children & adolescents under the School Health Programme.

Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana **(JSY)** is a safe motherhood intervention, replacing the "Maternity Benefit Scheme", under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women.

JSY is a 100 % centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care.

The scheme has identified ASHA, the accredited social health activist as an effective link between the Government and the poor pregnant women in l0 low performing states, namely the 8 EAG states and Assam and J&K and the remaining NE States. In other eligible states and UTs, wherever, AWW and TBAs or ASHA like activist has been engaged in this purpose, she can be associated with this Yojana for providing the services.

Vision Goals :

a. To **reduce MMR & IMR**
b. Increase **institutional deliveries** in BPL families

Target group :

a. All pregnant women of the age 19 yrs and above from BPL families up to 2 live births
b. All women from BPL families of 10 LPS (8 EAG plus Assam and J&K) even after third live birth

Strategy : Link cash incentive to Institutional Delivery by promoting-

1. **Early** registration
2. Identification of **complicated** cases
3. providing 3, ante-natal & post-natal visits
4. Organizing **referral** services and transport
5. Convergence with IMCD (ICDS) by involving Anganwadi workers
6. **Transparent & Timely disbursement** of cash assistance and incentive to ASHA from funds available with Female Health Worker
7. **24 X 7** delivery services at PHC
8. Making **FRUs** functional to provide Emergency Obstetric services
9. Building **partnership** through a process of recognition/ accreditation of Professional, Institutions in private sector specially in rural areas

Features :

1. Number of States covered- 10
2. 8 EAG (Economic Action Group) States
3. Assam
4. J& K
5. Categories under which 10 States are put-
6. High Performance States (HPS)
7. Low performance States (LPS)
8. Cash assistance linked to Institutional delivery
9. Cash assistance in Graded scale-

Eligibility for Cash Assistance:

LPS States	**All pregnant women** delivering in Government health centres like Sub-centre, PHC/CHC/ FRU / general wards of District and state Hospitals or accredited private institutions
HPS States	**BPL pregnant women**, aged 19 years and above
LPS & HPS	**All SC and ST women** delivering in a government health centre like Sub-centre, PHC/CHC/ FRU / general ward of District and state Hospitals or accredited private institutions

Note: BPL Certification – This is required in all HPS states. However**,** where BPL cards have not yet been issued or have not been updated, States/UTs would formulate a **simple criterion** for certification of poor and needy status of the expectant mother's family by empowering the gram pradhan or ward member.

Scale of Cash Assistance for Institutional Delivery:

Category	**Rural Area**		Total	**Urban Area**		Total
	Mother's Package	ASHA's Package	Rs.	Mother's Package	ASHA's Package	Rs.
LPS	1400	600	2000	1000	200	1200
HPS	700		700	600		600

Note 1: Importantly, such woman in both LPS and HPS states, choosing to deliver **in an accredited private health institution** will have to produce **a proper BPL or a SC/ST certificate** in order to access JSY benefits. In addition she should **carry a referral slip from the ASHA/ANM/MO and the MCH - Janani Suraksha Yojana (JSY) card.**

Note 2: ANM / ASHA / MO should make it clear to the beneficiary that Government is not responsible for the cost of her delivery. She has to bear cost, while choosing to go to an accredited private institution for delivery. She only gets her entitled cash.

While mother will receive her entitled cash, the scheme **does not provide for ASHA package** for such pregnant women choosing to deliver **in an accredited private institution.**

Limitations of Cash Assistance for Institutional Delivery:

In LPS States	**All births**, delivered in a health centre – Government or Accredited Private health institutions.
In HPS States	**Up to 2 live births.**

Disbursement of Cash Assistance: As the cash assistance to the mother is mainly to meet the cost of delivery, it should be disbursed **effectively at the institution itself.**

For pregnant women going to a public health institution for delivery, entire cash entitlement should be disbursed to her **in one go,** at the health institution. Considering that some women would access accrediting private institution for antenatal care, they would require some financial support to get at least 3 ANCs including the TT injections. In such cases, at least **three-fourth (3/4) of the cash assistance under JSY should be paid to the beneficiary in one go,** importantly, at the time of delivery.

To Beneficiary:

1. The mother and the ASHA (wherever applicable) should get their entitled money at the heath centre immediately on arrival **and** registration for delivery.

2. Generally the ANM/ ASHA should carry out the entire disbursement process. However, till ASHA joins, AWW or any identified link worker, under the guidance of the ANM may also do the disbursement.

At accredited private institution: Disbursement of cash to the mother should be done through the ANM/ASHA/ Link worker channel and the money available under JSY should be paid to the beneficiary only and **not to any other person or relative**.

System should ensure that:

1. Such accredited private institution would also be responsible for any postnatal complication arising out of the cases handled by them.
2. They should not deny their services to any referred targeted expectant mother.

Note: Every month, accredited private health centers would prepare a statement of JSY - delivery / ANC/ obstetric complication cases handled by them and send it to the Medical officer, along with the referral slips for **sample verification by the concerned ANM / ASHA.**

If there is no ASHA the total amount shall be paid to women, same if woman opts not to take assistance of ASHA

1. Assistance for Caesarean section- 1500/- per case for hiring services of private expert in cases of Facility for C/S not available at FRU/ CHC
2. Compensation payment for Tubectomies/ Laparoscopy
3. Disbursement of cash assistance at the earliest
    a. Impress of 5000/- with Female Health worker
    b. Cash advance of 1500/- with ANM at any point in time
4. Partnership with Private Sector - Empanel at least 2 private institutions
5. Provision to meet administrative expenses
   (7% (4% district, 2% for state & 1% nodal ministry) of the fund released to State is to be used for administrative expenses towards monitoring and IEC monitoring and IEC)

Payment of cash:

1. To expectant mother
    a. all payments in one installment
    b. Responsibility of disbursement-ANM / ASHA
2. To ASHA or equivalent worker
    a. In 2 installments
        i. Advance
        ii. Balance in 2 installments
            -50% on discharge of JSY beneficiary
            -50% after one month - (PNC, BCG, New born registration
3. Cause of delay to be dealt seriously
4. Display of names of JSY beneficiaries (mandatory) at SC, PHC and local Panchayat office

BPL Certification:

a. BPL card verification
b. Criteria to be laid down by State/ Municipalities
c. ASHA to facilitate obtaining of certificate

Micro-birth plan for JSY beneficiaries:

Step	Activity	To be undertaken by	Proposed Time Line
1	Identification and Registration of beneficiary	ANM/ASHA/AWW or any link worker	At least 20-24 weeks before the expected date of delivery.
2	Filling up of Maternal and Child card (In duplicate – one each for mother and ASHA/Link worker)	ANM/ASHA/AWW or an equivalent link worker	Immediately on registration
3	Inform dates of 3 ANC & TT Injection (s) Identify the health center for all referral Identify the Place of Delivery Inform expected date of delivery	ANM/ASHA/AWW or an equivalent link worker Provide the 1st ANC immediately on Registration. ASHA to follow up the ANCs at the Anganwadi Centres/ Sub-center (SC) and ensure that the beneficiary attends the SC/Anganwadi centre /PHC for ANC on the indicated dates Motivation: ANM should call the beneficiary to the Anganwadi/SC to participate in the Monthly meeting and explain enhanced cash and Transport assistance benefits for Institutional delivery.	Immediately on registration
4	Collecting BPL or necessary proofs /certificates Wherever necessary from Panchayat / local bodies / Municipalities	ANM/ASHA/AWW or an link worker	Within 2-4 weeks from Registration
5	Submission of the completed JSY card in the Health center for verification by the authorized/Medical officer. II. Take necessary steps toward arranging transport or making available cash to the beneficiary to come to the Health Centre III. Ensure availability of fund to ANM/Health worker/ASHA	MO, PHC ANM/ASHA/AWW/link worker ANM/ MO, PHC	Atleast 2-4 weeks before the expected date of delivery
6.	Payment of cash benefit / incentive to the mother and ASHA	ANM/ MO, PHC	At the institution.

For complicated cases or those requiring cesarean section etc:

Ac –1	Pre-determine a Referral health center and intimate the pregnant women	By ANM/ASHA/link worker
Ac –2	Familiarize the woman with the referral centre, if necessary carry a letter of referral from MO PHC	ANM/ASHA/link worker
Ac –3	Pre-organize the transport facility in consultation with family members/community leader	ANM/ASHA/Community
Ac –4	Arrange for the medical experts if the same is not available in the referred heath center	MO, PHC

Role of ASHA or other link health worker associated with JSY would be to:

1. Identify pregnant woman as a beneficiary of the scheme and report or facilitate registration for ANC,
2. Assist the pregnant woman to obtain necessary certifications wherever necessary,
3. Provide and / or help the women in receiving at least three ANC checkups including TT injections, IFA tablets,
4. Identify a functional Government health centre or an accredited private health institution for referral and delivery,
5. Counsel for institutional delivery,
6. Escort the beneficiary women to the pre-determined health center and stay with her till the woman is discharged,
7. Arrange to immunize the newborn till the age of 14 weeks,
8. Inform about the birth or death of the child or mother to the ANM/MO,
9. Post natal visit within 7 days of delivery to track mother's health after delivery and facilitate in obtaining care, wherever necessary,
10. Counsel for initiation of breastfeeding to the newborn within one-hour of delivery and its continuance till 3-6 months and promote family planning.

Note: Work of the ASHA or any link worker associated with Yojana would be assessed based on the number of pregnant women she has been able to motivate to deliver in a health institution and the number of women she has escorted to the health institutions.

Important Features of JSY:

The scheme focuses on the poor pregnant woman with special dispensation for states having low institutional delivery rates namely the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and Jammu and Kashmir. While these states have been named as Low Performing States **(LPS), t**he remaining states have been named as High performing States **(HPS)**.

Tracking Each Pregnancy: Each beneficiary registered under this Yojana should have a JSY card along with a MCH card. ASHA/AWW/ any other identified link worker under the overall supervision of the ANM and the MO, PHC should **mandatorily prepare a micro-birth plan**. This will effectively help in monitoring Antenatal Check-up, and the post delivery care.

In the District / Women's Hospital / State Hospital:

1. State / District should allocate sufficient amount of money (based on the load of deliveries in these institutions) for each of these institution. This money should be kept **in a separate account under the supervision of the Rogi Kalyan Samity**.

2. The residency of the beneficiary would determine entitlement of cash benefit in such institutions, to be verified based on the referral slip from the ANM, carried by the beneficiary.

Format of Referral Slip: State should prepare a format of the referral slip, which should mainly indicate, identification details of the beneficiary, JSY registration number in the register of the ANM, reason for referral (including medical complications), name of ASHA, amount already disbursed, amount due, including referral transport money (if applicable), amount due to ASHA and to be paid, signature of MO/ANM.

It is therefore, essential that all targeted expectant mother should carry a referral slip from the ANM/MO where she generally resides. This will, in fact, help all such pregnant woman who go to her mother's place for delivery.

Disbursement of money to expectant mother going to her mother's place for delivery should be done at the place she delivers. **The entitlement of cash should be determined by her referral slip carried by her and her usual place of residence.**
A **voucher scheme** may be introduced in such a way that along with admission slip for delivery, a voucher amounting to mother's package plus the transport assistance money is given to the expectant mother and that she should be able to en cash the same at the Hospital's cash counter, at the time of discharge.

Flow of Fund:
State/ District authorities would advance Rs. 5000/- and Rs. Rs.10,000/- to each ANM in HPS /LPS States respectively as a recoupable impressed money from the JSY fund.
This money could be kept in the joint account of ANM and Gram Pradhan, as in case of untied fund placed with sub-centers so that the ANM could 'roll' the entire amount by advancing Rs.1500 to Rs. 2,500/- to ASHA / AWW per delivery and later she could recoup it from the PHC or CHC, where JSY fund is parked by the authorities.

Expenditure Monitoring: ASHA / AWW should provide an expenditure statement of money advanced to her in previous month to the ANM in the monthly meeting held by ANM.

There should be a clear authority for ANM to withdraw cash from this account for advancing it to the ASHA or AWW / any other health link worker, needed for ready use towards disbursement to the pregnant and also for arranging the referral transport for escorting the pregnant women to the institution.

Note: Where an elected body of the Panchayati Raj Institution (PRIs) exists, the State Governments/Health society may keep the money in a joint account of the Gram Pradhan and the ANM (like that of the untied fund). The process of recoupment of fund should be so simple to be able to disburse the cash to the pregnant women in time.

ASHA Package: This package, as of now, is available **in all LPS, NE States and in the tribal districts of all states and UTs**. In **rural areas** it includes the following three components:

1. **Cash assistance** for **Referral transport (State to decide, not less than Rs.250/- per delivery)** depending on the topography and the infrastructure available in their state. ASHA and the ANM to organize or facilitate in organizing referral the transport, in conjunction with gram pradhan, Gram Sabha etc.
   Note: This assistance is over and above the Mother's package.

2. **Cash incentive to ASHA: This should not be less than Rs.200/- per delivery**. Generally, ASHA should get this money after her postnatal visit to the beneficiary and that the child has been immunized for BCG.
3. **Transactional cost** (Balance out of Rs.600/-) is to be paid to ASHA in lieu of her stay with the pregnant woman in the health centre for delivery to meet her cost of boarding and lodging etc.. Therefore, this payment should be made at the hospital/ heath institution itself.

Note 1: In Urban areas, ASHA package consists of only the incentive for ASHA, for providing the services,

Note 2: In case ASHA fails to organize transport for the pregnant woman to go to the health institution, transport assistance money available within the ASHA's package should be paid to the pregnant woman at the institution, immediately on arrival **and** registration for delivery.

Note 3: In case ASHA is yet to join, transport assistance money may be kept with the institution and a voucher scheme may be introduced for disbursement.

Payment to ASHA:

ASHA should get her-

First payment is to be made, for the transactional cost **at the health centre** after reaching the institution along with the expectant mother.

The **second payment** should be paid after she has made postnatal visit and the **child has been immunized for BCG.**

All payments to ASHA would be done by the ANM only. In this case too, a voucher scheme be introduced in such a manner that for every pregnant woman she registers under JSY, ANM would give two vouchers to ASHA, which she would be able to en cash on certification by ANM.

Important: It must be ensured that ASHA gets her second payment within 7 days of the delivery, as that would be essential to keep her sustained in the system.

Special Dispensation for LPS states:

1. Age restriction removed
2. Restricting benefits of JSY up to 2 births removed. In other words, the benefits of the scheme are extended to all pregnant women in LPS states irrespective of birth orders.
3. No need for any marriage or BPL certification provided woman delivers in Government or accredited private health institution.

Important: The state / UTs would be responsible for instituting an appropriate monitoring mechanism and ensure that a proper accounting procedure is put in place for all transactions.

Subsidizing cost of Caesarean Section or management of Obstetric complications: Generally PHCs**/** FRUs / CHCs etc. would provide emergency obstetric services free of cost. Where Government specialists are not available in the Govt. health institution to manage complications or for **Caesarean Section**, assistance up to Rs. 1500/- per delivery could be utilized by the health institution **for hiring services of specialists from the private sector**. **If a specialist is not available** or that the list of empanelled specialist is very few, specialist doctors working in the **other Government set-ups** may even be empanelled, provided his/her services are spare and he/she is willing. In such a situation, the cash subsidy can be utilized to pay honorarium or for meeting transport cost to bring the specialist to the health centre. It may however be remembered that **a panel of such doctors from private or Government institutions need to be prepared beforehand in all**

such health institutions where such facility would be provided and the pregnant women are informed of this facility, at time of micro-birth planning.

Important: *State Governments would ensure that this assistance is not miss utilized and would exercise adequate control and monitor expenditure under this component.*

Assistance for Home Delivery: In LPS and HPS States, BPL pregnant women, aged 19 years and above, preferring to deliver at home is entitled to cash assistance of Rs. 500/- per delivery. Such cash assistance would be available only up to 2 live births and the disbursement would be done **at the time of delivery or around 7 days before the delivery by ANM/ASHA/ any other link worker**. The rationale is that beneficiary would be able to use the cash assistance for her care during delivery or to meet incidental expenses of delivery. It should be the responsibility of ANM/ASHA, MO PHC to ensure disbursement. It is very important that the cash is disbursed in time. Importantly, such woman choosing to deliver at home should have a BPL certificate to access JSY benefits.

Compensation Money: If the mother **or** her husband, of their own will, undergoes sterilization, **immediately** after the delivery of the child, compensation money available under the existing Family welfare scheme should also be disbursed to the mother at the hospital itself.

JSY Benefits in Accredited Private Health Institution: In order to increase choice of delivery care institutions**, at least two willing private institutions per block** should be accredited to provide delivery services**. State and the district authorities should draw up a list of criterion / protocols for such accreditation. (Please see a model criterion at Annexure-2)** Such beneficiaries delivering in these institutions would get the cash benefits admissible under the JSY.

Equip Sub-centers for Normal delivery: For women living in tribal and hilly districts, it becomes difficult to access PHC/CHCs for maternal care or delivery. A well-equipped sub-center is a better option for normal delivery. Deliveries conducted in sub-centers, which are accredited by the state/ district authorities will be considered as institutional delivery and therefore, women delivering in these centers would be eligible for all cash assistance under JSY.

Important: *All States and UTs to undertake a process of accreditation of all such sub-centre located in Govt. buildings and having proper facility of light, electricity, water, and other medical requirements of basic obstetric services including drugs, equipments and services of trained mid-wife for the purpose of conducting normal deliveries in these institutions.*

Provision of Administrative Expenses: Up to 4 % and 1% of the fund released could be utilized towards administrative expenses like monitoring, IEC and office expenses for implementation of JSY by the district and state authorities respectively.

Essential Strategy: While the scheme would create demand for institutional delivery, it would be necessary to have adequate number of 24X7 delivery services centre, doctors, mid-wives, drugs etc. at appropriate places. Mainly, this will entail

1. Linking each habitation to a functional health centre- public or accredited private institution where 24X7 delivery service would be available,
2. Associate an ASHA or a health link worker to each of these functional health centre,
3. It should be ensured that ASHA keeps track of all expectant mothers and newborn. All expectant mother and newborn should avail ANC and immunization services, if not in health centres, at least on the **monthly health and nutrition day, to be organized in the Anganwadi or sub-centre**:

a. Each pregnant women is registered and **a micro-birth plan** is prepared
b. Each pregnant woman is tracked for ANC,
c. For each of the expectant mother, a place of delivery is pre-determined at the time of registration and the expectant mother is informed,
d. A referral centre is identified and expectant mother is informed,
e. ASHA and ANM to ensure that adequate fund is available for disbursement to expectant mother,
f. ASHA takes adequate steps to organize transport for taking the women to the pre-determined health institution for delivery.
g. ASHA assures availability of cash for disbursement at the health centre and she escorts pregnant women to the pre-determined health centre.

10. **Possible IEC strategy:**
    1. To **associate NGO and Self Help Groups** for popularizing the scheme among women's group and also for monitoring of the implementation.
    2. To provide wide publicity to the scheme by:
        a. **Promoting JSY as a component of total package of services** under RCH along with Programs like Pulse polio Program, Monthly Village Health Day, Health Melas.
        b. Printing and distributing JSY guidelines, pamphlets, notices in local languages at SC/PHCs/CHCs/ District Hospitals/ DM's and Divisional Commissioner's office and even in at the accredited Pvt. Nursing Homes, in abundance,
        c. Supporting printing of state's stationery, specially for State's Health Secretary, DMs / SDMs/ Block/ PHC/ CHC/ District Hospital, advocating on Institutional Delivery and cash benefits of JSY,
        d. Facilitate organizing workshops and meetings in villages / blocks - by women's group, local leaders (PRIs), Opinion Maker, at functional health institutions on promoting maternal health in general, Institutional Delivery and JSY,
        e. Undertaking wall painting in all sub-centers, PHCs and CHCs, District & State Hospitals and the accredited private institutions,
        f. **Supporting** women self help Groups and NGOs for promoting the scheme,
        g. **Facilitating** woman Panchayat member to take review of Janani Suraksha Yojana (JSY)

Establish a grievance redressal cell in each district, **under the District Project Management Unit**, mainly to facilitate meeting people's genuine grievances on -

1. Eligibility for the scheme,
2. Quantum of cash assistance,
3. Delays in disbursement of the cash assistance,

If necessary, fund available under administrative expenses could be utilized for this purpose.

Display of names of JSY beneficiaries: The list of JSY beneficiaries along with the date of disbursement of cash to her should **mandatorily be displayed** on the display board at the sub-center, PHC/CHC/District Hospitals (from where beneficiaries have got the benefit), being updated regularly on month-to-month basis. **Wherever necessary, display boards may be procured.**

Guidelines For urban areas: The state shall prepare detailed guidelines by stating a simple procedure of implementing the Janani Suraksha Yojana (JSY) in the urban areas through the Municipalities/local bodies ((where an elected body exits) and quickly obtain approval of the state Government/SHS. The guidelines should bring out clearly, the chain of fund flow as well as

disbursement of the benefits to the ultimate beneficiaries. The quantum of grants to be placed at the disposal of the Municipalities shall be in proportion to the BPL families in the Municipal area. **The district annual plan will also include the plan of the municipalities in the districts wherever applicable.** The Chief medical Officer of such an authority should be the implementing authority. It must be ensured that basic objectives and the scale of disbursements are not altered. A copy such plan along with necessary Government's order should be sent to the GOI.

Monitoring:

Monthly Meeting at Sub-centre Level: For assessing the effectiveness of the implementation of JSY, monthly meeting of all ASHAs / related health link workers working under an ANM should be held by the ANM, possibly on a fixed day (may be on the third Friday) of every month, at the sub-center or at any of Anganwadi Centres falling under the ANM's area of jurisdiction.

Prepare Monthly Work Schedule: In the monthly meeting, the ANM, besides reviewing the current month's work vis-à-vis envisaged activities, should prepare a Monthly Work Schedule for each ASHA / village level health worker of following aspects of the coming month:

1. **Feed back on previous month's schedule -**
   a. Number of pregnant women missing ANCs,
   b. No. of cases, ASHA/link worker did not accompany the pregnant women for Delivery,
   c. Out of the identified beneficiary, number of Home deliveries,
   d. No. of post natal visits missed by ASHA,
   e. Cases referred to Referral Unit (FRU) and review their current health status,
   f. No. of children missing immunization.

2. **Fixing Next Month's Work Schedule (NMWS):** To include -
   a. Names of the identified pregnant women to be registered and to be taken to the health center/Anganwadi for ANC,
   b. Names of the pregnant women to be taken to the health center for delivery (wherever applicable),
   c. Names of the pregnant women with possible complications to be taken to the health center for check-up and/or delivery,
   d. Names of women to be visited (within 7 days) after their delivery,
   e. List of infants / newborn children for routine immunization,
   f. To ensure availability of imprest cash,
   g. Check whether referral transport has been organized.

Note 1: While no target needs to be fixed, but for the purpose of monitoring, some monthly goal of institutional delivery for the village may be kept.

Note 2: A format of monthly work schedule to be filled by the ANM /ASHA incorporating the physical and financial aspect may be printed.

Reporting: For the purpose of reviewing the progress of implementation and also for allocating fund to the state, under the RCH-flexi Pool, all States would provide:

1. Annual District-wise report as per **Annexure IV, reaching MoHFW in the month of April of the following financial year**
2. Quarterly Report **reaching MoHFW in the month following the end of the Quarter.**

Criteria for accreditation of 24 hours comprehensive emergency obstetric care:

Casualty services

1. A pregnant woman in labor or distress on entering the hospital at any time during the day or night is directly taken to the obstetric casualty and immediately examined by a professional with midwifery skills and decision taken within fifteen minutes.
    a. If there are signs or bleeding, convulsions or shock, she should be immediately attended by the Obstetrician on duty and necessary treatment to be initiated.
    b. Send the mother to the labor room, ward or operation theatre, depending on the signs and symptoms.
2. No pregnant woman in labor or distress should be turned away from the hospital for any reason at any time of the day or night.
3. Casualty should be located close to the labor room and theatre.
4. Casualty to receive advance intimation about the arrival of the mother and keep the specialist team ready with blood, if needed.
5. Casualty should have the following round the clock:
    a. An obstetrician
    b. Life saving drugs and IV fluids
    c. Facility for examining the patient (including pv)
    d. Emergency protocols
    e. Telephone connection in the casualty, labor room and blood bank
    f. Patient transport system within the institution

Emergency Obstetric Procedures

1. **Procedures**
    a. Vacuum extraction
    b. Forceps delivery
    c. LSCS
    d. Emergency Hysterectomy
    e. Manual removal of placenta
    f. Dilation and Curettage
    g. Laparotomy
    h. Blood transfusion
2. **Facilities**
    a. Separate theatre for above obstetric procedures.
    b. The Government shall provide at least 4 obstetricians, 4 pediatricians, 2 general Surgeons and 2 anesthetists to each CEmONC centre.

Emergency Newborn Care

1. Every delivery to be attended by a staff nurse trained in newborn resuscitation.
2. Pediatricians to be available in the institution round the clock for emergency interventions
3. Emergency Protocol should be available

Laboratory Services

1. 24 hours laboratory services including
    a. Blood grouping, typing and cross matching
    b. All routine examinations such as hemoglobin, blood glucose, urine sugar, albumin.

Post Natal Care

All normally delivered mothers should be observed in the labour room for at least two hours after delivery. Before transferring the mothers to the postnatal ward, pulse, BP, firmness of the uterus and amount of vaginal bleeding should be checked.

In the postnatal ward vital signs and height of the uterus should be monitored once in two hours for the first six hours and once in six hours till 24 hours. Twice a day monitoring until discharge should follow this.

Those mothers who had instrumental vaginal delivery should be observed in the labour ward for six hours after delivery before transferring the mother to the postnatal ward pulse, BP, firmness of the uterus, urine output and amount of vaginal bleeding should be checked. Postnatal care in the ward is similar to the care provided for normal vaginal delivery.

Post Operative Care

1. **Staff**
    a. For the first two hours after surgery, staff nurse remains at the bedside to monitor patient continuously.
    b. Hourly checkups of vital signs (temperature, pulse, BP, and urine output), for the next six hours.
    c. Forth hourly check up of vital signs by staff nurse for next two days and thereafter twice daily till discharge.
    d. Check up by doctor at least once during the first two hours and every sixth hourly for three days and then twice daily till discharge.

Records and Registers

1. Parturition Register
2. Case Records
3. Reporting Formats
4. Referral register

Ambulance Services

1. For referral
    a. Ambulance with driver and fuel available 24 hours.
    b. Linkages with other ambulance providers.
    c. Casualty to have telephone attendant who will organize the transportation.

Adherence to standard emergency treatment protocol

1. Standard emergency treatment protocol should in the casualty, in labor ward and in theatre.
2. The obstetrician and staff nurse posted in the labor ward and theatre should be thorough with emergency protocol.

Quality of provider- Patient interaction

1. Patient treated with respect and dignity.
2. Privacy and confidentiality assured.
3. Informal payment from patients strictly banned.
4. Informed consent obtained from the family for major procedure.
5. Procedures clearly explained to family members.
6. A female attendant to be permitted in labor room while ensuring asepsis.

Performance under JSY

% of Institutional Deliveries as per NFHS-III (as per NFHS data)	Year	India	Rajathan
		40.70	32.20
Number of Institutional Deliveries (in Lakhs)	05-06	108.41	5.37
	06-07	119.59	7.23
	07-08	143.71	10.19
	08-09	144.85	11.36
	09-10	80.71	6.79
Number of beneficiaries of JSY (in Lakhs)	05-06	7.04	0.05
	06-07	29.31	3.88
	07-08	71.19	7.75
	08-09	85.30	9.17
	09-10	49.92	5.84
	Total	**242.77**	**26.68**
Number of pvt institutions accredited under JSY		732	138

ASHA

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – 'ASHA' or **Accredited Social Health Activist**. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system.

Eligibility for ASHA:

1. ASHA must primarily be a **woman resident** of the village – married/ widowed/ divorced, preferably in the **age group of 21 to 45** years.
2. She should be a **literate woman** with formal education up to class eight. This may be relaxed only if no suitable person with this qualification is available.
3. ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha.

Capacity building

Capacity building of ASHA is being seen as a continuous process. ASHA will have to undergo series of **training** episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles.

Performance-based incentives

The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare Programs, and construction of household toilets.

Compensation applicable for ASHA (Rajasthan) as on date

One time honorarium	**Amount**
Monthly meeting	100
Social mobilization for MCHN day	150
Organizing monthly VHSC meeting	100
Bi-monthly conduction of meeting for adolescent girls	100
Total to be paid by NRHM	450
Amount to be paid by WCD after attending monthly meeting at PHC	500
TOTAL	**950**

क्र. सं.	कार्य	प्रेरक/प्रतिपूर्ति राषि	राशि कब देय होगी	कहाँ से देय होगी।	किसके द्वारा देय होगी
1	महिला नसबन्दी के लिए प्रेरक	150/– रू. प्रति नसबन्दी	नसबन्दी के 48 घंटे बाद	जहाँ नसबन्दी की गई है।	चिकित्सा अधिकारी
2	पुरूष नसबन्दी के लिए प्रेरक	200/– रू. प्रति नसबन्दी	नसबन्दी के 48 घंटे बाद	जहाँ नसबन्दी की गई है।	चिकित्सा अधिकारी
3	**जननी सुरक्षा योजना के अन्तर्गत गर्भवती महिला को स्वास्थ्य संस्था पर प्रसव के लिए लेकर जाने के लिए प्रेरक राशि।**	**ग्रामीण क्षेत्र में 600/– रू. प्रति प्रसव (इस राषि में प्रसव के लिए महिला को संस्था पर लेकर जाने के लिए परिवहन व्यय भी शामिल है)** **शहरी क्षेत्र में 200/– रू. जिसमें परिवहन के लिये राशि सम्मिलित नही है।**	ग्रामीण क्षेत्र में 500/– रू. प्रसूता के संस्थागत प्रसव के पश्चात तथा 100/– रू. डी.पी.टी के 3 टीकों के पश्चात् मातृ शिशु स्वास्थ्य दिवस पर। शहरी क्षेत्र में 100/– रू. संस्था पर तथा शेष 100/– रू. डी. पी.टी.के 3 टीकों के पश्चात् मातृ एवं शिशु स्वास्थ्य दिवस पर।	अस्पताल जहाँ पर प्रसव हो, **ए.एन.एम. द्वारा**	• संस्था पर चिकित्सा अधिकारी प्रभारी द्वारा तथा द्वितीय किश्त ए.एन.एम. द्वारा जहाँ लाभार्थी प्रसूता का पंजीयन किया गया है।
5	सरकारी एवं निजी अस्पताल में मोतियाबिन्द बीमारी ग्रसित व्यक्ति को ऑपरेषन करने के लिए लेकर जाने पर प्रतिपूर्ति।	175/– रू. यह राषि गैर–सरकारी संस्थाओं के कैम्प में होने वाले ऑपरेषन पर देय नही है।	ऑपरेशन के तुरन्त पश्चात्	उसी अस्पताल से जहाँ मोतियाबिन्द का ऑपरेशन किया गया है।	• चिकित्सा अधिकारी प्रभारी द्वारा एम. आर. एस. से देय है।
6	डॉट्स की दवाईयाँ मरीज को दिशा निर्देशानुसार उपलब्ध कराने के लिए	250 /– रू. प्रति टी. बी. मरीज इलाज पूर्ण होने के पष्चात्	इलाज पूर्ण होने पर ए. एन.एम. के प्रमाणीकरण के पश्चात्	सम्बन्धित प्राथमिक स्वास्थ्य केन्द्र पर आयोजित मासिक /द्विमासिक बैठक में।	• चिकित्सा अधिकारी प्रभारी द्वारा देय है।
7	प्रषिक्षण में सम्मिलित होने हेतु प्रति दिन प्राप्त होने वाली प्रतिपूर्ति रषि।	100 /– रू. प्रति दिन	प्रशिक्षण के अन्तिम दिन, घर जाने से पूर्व	प्रशिक्षण स्थल पर	आयोजक संस्था द्वारा/चिकित्सा अधिकारी प्रभारी प्राथमिक चिकित्सा केन्द्र द्वारा
9	घरेलू शौचालय बनाने के लिए	• रू 30 /– रू. गरीबी रेखा के	जब शौचालय बनाने का कार्य पूर्ण हो जाए	सम्पूर्ण स्वच्छता	मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी

	प्रेरक राषि ।	ऊपर के परिवारों के लिए प्रति शौचालय • रू 20/– रू. गरीबी रेखा के नीचे के परिवारों के लिए प्रति शौचालय • रू 10/– रू. प्रति माह यदि परिवार 6 माह तक शौचालय का प्रयोग करता है।	तथा उपयोग शुरू हो जाए	कार्यक्रम (टी. एस. सी.) मद से	अपने जिले में सम्पूर्ण स्वच्छता कार्यक्रम के प्रभारी अधिकारी से सम्पर्क कर प्रेरक राशि आषा–सहयोगिनी को देना सुनिश्चित करे।
10	समुदाय से प्राथमिक इलाज के लिये	5/– रू. प्रति व्यक्ति	दवाई देने के पश्चात्	परिवार द्वारा देय	

Role of ASHA:

Empowered with knowledge and a drug-kit to deliver first-contact healthcare, every ASHA is expected to be a fountainhead of community participation in public health programs in her village.

ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.

ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services.

1. She would be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.
2. ASHA will provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.
3. She will counsel women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the young child.
4. ASHA will mobilize the community and facilitate them in accessing health and health related services available at the Anganwadi/sub-centre/primary health centers, such as immunization, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government.
5. She will act as a depot older for essential provisions being made available to all habitations like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet(IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.
6. At the village level it is recognized that ASHA cannot function without adequate institutional support. Women's committees (like self-help groups or women's health committees), village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and Anganwadi workers, and the trainers of ASHA and in-service periodic training would be a major source of support to ASHA.
7. Knowing the beneficiaries:

For every 1000 population ASHA shall get following number of Beneficiaries in the village-

Beneficiary category	Expected number in an Year
Pregnant women	30-31 • Out of which 4-5 may have complications • 50% shall have anemia
New Borne	27-28
Children in 0-1 Year	30 (3 % of the population)
Children 1-5 years	130, (13 % of Population
Eligible couples	16-17% (15-45 years of Age group)
Eligible for Vasectomy/ Tubectomy	5-7% of Eligible couples
Eligible for spacing Methods	11-12% of Eligible couples

Support Mechanism for ASHA

The following set of guidelines is issued to enable the States to develop and put in place a proper support mechanism for ASHA.

1. **ASHA Mentoring Group**:
   The Government of India has set up an ASHA Mentoring Group comprising of leading NGOs and well known experts on community health. Similar mentoring groups at the State/District/Block levels could be set up by the States to provide guidance and advise on matter relating to selection, training and support for ASHA. At the District level, MNGOs and at Block level, FNGOs could be involved in the mentoring of ASHA. The State Govt. may utilize the services of Regional Resource Centre (RRC) and include them in the Mentoring Group at the State level.

2. **Selection of ASHA**
   As ASHA will be in the village on a permanent basis, she should be selected carefully through the process laid down in the first set of ASHA guidelines. It is possible that the selected ASHA drops out of the program. It is, therefore, necessary to keep a record of such cases at SUb-Centre/ PHC level. In the above circumstance, a new ASHA could be selected from the panel of three names previously prepared on the recommendation of the Gram Sabha.

3. **Training of ASHA**
   a. The guidelines envisage a total period of **23 days training in five episodes**. (**15 days comprehensive training to new ASHAs)**
   b. ASHA training is a continuous one and that she will develop the necessary skills & expertise through continuous on the job training.
   c. After a period of 6 months of her functioning in the village it is proposed that she be sensitized on HIV / AIDS issues including STI, RTI, prevention and referrals and also trained on new born care.

4. **Familiarizing ASHA with the village**
   a. Visit every household and make a sample survey of the residents of village to understand their health status.

b. Know the villagers, the common diseases which are prevalent amongst the villagers, the number of pregnant women, the number of newborn, educational and socio economic status of different categories of people, the health status of weaker sections especially scheduled castes/scheduled tribes etc.
c. Simple format for conducting the surveys. In this she should be supported by the AWW and the Village Health & Sanitation Committee.
d. The SHGs, Woman's Health Committees', Village Health and Sanitation Committees' of the Gram Panchayat will be major sources of support to ASHA. The Panchayat members will ensure secure and congenial environment for enabling ASHAs to function effectively to achieve the desired goal.

5. **Maintenance of Village Health Register**:
A village health register is maintained by the AWW which is not always complete. ASHA can help AWW to complete and update this register by maintaining a daily diary. The diaries, registers, health cards, immunization cards may be provided to her from the untied funds made available to the Sub-Centres.

6. **Organization of the Village Health and Nutrition Day**:
   a. Mobilize women, children and vulnerable population for the monthly health day activities.
   b. Ensure a list of beneficiaries is maintained
   c. Facilitate immunization, assessment of nutritional status of pregnant/lactating women, newborn & children, ANC/PNC and other health check-ups of women and children, taking weight of babies and pregnant women etc. and all range of other health activities

7. **Co-ordination with SHG Groups**:
   a. Interact with SHG Groups, if available in the villages, along with AWW,
   b. Jointly organize check up of pregnant women, their transportation for safe institutional delivery to a pre-identified functional health facility.

8. **Meeting with ANM**:
ANM should have a monthly meeting with the ASHAs stationed (5-6 ASHAs) in the villages of her work area at the Anganwadi Centre during the monthly Health and Nutrition Day to assess the quality of their work and provide them guidance

9. **Monthly meetings at PHC level**:
The Medical Officer In-charge of the PHC will hold a monthly meeting which would be attended by ANM and ASHAs, LHVs and Block Facilitator. On meeting day, following are to be ensured-
   a. Review health status of the villages.
   b. Payment of incentive to ASHAs under various schemes.
   c. Assess support received from the Village Health and Sanitation Committee.
   d. Replenish ASHA kits

10. **Monthly meetings of ASHAs**:
A meeting of ASHA could be organized on the day monthly meetings are organized at the PHC level to avoid unnecessary travel expenditure and wastage of time. In addition to monthly meetings at PHC, periodic retraining of ASHAs may be held for two days once in

every alternate month where interactive sessions will be held to help then to refresh and upgrade their knowledge and skills, as provided for in the original guidelines for ASHA.

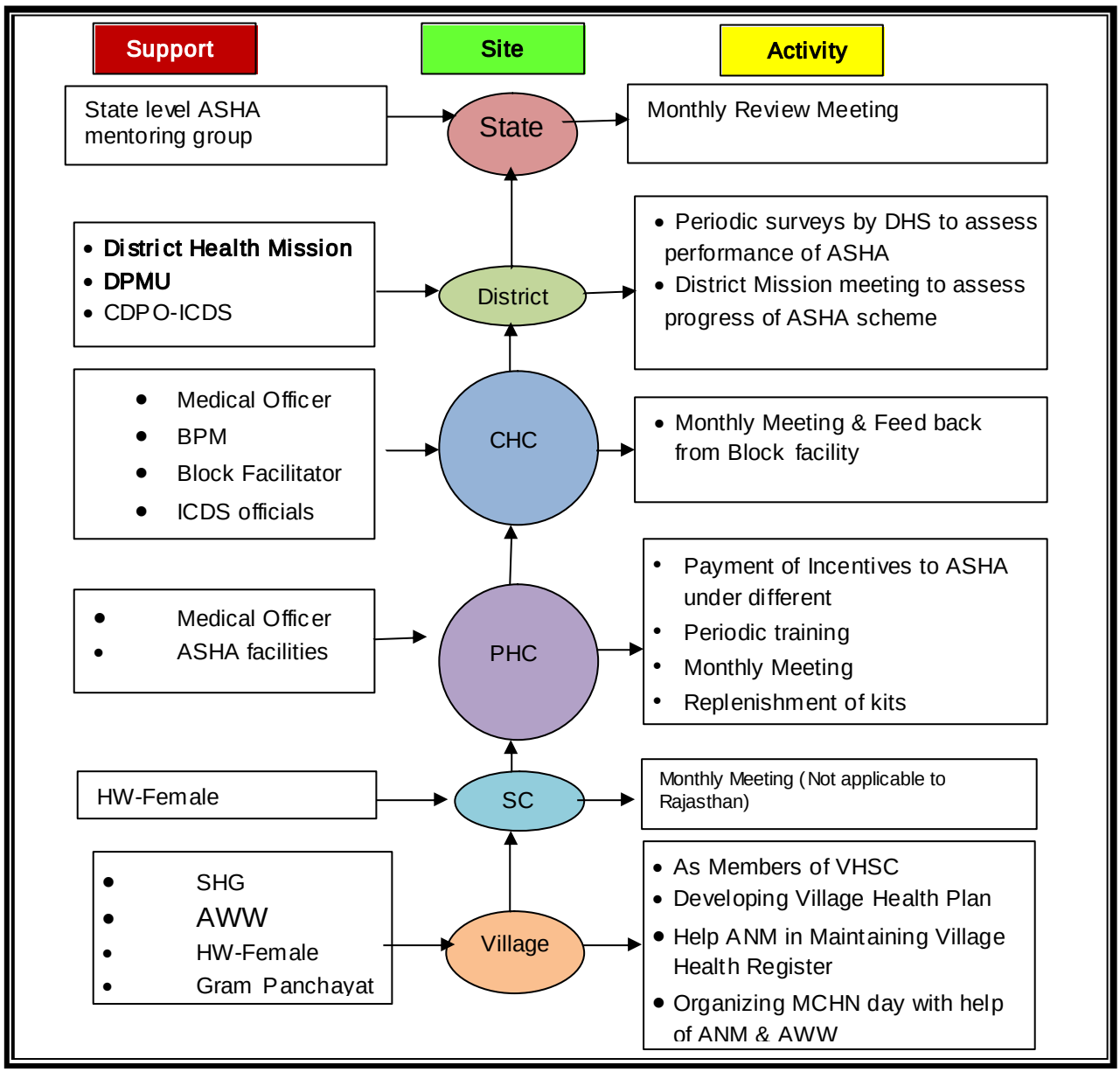
11. **Block level management**:
At the block level, the BMO will be in overall charge of ASHA related activities. However, an officer will be designated as Block level organizer for the ASHA to be assisted by Block Facilitators (one for every 10 ASHAs). Block Facilitators could be appointed as provided for under the first set of guidelines on ASHA already issued to the States. The Block Facilitator may be necessarily women. However, male members if any, who may have already been appointed earlier as Block Facilitator may continue. The Block Facilitators would provide feedback on the functioning of ASHAs to the BMO & Block level organizers. They shall also visit the ASHAS in villages.

12. **Management Support for ASHA**:
    a. Involve ICDS Officials.
    b. Creating a network for support to ASHA including timely disbursement of incentives, at various levels.
    c. Information system that has full information on the number of ASHAs, quality of their out put, outcomes of the Village Health and Nutrition Day, periodic health surveys of the villages to assess her impact on community.

13. **Community monitoring**:
    a. **Periodic surveys** are envisaged under NRHM in every village to assess the improvement brought about by ASHA and other interventions.
    b. The **funding** for the survey will be provided **out of the untied funds** provided to the Sub-Centre.
    c. The first survey would provide the base line for monitoring the impact of health activities in the village.

14. **Role of District Health Missions**:
    a. Assess the progress of selection of ASHAs, their training and orientation, usefulness to the villages etc.
    b. They should also have a Cell in the DPU to collect all information related to ASHA and the community which should be available on the computer network. This information should be accessible by the State Health Missions as well as the Mission at the national level.

15. **Linkage with Health Facility, in terms of**:
    a. Prompt action on the referrals made by her; otherwise the system cannot be sustained.
    b. Every ASHA must be familiar with the identified functional health facility in the respective area where she can refer or escort the patients for specific services.
    c. The persons manning these health facilities should be sensitized to effectively respond to the instant needs of the local people.
    d. Funds available under IEC-program may be used for education and publicity in respect of above services. The role of the State & District level Missions would be to provide support to ASHA from village to the district level without any blockage on the way.



Services available at different levels:

स्तर	संस्थान	सेवाएँ
ग्राम स्तर	आंगनबाड़ी केन्द्र	पूरक पोषाहार, पूर्व प्रारंभिक षिक्षा, टीकाकरण, पोषण एवं स्वास्थ्य षिक्षा, स्वास्थ्य जॉच, संदर्भ सेवा, आषिंक डे–केयर (षिषु गृह)
	उपकेन्द्र	मातृ स्वास्थ्य–प्रसवपूर्व देखभाल, प्रसव के दौरान, प्रसवोत्तर देखभाल, आवष्यक नवजात देखभाल, जननी सुरक्षा योजना, पोषण परामर्ष व रेफरल बाल स्वास्थ्य–टीकाकरण, विटामिन ए परिवार कल्याण–गर्भनिरोधकों को प्रोत्साहन व आपूर्ति, आई.यू.डी. (कॉपर टी) लगाना, स्थाई पद्धतियों के लिए अनुवर्ती सेवाएँ , परामर्ष। किषोर स्वास्थ्य–किषोर–अनुकूल स्वास्थ्य सहायता व रेफरल, गर्भ निरोधक व किषोर स्वास्थ्य सेवाएँ
सेक्टर	प्राथमिक	**प्रजनन व बाल स्वास्थ्य संबंधी सेवाएँ**

स्तर	स्वास्थ्य केन्द्र (पी. एच.सी.)	• सामान्य व सहायता प्राप्त दोनों तरह की प्रसूतियों के लिए 24 घंटे सेवाएँ । • जटिल प्रसूति की आपात स्थितियों के लिए प्राथमिक चिकित्सा एवं रेफरल । • नवजात देखभाल • बीमार बच्चों की आपात देखभाल • प्रसवोत्तर एवं बच्चों की बीमारियों का समेकित प्रबंध • परिवार नियोजन के लिए अंतराल व स्थाई पद्धतियाँ व उनका फॉलो–अप • गर्भपात सेवाएँ **राष्ट्रीय स्वास्थ्य कार्यक्रम** • आर.टी.आई./एस.टी.आई., टी.बी. अंधता, मलेरिया, टाइफॉइड, माइक्रोफिलेरिया, डेंगू तथा एच.आई.वी. की जाँच। • खून, कफ, पेषाब, मल की सामान्य लैब जाँच • असामान्य स्वास्थ्य परिस्थितियों व प्रकोप की स्थिति में पहले स्तर की कार्यवाही। • स्थाई परिवार नियोजन, एम.टी.पी., हाइड्रोसिल व मोतियाबिंद के लिए विषेष ऑपरेषन षिविर। • आयुर्वेद, योग, प्राकृतिक चिकित्सा, यूनानी, सिद्ध व होम्योपेथी (आयुष) उपचार। • शाला स्वास्थ्य कार्यक्रम में नियमित जाँच व स्वास्थ्य कार्यक्रम की सहायता । • शारीरिक कमजोरियों/कमियों का ठीक समय पर पता करना ,षुरूआती इलाज व रेफरल। • पेयजल जाँच व शुद्धिकरण । • प्रजनन व बाल स्वास्थ्य संबंधी षिविर।
खण्ड (ब्लॉक) स्तर	सामुदायिक स्वास्थ्य केन्द्र (सी. एच.सी.)	प्राथमिक स्वास्थ्य केन्द्र द्वारा प्रदान की जाने वाली उपरोक्त समस्त सेवाएँ एवं उनके अतिरित – • आपात स्थितियों से निपटने के लिए उपकरणों से सुसज्जित मध्यम आकार का अस्पताल। • स्थानिक बीमारियों का विषेषज्ञों द्वारा इलाज। • सामान्य शल्य प्रक्रियाएँ व आसान आपरेषन। • आवष्यक व आपात प्रसूति देखभाल व सामान्य एवं सहायता प्राप्त प्रसूतियों के लिए 24 घंटे सेवाएँ। • लैप्रोस्कोपी, स्त्री रोग व सुरक्षित गर्भपात सेवाएँ। • आर.टी.आई./एस.टी.आई. के लिए परामर्ष व इलाज। • रक्त बैंक की सुविधाएँ, • पेयजल स्त्रोतों की जाँच व सफाई। • महामारियों व प्रकोपों को रोकने के लिए प्रबंध।
जिला स्तर	जिला चिकित्सालय	• उपरोक्त समस्त सेवाएँ • आधुनिक साधन व विषेषज्ञ द्वारा सेवाएँ • आपातकालीन सेवाएँ

Factors Critical to the Success of ASHA

1. Selection of ASHA by prescribed process as per the ASHA guidelines.
2. Linkage with nearest functional health facility for referral services.
3. Identified transport for referral of cases from village to facility
4. Priority and recognition of cases referred by ASHA to MO / ANM.
5. Successful organization of monthly Health and Nutrition Day (in every village with the ANM / AWW).
6. Monthly meeting of ASHA at PHC.

7. Timely payment of incentives to ASHA.
8. Timely replenishment of ASHA kit.

How to know that ASHA is effective

1. Devising indicators for each state:
    a. % of newborns who were visited thrice in first week including once in first day
    b. % of ASHAs who received more than 20 visits for common illnesses per month
    c. % of ASHAs who have referred all (or at least half) their pregnant women for institutional delivery. Etc etc.
2. Deciding who will collect information and validate it while collecting it – by group processes and by village visits.
3. Decide on frequency and heirarchy of participatory review meetings where the data flows up as well as gets acted upon

Reflections of ASHA performance:

1. Increase in ANC registration in first trimester
2. Institutional Deliveries – 80.7% in Govt. hospitals (31.12.09)
3. Immunization – full immunization (Source: rajmedical)
    a. OPV3: 67.73;
    b. DPT3:68.08;
    c. BCG:71.15;
    d. Measles:69.02
4. No. of Sterilization
5. Practices
    a. Breast feeding practices
    b. Health seeking behavior
6. Referral
7. Community involvement –VHC/MCHN

ASHA and Expectations from DPMU:

Role of DPM

1. Develop annual plan for selection and training for ASHA
2. Drafting of annual targets for CHC-PHC wise ASHA to achieve the health targets of District like; sterilization, institutional deliveries and immunization etc.
3. Ensure adoption and implementation of plan and fund flow at local level.
4. Support District ASHA Coordinator in developing localised implementation plans.
5. Monitor physical and financial progress of the component.

Role of DAC

1. Create database of ASHA.
2. Liaise with district level stakeholders for mobilizing support
3. Supervision and monitoring of the ASHAs, NGOs involved in asha training and Block ASHA facilitators and PHC ASHA Supervisors.
4. Attend ASHA meetings at block and PHC.
5. Prepare annual training plan of ASHA for different rounds.
6. Compilation of monthly report with the help of Data Assistant of DPMU.
7. Dissemination of guidelines related to ASHA to all functionaries at different levels.
8. Follow up with Block ASHA facilitators/ BPMs on the progress of assigned job.

9. Monitor timely payments of ASHAs
10. Monitor physical and financial progress of the component.
11. Field visits

Monitoring indicators for ASHAs

Role of Block ASHA Facilitator

1. More stress on field supervision
2. Compile PHC-CHC wise data base of ASHA with the details of their name, joining, training and performance etc.
3. Attend block meetings of medical officers and PHC monthly meetings of ASHAs.
4. Draft training plan of ASHAs in consultation with DAC.
5. Monitoring and supervision of ASHAs and PHC ASHA Supervisors.
6. Monitor the availability of funds at PHC level for the payment of incentives and organising monthly meetings of ASHAs.
7. Collect and compile the monthly progress report of selected, trained, drop out and functional ASHAs.
8. Hand holding support to ASHAs during field visits.

Institutional deliveries	**5 Deliveries per year** (80% of total deliveries should be escorted by ASHAs)
Social Mobilization	**80% beneficiaries** (ANC & children) of the due list should be mobilized for MCHN day.
Sterilization	**1 case per month**.

Role of PHC ASHA Facilitator

1. Intensive field visits.
2. On the job hand –holding support to ASHAs (during field visits)
3. Organise PHC monthly meetings of ASHAs at PHC.
4. Collection and compilation of reports of ASHA with support of ANM.
5. Support MO/IC in reviewing the performance of ASHAs.

What can help ASHA to be more effective

1. A clear role definition.- state specific
2. A proper process of selection- are guidelines adequate?
3. A high quality and minimum duration of training- is training schedule and in place?
4. A Continued high quality on-the- job support- is the support structure in place
5. The spirit of a peoples movement…
    a. Health are as an entitlement, a basic right
    b. Collective action by local communities cause change to occur.
    c. Behaviour change needs both inter-personal interaction and an enabling atmosphere
6. Is there an understanding of ASHA as “social mobilisation”.
7. Are the drug kits in place? Where is the hold-up
8. Is incentive payments streamlined and adequate? personal incentive scheme to get sanction and support of the family and compensate for wage loss.

List of Circulars issued by NRHM, Rajasthan

कम सं0	विषय सूची
	ASHA Selection
1	F21/NRHM/ASHA/Convergence/2009/4387 date 5/10/09 चयन परिपत्र चिकित्सा विभाग व आई.सी.डी.एस का सयुक्त पत्र
2	F21/NRHM/ASHA/ASHA-4/09-10/4494 date 9/10/09 नवीन आषा चयन एवं 15 दिवसीय प्रषिक्षण के संबंध में
3	F21/NRHM/ASHA/ASHA-4/09-10/3863 date 2/09/09 आषा सहयोगिनी के कार्य की समीक्षा एवं उनको देय राषि के भुगतान के क्रम में
	ASHA Monthly Meetings
1	F21/NRHM/ASHA/ASHA monthely meeting/09-10/2435 date 22/06/09 आषा सहयोगिनियो के मासिक बैठक आयोजन के संबंध में
2	F21/NRHM/ASHA/2009/2902 date 14/07/09 आषा सहयोगिनी पी.एच.सी मासिक बैठक
3	F21(1)/NRHM/ASHA/ASHA meeting/2008/4135 date 18/09/09 शहरी आंबनबाड़ी केन्दों की आषा –सहयोगिनी के क्रम में
4	F21(1)/NRHM/ASHA/ASHA Sah./2008/1881 date 15/11/06 आषा –सहयोगिनी के मासिक बेठको के क्रम में एन.आर.एच.एम एवं आई.सी.डी.एस द्वारा सयुक्त पत्र
5	जिला/ब्लाक/पी.एच.सी (F21/NRHM/2008/3136 Date 22-9-08)
	ASHA Trainings
1	आषा – सहयोगिनी के तृतीय चरण प्रषिक्षण के लिए ब्लाक स्तरीय प्रषिक्षक –प्रषिक्षण एवं आषा प्रषिक्षण के सदंर्भ में (F21/NRHM/ASHA/III round trg./2009/1659 Date 21.4.09)
2	F21(1)/NRHM/ASHA/SARC/2009/3673 date 25/08/09 नवचयनित एवं अप्रषिक्षित आषा –सहयोगिनी के 15 दिवसीय प्रषिक्षण हेतु जिला स्तरीय प्रषिक्षण दल के नामांकन एवं आषा प्रषिक्षण के संदर्भ में
3	**NGO's Selection**
4	Review of performance of NGOs involved in ASHA training (F21/NRHM/ASHA/NGOs/2009/817 Date 17-2-09)
5	F21(2)/NRHM/2005/942 date 08/12/05 Expression of interest for selection of NGO's for training of ASHA at Block Level's
	ASHA Incentives
1	आषा – सहयोगिनी को एकीकृत मासिक मानदेय हेतु।(F21/NRHM/ASHA/2008/SPL-1 Date 13-10-2008)
2	F26/NRHM/ARSH/adol cou./2009/2594 date 30/06/09 किषोरी बालिका हेतु नवीन दिषा निर्देष
3	F21/NRHM/VHC/2009/4224 date 24/09/09 Strengthening of VHC's streamlining the VHC meetings
4	F()/malaria/direc./2009/450 date 21/05/09 म्लेरिया का आर.टी आषा द्वारा किया जाने पर रू 50 /– इन्सेन्टीव दिये जाने की स्वीकृति के संबंध में
5	F21/ASHA/ASHA-4./09-10/3896 date 07/09/09 आषा सहयोगिनी के दवा पेटी के संदर्भ में
6	F21/ASHA/ASHA-4./09-10/1693 date 23/0/09 आषा सहयोगिनी द्वारा संस्थागत प्रसव एवं नसबंदी वृद्वि हेतु लक्ष्य आवंटन
7	F21/NRHM/VHC/2009/2078 date 21/05/09 ग्राम स्वास्थ्य समिति की मासिक बैठक हेतु दिषा निर्देष
8	सी.एचधनि.टी.सु/2009.10/1355 दिनांक 13.04.09 नियमित टीकारण हेतु सोषल मोबिलाइजेषन के लिए आषा सहयोगिनी को देय राषि के क्रम में

9	सी.एचध्एमसीएचएन/268 दिनांक 2.12.08 टीकाकरण एवं एमसीएचएन दिवस के आयोजित के संबंध में
10	जननी सुरक्षा योजना के क्रियान्वयन हेतु दिषा निर्देष (NRHM/RCH-II/JSY/08/536 Date 24.11.08)
11	जननी सुरक्षा योजना के अन्तर्गत आषा – सहयोगिनी को प्रसवोपरान्त दूसरी किष्त के भुगतान के क्रम में। (NRHM/RCH-II/JSY/661 Date 23-4-09)
12	जननी सुरक्षा योजना के अन्तर्गत 25 प्रतिषत उपकेन्द्रों एवं शत् – प्रतिषत प्राथमिक स्वास्थ्य केन्द्रों पर प्रसव कराये जाने हेतु। (NRHM/RCH-II.JSY/09/662
	MIS
1	Monthly reporting format
2	ASHA report up to Sept-09

Skilled Birth Attendant (SBA)

With an estimated 28 million pregnancies per year and 26 million deliveries, almost 15% of the expectant mothers land up with one or the other life threatening obstetric complication during or immediately after delivery as a consequence of which there are 67,000 maternal deaths every year (254/100,000 live births, SRS Bulletin Oct. 2009). It becomes imperative that all expectant mothers have access to birth attendant with requisite midwifery skills for ensuring safe delivery and timely recognition of complications.

Government of India took policy initiatives to empower ANM/LHVs/Staff Nurses to make them competent for undertaking life saving measures like use of Uterotonic drugs for prevention of PPH, drugs in emergency situations prior to referral and perform basic procedures at community level in emergency.

Skilled Birth Attendant

A SBA is an accredited health professional such as midwife, doctor or nurse who has been educated and trained to achieve proficiency in the skills needed to manage normal pregnancies, child birth and immediate post natal period and in the identification, management and referral of complications in women and the new born.

Training Objectives

This training is meant to upgrade the skills of practicing birth attendants. It aims to achieve the mandatory minimum standard for a skilled birth attendant at all levels. Given that more facilities and supervisory capacity is available at institutional level (PHCs/CHCs) additional skills may be practiced by ANMs, LHVs and Staff Nurses.

Knowledge based objectives

At the end of the training the participants are expected to have improved understanding of:

1. Steps in the care and importance of health of the woman and the baby during antenatal, labour, delivery and postnatal period.
2. Steps of essential newborn care and their importance for the health of the baby.
3. The clinical features and management of common obstetric complications during pregnancy, labour, delivery and postpartum period.
4. The importance of quality of care for midwifery services through client-centered approach, using infection prevention practices, community involvement and supportive environment to the mother and family.

Skills based objectives

At the end of the training the participants are expected to perform the following skills

1. Measure the blood pressure, height and weight, fundal height, foetal lie, presentation and foetal heart sounds accurately.
2. Measure haemoglobin and examine urine for protein and sugar.
3. Provide care and counseling to the woman during antenatal, labour and postpartum period.
4. Monitor labour and identify prolonged labour using partograph.
5. Conduct delivery with active management of third stage of labour {use of uterotonic drug, controlled cord traction (CCT) and uterine massage} using infection prevention practices.
6. Provide essential newborn care, and newborn resuscitation, weigh the newborn.

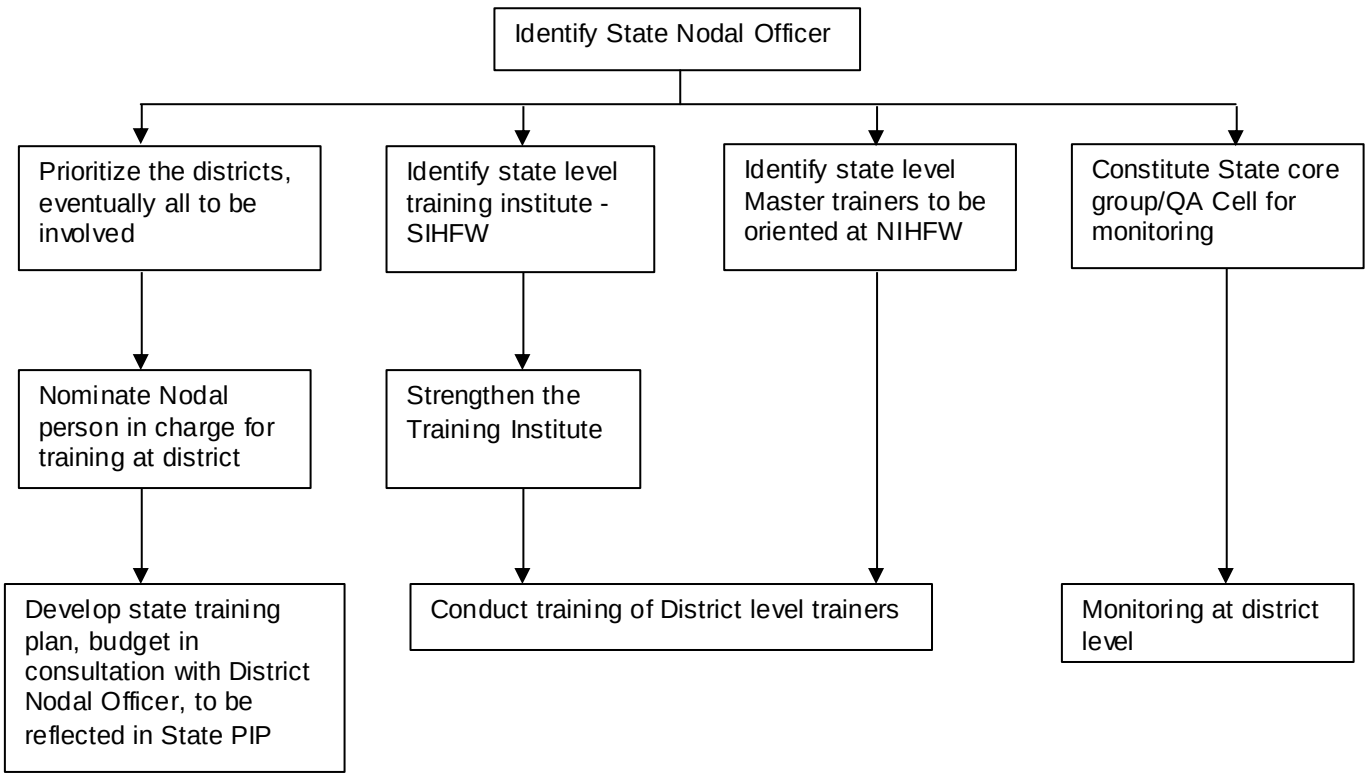
7. Identify danger signs during pregnancy, labour, delivery and postpartum period and danger signs in newborns; provide supportive care prior to referral at home/in community.
8. Insert Intravenous (IV) line and give IV fluids.
9. Give deep intramuscular injections (magnesium sulphate) and IM/IV antibiotics.
10. Perform uterine massage to expel clots in case of PPH and digital removal of clots and POC for bleeding after an abortion.
11. Prepare High Level Disinfected (HLD) gloves and instruments.

Training methodology

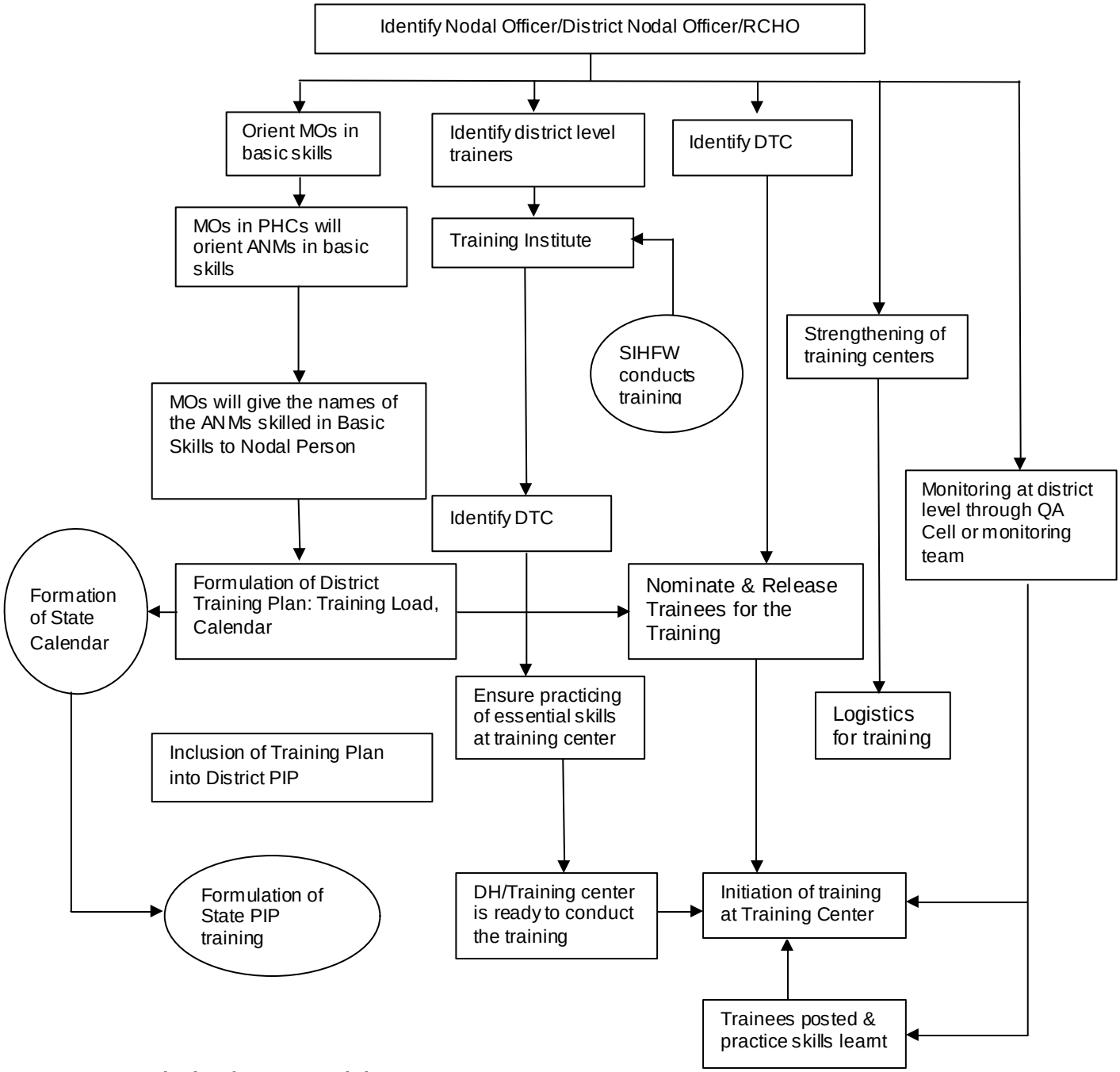
The following training techniques and methods are used to conduct the SBA training:
- interactive presentation and discussion
- demonstration and simulated practice of skills on models and clients/patients
- intensive hands-on guided practical training on clients/patients under supervision of the trainers/facilitators of the training site

Training Plan

A. State Level



B. District Level



Batch size for SBA Training

No. of deliveries per month	Recommended batch size
150	2
150-250	3
>250	4-8

Training Duration

Staff Nurses 2-3 weeks
ANMs & LHVs 3-6 weeks

Monitoring of Training by -

QA Cell/Core Group at State/District in coordination with SIHFW/SPMU/DPMU

SBA District Training Monitoring Format

Name of the Observer ----------

Designation ----------

District Posted ----------

District Observed ----------

Training Site :			
Dates Theory	Start		End
Date of Observation	Start		End
Total no. of participants attending the training:			
Total no. of participants joined on first day of the training:			
Total no. of participants who were supposed to attend the training:			
No of Participants : 1. From Model Sub Centres : 2. From Sub Centres : 3. From PHCs :		4. From CHCs : 5. District Hospital : 6. Others :	
Training Residential : Yes / No		Residential Facilities Safe or not : Yes / No	
Arrangements: Toilets Available 3-5 : Good Toilets Available 2-3 : Available Toilets Available 1 : Poor		**Distance of Training Site from Residence** < 1 Kms : Good 1-2 Kms : Average >-2 Kms : Poor	
No of Participants Residing at the Residential Location :			
Residing Facilities: Good /Satisfactory /Poor			
Welcome & Briefing Session held Yes / No			
Name Training Coordinator : MRC / ARTH Trained : Yes / No			
No of Person who Underwent Training At MRC/ARTH :			
No of Team Members Who Underwent Training At MRC/ARTH Available During the Training :			
Details of Trainers Appointed for the Training			
Does the training include an Ob/Gyn and Paed. Specialist? Yes / No			
Name :	Designation :	MRC/ARTH Trained: Yes / No Ph.No:	
Name :	Designation :	MRC/ARTH Trained: Yes / No Ph.No:	
Name :	Designation :	MRC/ARTH Trained: Yes / No Ph.No:	
Name :	Designation :	MRC/ARTH Trained: Yes / No Ph.No:	
Name :	Designation :	MRC/ARTH Trained: Yes / No Ph.No:	
Name :	Designation :	MRC/ARTH Trained: Yes / No Ph.No:	

Checklist for monitoring

S.no	Supply	Yes/No
1.	Training Modules for every Participant (Individual Copy)	
2.	Guidelines for Ante-Natal Care & Skilled Attendance at Birth by ANM and LHVs (Individual Copy	
3.	Facilitator's Guide	

4.	Partograph Booklet (Individual Copy)	
5.	Operational Guidelines with the Facilitators	
6.	Training Schedule	
7.	Hemoglobinometer	
8.	B P instrument & Stethoscope	
9.	Neonatal size Ambu – Bags & Makes	
10.	Midwifery mannequin	
11.	Baby mennequin	
12.	Training Schedule	
13.	Diary and bag	

Assessment of Theory:
Feedback from the trainers

- Number of participants not showing interest in learning? _____
- Difficulties experienced by trainers in transcending the knowledge / teaching and why?
  _____
- Which are the topics which most of the participants find difficulty to understand?
  _____
- What are their suggestions?
  _____

Interaction with the participants:

- What new learning they have learnt during this period?
  _____
- Which topics were difficult to understand?
  _____
- What they would like to do after reaching their Health facility and in their area?
  _____
- What kind of support is required to practice the learning at their facility level?
  _____

Class Room Observations:

- Gaps in teaching content **Yes / No**
- Interaction level between facilitators & Trainees **Good / average / satisfactory**
- Level of interest and learning by the participants. **Good / Average / Poor**
- Attitude and confidence level of the trainer : **Excellent/ Good / Average / Poor**
- Appropriateness of Teaching Methodology during the session observed **Yes / No**
- Use checklist for monitoring **Yes / No**

Mention what Methodology could have been better:
_____

See 3-4 sample of Daily Dairy and note your observations on Quality **& Content** of training:
_____

To be assessed on the basis of what has been taught till the day of visit, by interaction with the participants and the facilitators.

1. **Probable Question for assessing learning :**
   1. List four Major Causes of Maternal Mortality?
   2. What are important things to observe during ANC check-up?
   3. How do you diagnose pre Eclampsia?
   4. Assess counseling skills through a role pay.

5. Name and describe four fundal grips?
6. Knowledge on fundal height at different gestational period?
7. List 10 danger signs during pregnancy?
8. Describe stage of labour?
9. What is to be seen while conducting during P. V in labour?
10. What is partograph?
11. What components are marked in partograph? (Give a sample exercise and let the participants mark on it and check it for correction.)
12. How do you differentiate between true and false labour pains?
13. Define PPH? What tablet and does is given whether the patient needs referral or not?
14. How is PPH managed?
15. What symptoms will support you to decide whether the patient needs referral or not?
16. What are the important symptoms to be observed for post partum care?
17. What is APGAR score?
18. What is new learning during the program?
19. What learning you have found most useful?
20. What learning do you think will be difficult to use in daily practice?

Comments (can be given in Hindi):

Name ----------**Place of posting**----------
Designation---------
Signature---------- **Date**----------

2. Practical Training

Observation during practical Training

Make Assessment individually by practically asking them to Perform. (As far as possible 2-3 Case each for given Points) Select the Participant yourself for Assessment.

1. Observe for hand washing steps.
2. Ask practically to take BP and assess for correct reading for Measuring BP.
3. Practically make the participants do hemoglobin estimation and urine test and assess for correct estimation.
4. Let the participants/take ANC history and do all the procedures for conducting quality ANC care. (Practically or through role play)
5. Assess for the abdominal grips and FHS.
6. Assess for conducting PV examination
7. Birth preparedness.
8. Observe for plotting of pantograph, if supporting a delivery. (or through an exercise)
9. Correct assess mental for dilation.
10. Observe for practice during conducting labour (behavior & counseling skill also)
11. Ask for when are the Tab Misoprostral/Injection Oxytocin should be administered
12. Whether knows about Controlled Cord Traction? Has she done it?
13. Whether knows about Uterine massage? Has she done it?
14. Assess skill for putting IV line and canula.
15. Assess for resuscitation skill (Use of Ambu bag)
16. Let the participant assess for **APGAR** score
17. Counseling skills

Assessment Sheet for Practical Knowledge

Name of the Observer----------

Designation ----------

District Posted----------

Observing District----------

Venue of Training----------

Date of Practical (First Batch) Start		End
Date of Observation Start		End
No. Of Participants Attending The Training:		
No. Of Participants Residing at the Residential Location on:		
Are the trainees provided duty schedules	Yes / No	
Are the trainees given duty at	Labour room Laboratory OPD/ANC clinic PP ward	Yes / No Yes / No Yes / No Yes / No
Details about the trainers available		
Name : Designation :	MRC/ARTH Trained: Yes / No Ph.No:	
Name : Designation :	MRC/ARTH Trained: Yes / No Ph.No:	
Name : Designation :	MRC/ARTH Trained: Yes / No Ph.No:	
Name : Designation :	MRC/ARTH Trained: Yes / No Ph.No:	

S.No	Topic	Assessment	Assessment
1.	Observe for hand washing step (participant)	Correctly / Done / Satisfied/poor	Correctly / Done / Satisfied/ poor
2.	Mea sure BP (Assess for correctly)	Diastolic : Yes / No Systolic: Yes / No	Diastolic : Yes / No Systolic: Yes / No
3.	Hemoglobin Estimation	Correct : Yes / No	Correct : Yes / No
4.	Urine Examination	Correct : Yes / No	Correct : Yes / No
5.	**ANC** History Taking Recording ANC JSY Card filed B P Measurement Urine Examination Weight Taking PV Assessment Counseling skill (Expectant Mother)	 Good/Satisfactory /Poor Done / Not Done Yes / No Correct / in Correct/ Not Done Correct / in Correct/ Not Done Done / Not Done Good/Satisfactory /Poor Good/Satisfactory /Poor	 Good/Satisfactory /Poor Done / Not Done Yes / No Correct / in Correct/ Not Done Correct / in Correct/ Not Done Done / Not Done Good/Satisfactory /Poor Good/Satisfactory /Poor
6.	Abdominal grip (Expectant Mother Mannequins	Fundal grip Yes / No Lateral grip Yes / No Pelvic grip l Yes / No	Fundal grip Yes / No Lateral grip Yes / No Pelvic grip l Yes / No

		Pelvic grip II Yes / No	Pelvic grip II Yes / No
7.	Birth preparedness	Excellent/ good/ Satisfactory/ Poor	Excellent/ good/ Satisfactory/ Poor
8.	Partograph (Expectant Mother/ Exercise)	Plots Correctly Yes/No Understands when to refer Yes / No Understanding on Usage Good/Average/Poor	Plots Correctly Yes/No Understands when to refer Yes / No Understanding on Usage Good/Average/Poor
9.	Dilation Assessment	Correct Yes /No	Correct Yes / No
10.	Delivering & Assessing Placenta	Correctly Done/ Satisfactory /Poor	Correctly Done/ Satisfactory /Poor
11.	Foetal Heart Rate Taken (child)	Correct Yes / No	Correct Yes / No
12.	Use of Ambu Bag	Understanding on use Good/Average/poor	Understanding on use Good/Average/poor
13.	APGAR Score (child)	Good/Satisfactory /Poor	Good/Satisfactory /Poor
14.	Individual Diary	Maintained: Daily /incomplete Quality of Contents: Good/Satisfactory /Poor	Maintained: Daily /incomplete Quality of Contents: Good/Satisfactory /Poor
15.	No. of deliveries assisted No. of deliveries independently conducted		

- For point 7 please mention whether actually carried out during delivering a patient or through an exercise.

  The following are mandatory for assessment of all 5 participants:
  1. Hand washing Step
  2. ANC
     - History Taking
     - Measuring BP
     - Hemoglobin Estimation
     - PV Assessment
     - Counseling Skills
  3. Dilation Assessment
  4. Foetal Heart Rate
  5. Plotting Partograph
  6. APGAR Score

Observations for Training site:

1. Availability of drugs- Inj oxytocin / Diazepam/Tab. Nifedifine/ Inj. MgSO4/ Inj. Lignocaine Hydrochloride/ Ta. Misoprostral/ Inj. Gentamycin/ Inj. Ampicillin/ oral metranidazole / sterilized cotton and gauze/ gloves/ sterile syringes and needles/ sterile I/V sets
2. Availability of equipments- delivery kits –normal and assisted/ Cheattle forceps ina dry bottle/ foetal stethoscope/ baby weighing scale/ radiant warmer/ table lamp with 200 watt bulb/ phototherapy unit/ self inflating bag and mask/ oxygen hood/ laryngoscope and endotracheal tubes/ mucus extractor with suction tube and foot operated suction

machine/ feeding tubes/ blankets/ clean towels/ baby feeding cup/ BP apparatus and stethoscope/ sterile clean pads/ bleaching powder/ Providine Iodine solution/ Spirit/ micropore tape/ antenatal card/ partograph

3. Is the partograph being maintained in every delivery?
4. Is the staff (other than trainers) involved in conducting of delivery/LR following the SBA training protocol?
5. Is the staff in LR aware of any training being conducted for SBA?
6. Is the teaching schedule posted at LR/wards/OPDs?
7. Is the duty roster for the trainees posted at the LR/wards/OPDs?
8. Is a functional New born corner with at least ambu bag, baby warmer, suction etc. available in the LR?

Feedback from Clinical Trainers:

_____

Comments Observer

Name ----------**Place of posting**----------**Designation**----------
Signature---------- **Date**----------

Model Sub Centre:

The Model Sub Center scheme represents a critical policy intervention to provide essential obstetric care at sub centers. Model sub centers are intended to provide services included antenatal care, intra natal care, (institutional deliveries), post natal care, new born care services, family planning and immunization services.

Under this program, NRHM has sanctioned Rs. 61.12 crores till 2008-09 and money has been transferred to District Health Societies from the State Health Society. The physical progress envisages the construction of 3000 model sub centers in Rajasthan.

Check-list

1. District Observed ……
2. Name of the Model sub center ……
3. Population covered ……
4. Name of the PHC ……
5. Name of the Block ……
6. Location of Sub centre — Within Village | Outside Village
7. Building — Govt. | Rented | No building
8. Construction of Labor room — Complete | Under construction | Not started
9. Whether labor room is being constructed in the same building — Yes | No
10. Labour room functional — Yes | No
11. Electricity — Yes | No
12. Water availability — None | Own tap | Boring | Community Tap

13. No. of Health Workers-Female(ANM)
    a. Sanctioned — 1 2 0
    b. Posted — 1 2 0
    c. Vacant — 1 2 0
14. Name: (ANM 1) ……
15. Contact no ……
16. SBA trained — Yes No
17. Name: (ANM 2) ……
18. Contact no. ……
19. SBA trained — Yes No

20. Other service provider available
    a. If Yes, Category ……
    b. Number ……
21. Number of pregnant women registered with Sub centers (Since April 08-Check from register) ☐
22. Number of pregnant women offered ANC in last one month ☐
23. Number of deliveries at the sub-center in last one month ☐
24. Number of deliveries conducted at home in last one month ☐

25. Referral institution identified for emergency referral……
26. Distance of referral institution from the sub-center — Less than 5 K.m. | 5-10 K.m. | More than 10 K.m.
27. Number of pregnant women referred to the Institutions in last month — None | 1-3 | 4-5 | 5+
28. Number live births and Still Births
    i. at Sub center delivery — Live Births…… | Still Births……...
    ii. home delivery — Live Births…….. | Still Births……..

29. Number of neonates referred to higher centers in the last month. ☐
30. Availability of fund — Yes No
    a. Nature of fund
        i. Untied fund
            1. Amount — Less than 1000 | 1000 | More than 1000
        ii. Model sub center development fund — Yes No
            1. Amount — Less than 5000 | 5000
31. Funds utilized — Yes No
32. Whether accredited for Institutional Deliveries — Yes No
33. Are the records of ANC/ Intra natal/ PNC records maintained — Yes No

34. Equipments available (Check and tick):

S.no.	Basic Equipments	Number available	Functionality Yes/No
i.	Weighing Machine (Adult)		
ii.	Weighing Machine (Baby)		
iii.	BP Instrument		
iv.	Stethoscope		
v.	Hemoglobinometer		
vi.	Urostix		
vii.	Thermometer (dual Cel/Fah scale)		
viii.	Instrument sterilizer		
ix.	Table		
x.	Chairs		
xi.	Wooden benches		
xii.	Patient stool (revolving)		
xiii.	Dressing forceps (stainless steel)		
xiv.	Kidney basins (stainless steel) large		
xv.	Kidney basins (stainless steel) small		
xvi.	Sponge bowls small (stainless steel)		
xvii.	Sponge bowls large (stainless steel)		
xviii.	Urinary catheters		
xix.	Mouth gag		
xx.	Scissors		
xxi.	Mackintosh		
xxii.	Labor table: stainless steel		
xxiii.	Chittle forceps		
xxiv.	Foot step		
xxv.	Emergency Light		
xxvi.	Dressing drum		
xxvii.	Dressing trolley		
xxviii.	Infant tray		
xxix.	Gallies Pads		
xxx.	Movable curtains		
xxxi.	IV stand		
xxxii.	Foetoscope		
xxxiii.	Inj. MgSO4		
xxxiv.	Tab. Mesoprostral		
xxxv.	Ambu bag & masks (neonatal size)		
xxxvi.	Pedal Suction		
xxxvii.	Mucus Sucker		
xxxviii.	New born corner		

35. Skill Assessment

S.no.	Topic	Knowledge	Performing
1.	Hand Washing steps	Correct/ Incorrect	Yes/ No
2.	Measuring BP • Systolic • Diastolic	 Correct/ Incorrect Correct/ Incorrect	 Yes/ No Yes/ No
3.	Weight Taking	Correct/ Incorrect	Yes/ No
4.	Hb Estimation	Correct/ Incorrect	Yes/ No
5.	Urine Examination • Sugar • Albumin	 Correct/ Incorrect Correct/ Incorrect	 Yes/ No Yes/ No
6.	Counselling Skills	Correct/ Incorrect	Yes/ No
7.	Abdominal grips • Fundal • Lateral • Pelvic • Pawlic	 Correct/ Incorrect Correct/ Incorrect Correct/ Incorrect Correct/ Incorrect	 Yes/ No Yes/ No Yes/ No Yes/ No
8.	PV Assessment	Correct/ Incorrect	Yes/ No
9.	Plotting Partograph	Correct/ Incorrect	Yes/ No
10	Fetal Heart Rate	Correct/ Incorrect	Yes/ No
11	Conducting Deliveries	Correct/ Incorrect	Yes/ No
12	ANC visits per pregnant woman	1/2/3/4	1/2/3/4
13	Active mgmt of 3rd stage of labour	Correct/ Incorrect	Yes/ No

Observations and Comments (can also give in Hindi)
……
……
Name of observer
Designation……District ……
Mobile Number ……
Email id. ……
Observation in the month of……
Date of observation……
Distance from city (observer's head-quarter)……kms.

Signatures

Village Health and Nutrition Day (MCHN day):

The VHND is to be organized once every month (preferably on Wednesdays and for those villages that have been left out, on any other day of the same month) at the AWC in the village

On the appointed day, ASHAs, AWWs, and others will mobilize the villagers, especially women and children, to assemble at the nearest AWC

Services to be provided:

1. All pregnant women are to be registered.
2. Registered pregnant women are to be given ANC.
3. Dropout pregnant women eligible for ANC are to be tracked and services are to be provided to them.
4. All eligible children below one year are to be given vaccines against six Vaccine-preventable diseases.
5. All dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated.
6. Vitamin A solution is to be administered, to children.
7. All children are to be weighed, with the weight being plotted on a card and managed appropriately in order to combat malnutrition.
8. Anti-TB drugs are to be given to patients of TB.
9. All eligible couples are to be given condoms and OCPs as per their choice and referrals are to be made for other contraceptive services.
10. Supplementary nutrition is to be provided to underweight children.

Issues to be discussed with the community:

1. Danger signs during pregnancy
2. Importance of institutional delivery and where to go for delivery
3. Importance of seeking post-natal care
4. Counseling on ENBC
5. Registration for the JSY
6. Counseling for better nutrition
7. Exclusive Breastfeeding
8. Weaning and complementary feeding
9. Care during diarrhea and home management
10. Care during acute respiratory infections
11. Prevention of malaria, TB, and other communicable diseases
12. Prevention of HIV/AIDS
13. Prevention of STIs
14. Importance of safe drinking water
15. Personal hygiene
16. Household sanitation
17. Education of children
18. Dangers of sex selection
19. Age at marriage
20. Information on RTIs, STIs, HIV and AIDS
21. Disease outbreak
22. Disaster management

Identification of cases that need special attention:

1. Identify children with disabilities.
2. Identify children with Grade III and Grade IV malnutrition for referral
3. Identify severe cases of anemia.
4. Identify pregnant women who need hospitalization.
5. Identify cases of Malaria, TB, leprosy, and Kala Azar.
6. Identify problems of the old and the destitute.
7. Pay special attention to the SC, ST, the minorities, and the weaker sections
8. Reproductive & Child Health Program(RCH)

Collection of data:

1. Compile data on the number of children with special needs, particularly girl children with disabilities.
2. Report outbreaks of disease.
3. Report/audit deaths of children and women.
4. Compile data pertaining to the SCs, the STs, the minorities, and weaker sections of society that need services.

Check List:

1. **ASHA**

   Actions to be taken before the Village Health and Nutrition Day:

   a. Visit all households and get to know all the families. Make it a point to visit all poor households, especially SC/ST families.
   b. Make a list of pregnant women.
   c. Make a list of women who need to come for ANC for first time or for repeat visits.
   d. Make a list of infants who need immunization, were left out or dropped-out.
   e. Make a list of children who need care for malnutrition.
   f. Make a list of children who were missed during the pulse polio round.
   g. Make a list of children with special needs, particularly girl children.
   h. Make a list of TB patients who need anti-TB drugs.
   i. Coordinate with the AWW and the ANM.

   On the day:

   a. Ensure that all listed women come for services.
   b. Ensure that all listed children come for services.
   c. Ensure that malnourished children come for consultation with the ANM.
   d. Ensure supplementary nutrition to children with special needs.
   e. Ensure that all listed TB patients collect their drugs.
   f. Assist the ANM and the AWW.

2. **AWW**

   a. Ensure that the AWC is clean.
   b. Ensure availability of clean drinking water during the VHND.
   c. Ensure a place with privacy at the AWC for ANC.
   d. Keep an adequate number of MCH cards.
   e. Coordinate activities with the ASHA and the ANM.

3. **ANM**
    a. Ensure that the VHND is held without fail. Make alternative arrangements in case the ANM is on leave.
    b. Ensure that the supply of vaccines reaches the site well before the day's activities begin.
    c. Ensure that all instruments, drugs, and other materials as listed in the annexure are in place.
    d. Carry communication materials.
    e. Ensure that adequate money is available for disbursement to the ASHA.
    f. Ensure reporting of the VHND to the MO in charge of the PHC.
    g. Coordinate with the ASHA and the AWW.

4. **PRIs**
    a. Ensure that the members of the VHSC are available to support the sessions.
    b. Ensure participation of schoolteachers and PRI members.
    c. Ensure availability of clean drinking water, proper sanitation, and convenient approach to the AWC for participating in the VHND by all.

Service Package:

1. Maternal Health
2. Early registration of pregnancies.
3. Focused ANC.
4. Referral for women with signs of complications during pregnancy and those needing emergency care.
5. Referral for safe abortion to approved MTP centres.
6. Counseling on:
7. Education of girls.
8. Age at marriage.
9. Care during pregnancy.
10. Danger signs during pregnancy.
11. Birth preparedness.
12. Importance of nutrition.
13. Institutional delivery.
14. Identification of referral transport.
15. Availability of funds under the JSY for referral transport.
16. Post-natal care.
17. Breastfeeding and complementary feeding.
18. Care of a newborn.
19. Contraception.
20. Organizing group discussions on maternal deaths, if any; that have occurred during the previous month in order to identify and analyze the possible causes.

Child Health:

Infants up to 1 year:

1. Registration of new births.
2. Counseling for care of newborns and feeding.
3. Complete routine immunization.
4. Immunization for dropout children.
5. First dose of Vitamin A along with measles vaccine.
6. Weighing.

Children aged 1-3 years:

1. Booster dose of DPT/OPV.
2. Second to fifth dose of Vitamin A.
3. Tablet IFA - (small) to children with clinical anemia.
4. Weighing.
5. Provision of supplementary food for grades of mild malnutrition and referral for cases of severe malnutrition.

All children below 5 years:

1. Tracking and vaccination of missed children by ASHA and AWW.
2. Case management of those suffering from diarrhea and Acute Respiratory Infections.
3. Counseling to all mothers on home management and where to go in even of complications.
4. Organizing ORS depots at the session site.
5. Counseling on nutrition supplementation and balanced diet.
6. Counseling on and management **of worm infestations.**

Family Planning

1. Information on use of contraceptives.
2. Distribution - provision of contraceptive counseling and provision of non-clinic contraceptives such as condoms and OCPs.
3. Information on compensation for loss of wages resulting from sterilization and insurance scheme for family planning.

Reproductive Tract Infections and Sexually Transmitted Infections

1. Counseling on prevention of RTIs and STIs, including HIV/AIDS, and referral of cases for diagnosis and treatment.
2. Counseling for premenopausal and post-menopausal problems
3. Communication on causation, transmission, and prevention of HIV/ AIDS and distribution of condoms for dual protection.
4. Referral for VCTC and PPTCT services to the appropriate institutions.

Sanitation

1. Identification of households for the construction of sanitary latrines
2. Guidance on where to go and who to approach for availing of subsidy for those eligible to get the same under the Total Sanitation Campaign.
3. Avoidance of breeding sites for mosquitoes.
4. Mobilization of community action for safe disposal of household refuse and garbage.

Communicable Diseases

1. Group communication activities for raising awareness about signs and symptoms of leprosy, suspected cases, and referrals.
2. Group communication activities for elimination of breeding sites for mosquitoes, management of fever cases, i.e. importance of collection of blood film for MP and presumptive treatment.
3. Awareness generation about symptoms of TB (coughing for more than three weeks), importance of continued treatment, referral of symptomatics for sputum examination at the nearest health centre.
4. Provision of anti-TB drugs to patients.
5. Reporting of unusual numbers of cases of any disease or disease outbreak in village.

Gender

1. Communication activities for prevention of pre-natal sex selection, illegality of pre-natal sex selection, and special alert for one-daughter families.
2. Communication on the Prevention of Violence against Women, Domestic Violence Act, 2006.
3. Age at marriage, especially the importance of raising the age at marriage for girls.

AYUSH

1. Home remedies for common ailments based on certain common herbs and medicinal plants like tulsi found in the locality.
2. Information related to other AYUSH components, including drugs for treating conditions like anemia.

Health Promotion

1. Chronic diseases can be prevented by providing information and counseling on:
2. Tobacco chewing
3. Healthy lifestyle
4. Proper diet
5. Proper exercise

Nutrition

Diseases due to nutritional deficiencies can be prevented by information and counseling on:

1. Healthy food habits.
2. Hygienic and correct cooking practices.
3. Checking for anemia, especially in adolescent girls and pregnant women; checking, advising, and referring.
4. Weighing of infants and children.
5. Importance of iron supplements, vitamins, and micronutrients
6. Food that can be grown locally.
7. Focus on adolescent pregnant women and infants aged 6 months to 2 years.

Who Are Needed

1. ASHA
2. AWW
3. PRI member
4. Helper of AWW
5. Staff to come from outside the village
6. ANMs
7. Male MPW (if available)
8. ASHA facilitators (if available)

Instruments and Equipments:

1. Weighing scale-adult, child
2. Examination table
3. Bed screen/curtain
4. Hemoglobin meters, kits for urine examination
5. Gloves
6. Slides
7. Stethoscope and blood pressure instrument

8. Measuring tape
9. Foetoscope
10. Vaccine carrier with ice packs

If these items are not available, their provision could be arranged by using the untied fund of Rs 10,000/- available with the ANM or with the VHSC.
These items should be kept under the safe custody of the ANM/ AWW/ASHA

Supplies:

1. Vaccines,
2. Medicines-
    a. IFA tablets,
    b. Vitamin A,
    c. **Cotrimoxazole**
    d. Anti-helminthic drug
    e. Chloroquin
    f. Anti-TB drugs
    g. Paracetamol
3. Stains for fixing BF
4. condoms, OCPs, (ECPs), ORS,
5. AD syringes in sufficient quantity
6. IEC material for communication and counseling

Supervisory Checklist:

(To be used by the different cadres of supervisors during visits to the VHND sites)

1. General information: Session site, availability of staff, timings displayed
2. Cold chain: Vaccine carrier with ice packs, VVM's status on vaccine vials
3. Availability of essential supplies in adequate quantities
4. Procedure of vaccination, especially injection safety
5. Availability of communication and counseling materials
6. Record review for
    i. Women and children from vulnerable communities
    ii. Immunization for children scheduled to arrive
    iii. Follow-up activities for ANC
    iv. Blood films collected for MP
7. Disposal of AD syringes
8. Client satisfaction: Exit interviews with some clients about the dates of repeat visits for immunization, birth preparedness, and the institution identified for delivery
9. Disbursement of incentives to ASHA for mobilizing clients to get immunization.

MCHN Week- Guidelines

1. Urban strategy:
Focus will be on recognized urban slums. RCH officer will be the nodal officer for urban slums in the district. Deputy CMHOs will be the nodal officers for urban slums in their own areas.

a. **Sites for vaccination:**

Anganwadi centers, schools and urban dispensaries will be the sites for vaccination. In addition, private clinics identified under PPI will also be used as session sites. For scattered slums, mobile vans could be used to cover all families.

b. **Team:**

Each team should have on vaccinator (staff skilled in immunization and authorized to provide immunization) and 2-3- social mobilizers (to mobilize children and women, control crowd and support recording)

Vaccinator can be drawn from the following:

- ANMs of the revamping scheme.
- Nursing staff of the dispensaries.
- Nursing staff/ ANMs posted at the district headquarters.
- ANMs/ LHVs of the nearest CHC
- Trained MPWs
- Social mobilizers: Social mobilizers will be drawn from the following: AWWs, workers of local NGOs, other women residing in that area.

c. **Timing:**

Sessions will begin at 10:00 am not more than two sessions should be conducted per day. Timings of each session should be clearly identified and communicated to the community.

2. Rural Strategy:

Each PHC will be the planning unit. Medical officer will be the overall in Charge.

a. **Team:**

Vaccinators:All the ANMs and LHVs will form the PHC team. When required, additional vaccinators could be deployed from neighboring PHCs where activities are not planned. Social mobilizers: In each village, ANM/LHV will identify 1 mobillizer (AWW, Sahyogini, ASHA: if none of these are available, identify another local woman)

b. **Sites:**

Sub- center, Anganwadi, school, panchayat ghar. For remote hamlets, a site as close to the hamlets as possible should be identified. For scattered hamlets, mobile teams should cover the populations.

Remember: Conduct the MCHN session as scheduled on Thursdays

3. Conducting a Session

a. **Timing:**

10:00 am to 05:00 pm. If two sessions are planned, conduct sessions from 10-1 pm and 2:00 to 05:00.

b. **Informing families and mobilizing children:**

One day prior to the session, social mobilizer should be requested to conduct house-to house canvassing ans community line-listing to identify all eligible children and pregnant women.

c. **Preparing the vaccine and logistics:**

Cold chain handler at the PHC will be vaccine- carrier as per the requirements specified in the PHC plan, and label each vaccine- carrier.

d. **Transporting vaccines, logistics and staff:**

One vehicle will be hired at the vaccine depot for transporting vaccines, logistics and manpower to the session- site. Vehicle will leave the vaccine depot at 07:00 am so as to

cover all the session sites by 10:00 am. If all session- sites cannot be reached in three hours due to large distance/ inaccessibility, another vehicle may be hired.

e. **Supervising:**

Supervisor (LHV and or MO) will monitor the sessions using the monitoring Checklist using the same vehicle after dropping the vaccines and logistics. In the evening, same vehicle will return to the vaccine depot, collecting all the vaccine carriers and dropping back the staff.

Outcomes:

The organization of the Village Health and Nutrition Day on a regular basis as per the guidelines will result in the achievement of the following outcomes:

1. Hundred per cent coverage with preventive and promotive interventions, especially for pregnant women, children, and adolescents
2. Preventive and promotive coverage for the National Disease Control Programs
3. Increased awareness about the determinants of health such as nutrition, sanitation, timely care.
4. Improved knowledge about the services offered under the various Nutritional Health Programs.
5. Greater emphasis on the community's role in making the health system responsive to the health needs of the community and in demanding and ensuring accountability.

Interpersonal Communication & BCC

The National Rural Health Mission accords priority to BCC (Behavior Change Communication) interventions as a mechanism for achieving its goals.

The State PIP for Rajasthan has identified the "lack of a state specific integrated BCC strategy and implementation plan" as a key area for strategic input. It is also required to undertake the regular research and evaluation studies for BCC interventions.

Uttar Pradesh is one of the first states in India to initiate the process of development of a state level comprehensive BCC strategy for NRHM. Similar efforts need to be initiated in Rajasthan also where the past experiences of IEC Bureau need to be revived

The BCC strategy seeks to address the following gaps in BCC services in the state –

1. lack of a coordinated BCC effort across and within national programs;
2. lack of decentralized BCC planning at the district, block and village levels
3. lack of behaviorally focused, socio-culturally driven BCC approaches and
4. an excessive focus on electronic mass media without large scale community based Activities
5. Rajasthan is largely rural, with a high level of non-literacy in women.
6. Strategy focuses on community based approaches while using mass media to create an enabling environment. Community based approaches to BCC include home visits, group meetings and working with existing local structures and community groups.

Communication is a process of "convergence"

"Communication is a process in which participants create and share information with one another in order to reach a mutual understanding" "Mutual understanding builds the foundation for mutual agreement, which in turn makes collective action possible. Effective communication begins with the audience and continues over time as a process of mutual understanding and convergence.

The main difference between IEC (information education and communication) and BCC is that while IEC is more one-way and focused on "messages", BCC is more "outcome oriented" and also includes the role of participatory methods and motivation in the behavior change process.

IEC is based on the implicit assumption that awareness creation will automatically lead to behavior change. Hence the emphasis of IEC is on "creating messages", entertainment and media.

Behavior Change Communication

BCC is a research-based, consultative process of addressing knowledge, attitudes, and practices through identifying, analyzing, and segmenting audiences and participants in programs and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass media channels, including participatory methods.

What is Behavior Change Communication

BCC is about changing specific behaviors – "well defined actions at the household, community and health service levels". BCC approaches recognize that behavior change is more about identifying the causes and barriers to behavior change and overcoming the barriers.

It is about understanding the communities, contexts and environments in which behavior occur. BCC is also about using persuasive techniques to demand health rights and to make public sector health services available and accessible to the neediest. BCC is about integrating new practices into long standing social, cultural and communication systems.

Communication process:

In the process of communication the message has to have the following attributes-

1. Command Attention
2. Cater to the Heart and Head
3. Clarify the Message
4. Communicate a Benefit
5. Create Trust
6. Convey a Consistent Message
7. Call for Action

For example- Small family is happy family, Buy one, get one free, Small is beautiful, No substitute for hard work, Team works, Together everyone achieves more.

Difference between IPC and Mass communication:

S.No.	Characteristics	IPC	Mass communication
1	Nature	Personal	Impersonal
2	Reach	Very Slow	Very Fast
3	Audience	Specific	General
4	Message	Focused	Generalized
5	Purpose	Help Take Decisions	Create Awareness/Sensitize
6	Cost Effectiveness	Very Expensive	Cheap
7	Feed Back	Instant	Delayed
8	Support of Other Media	It Becomes More Effective	Supplements Each Other
9	Retention of Message	For a Long Time/till Adoption of an Idea	for a Short Time

How to Initiate Inter-Personal Communication

1. Proper introduction of yourself/revealing your identity and explaining the purpose of your visit.
2. Establish mutual understanding of each other
3. Allow the audience to speak more and facilitate
4. Win the confidence of the audience.
5. Understand his/her problems in proper perspectives
6. Analyze whether your interest and his/her problems are the same or different.
7. If same, your task becomes simpler, otherwise, you need to take up your interest in the second phase
8. Do not make falls promises/pose yourself

How to terminate IPC

1. Leave good impression of yourself
2. Have issues for next meeting
3. Identify contact people/influencers
4. Should become one among the audiences/sense of belongingness
5. Give an opportunity for the audiences to come with their real problems

Skills required for IPC

1. Keep your mind open
2. Be flexible
3. Find area of interest
4. Listen to ideas
5. Judge content, not delivery
6. Resist distractions
7. Hold your fire
8. Work at listening
9. Capitalize on thought speed
10. Face the audience
11. Maintain eye contact
12. Use appropriate aids, if you can
13. Use appropriate language
14. Focus on the needs of the audience
15. Be brief and to the **point without having any ambiguity**
16. Understand the audiences profile first – their need, interest, culture, socio-economic status, religious beliefs etc.
17. Put questions in such a way the audience understand and reply favorably
18. Start questions from simpler to complex
19. Do not put questions in such a way which may embarrass you – the way you ask questions is important

Developing BCC strategy

First need to understand the BCC Gaps-

To develop the BCC strategy and action plan first need is to identify the Gaps and resources available to address these BCC gaps through different interventions. Following areas may be consulted to identify the BCC gaps

1. Status of BCC supervision at the state, district, block & village levels
2. Status of capacity for planning and Implementing BCC programs at different level
3. Status of community based BCC inputs
4. Status of mass media campaigns
5. Capacity in the state to implement BCC programs at scale
6. Understanding of health personnel in the state on “BCC”

The situational analysis can help to indicate the health scenario in Rajasthan: For example

1. Infant and child mortality rates.
2. Infant mortality rates are higher in young mothers (< 20 years) compared to women 20-29yrs.
3. maternal mortality ratio
4. Maternal coverage in terms of antenatal care, institutional deliveries and postnatal care
5. contraceptive use by eligible couples (Current CPR)
6. Unmet need of contraceptives
7. New born care practices are another area where there is scope for improvement
8. Anemia levels in women and in children ages 6- 36 months.
9. TB rates in state

Selection of Priority Behaviors & BCC Barriers Analysis

There are about 10 National Health Programs under the NRHM umbrella ranging from maternal health to blindness control. This BCC strategy proposes a two-pronged approach to circumvent the dilemma of addressing too many care seeking and household behaviors at one time. The approach includes:

1. The selection of priority behaviors for mass promotion and
2. Addressing specific behaviors through interpersonal communication (IPC) and community based BCC approaches.

Priority Areas for BCC Strategy

The priority areas for BCC focus within NRHM based on the situational analysis of Rajasthan are:

1. Antenatal Care
2. Institutional Deliveries
3. Post Natal & New Born Care
4. Married Adolescents
5. Gender discrimination (female feticide, infant girl, under 5 girl, son preference and
6. therefore large family size)
7. Unmet need for family planning
8. Nutrition through the life cycle (infant, under three, adolescent, woman)
9. Routine immunization
10. Hygiene and safe water practices
11. Marginalized groups and households including urban poor
12. Need for supportive supervision of ASHAs
13. Capacity building of BCC skills for service providers across NRHM
14. Workload definition and structuring of workload for the ASHAs

BCC Barriers Analysis:

The behavioral analysis for health care can indicate at common themes related to behavioral barriers. Behaviors in the household and/or community are not dependent on health services. These include hygiene, nutrition, new born care related behaviors.

Barriers related to health providers and health services are another common theme. These barriers range from lack of regular outreach and other health services to low motivational levels and low community accountability of the service provider.

Priority Behavior for BCC Campaigns	
Core Trigger Behavior	
1	Age at marriage > 18 yrs; Delay first pregnancy till 21 years for girls
2.	Eat three times a day (women and adolescent girls); eat 3-4 times a day (pregnant women)
3.	Early registration <12 weeks; 3 ANC check ups
4.	Institutional Delivery; Stay in the hospital for 24 hrs after delivery
5.	Immediate health seeking behavior on recognition of danger signs in mother and newborn
6.	Immediate and exclusive breast feeding within one hour of birth and continue exclusive breast feeding up to six months
7.	Keep the newborn warm with skin to skin care
8.	Complete Immunization/ Booster / Vit A
9.	Complementary feeding from six months 4-5 times a day in addition to breast feeding

10.	Wash hands with soap after defecation and prior to feeding child under three years
11.	Increase birth interval to three years
12.	Adopt any limiting method after two children even if both are girls
13.	Early detection of TB
14.	Empty and dry water containers once a week

Barriers to Behavior Change:
Socio-Cultural Barriers • Gender discrimination; son preference • Norm of early child bearing/early marriage • Colostrum feeding & other new born care practices • Dietary pattern of eating two meals a day, women eat last
Health Services • Lack of regular outreach services at the village level • Health provider attitude and low motivation levels • Lack of trust in public sector services
Socio-Economic and Infrastructure • Transport constraints • Households with food insecurity
BCC • Too much focus on awareness creation • Limited reach of mass media in rural areas • Weak systems for BCC supervision • Community based BCC (IPC, group meetings, community events) is limited • Uncoordinated mass media campaigns

BCC Strategy for NRHM in Rajasthan

The core strategic input for the NRHM BCC strategy should be focused around interpersonal communication (IPC) and community level BCC activities. This in turn will be supported by mass media and community mobilization interventions.

BCC Interventions

The NRHM BCC interventions required to be initiated at various levels such as:

1. State
2. Facility/institution
3. Local/village-slum
4. Household/family

These interventions are linked together by a common strategic plan. However interventions at the household and facility levels will provide need based BCC that will include a much larger set of behavior.

State Level

1. Airing TV, radio spots, health related serials etc.,
2. Celebration of health days,

3. Implementing mass campaigns, ranging from 3-4 months to 1 week, (initiating use of alternate media such as cell phones using SMS campaigns and contests)
4. Political & Media Advocacy
5. Use of outdoor media such as bus and auto-rickshaw panels, hoardings etc.

Facility/Institution

BCC interventions at health facilities and schools can be implemented through counseling sessions organized by a trained professional health worker – patient counselor, teacher, ANM or Male Health worker. He /she should be equipped with audio visual tools for counseling. BCC areas to be prioritized such as-

1. Maternal & Child Health,
2. Family Planning and
3. National Programs TB Malaria, or any other focused program
4. Postnatal care of mother,
5. new born care and family planning to JSY beneficiaries at the PHC

Community Based BCC Interventions

1. Community level BCC interventions include-
2. Group meetings, VHND,
3. community notice boards,
4. use of short films, “CD Spots” etc.

Household/Family Level (Interpersonal Communication)

1. Home visits by ASHA to eligible women and pregnant women.
2. An IPC (interpersonal communication) tool for maternal and newborn health can be suggested to enable ASHAs to do need specific BCC at the household level.
3. Other household level BCC interventions include child to community approaches and promoting couple and family communication

Interpersonal Communication (IPC) & Community Level BCC Activities

Health related behavior can be divided into two broad sets. One within the microenvironment of the home e.g. hygiene and dietary behavior; condom use, oral pill use etc.; the other which requires contact with the health delivery system e.g. antenatal checkups, routine immunization, sputum testing.

Behavior occurring within the micro-environment of the household can be changed irrespective of the availability or accessibility of health services[26]. In the case of health seeking behavior, government health services have to be made accessible, available and of good quality, for people to use them consistently and BCC needs to address health service barriers.

Why IPC & Community Level BCC Approaches?

A total of 18 contacts with mother and child over five years (3 contacts per year) can **“deliver effective child survival interventions, almost entirely through community based and outreach delivery efforts”**.

This BCC strategy proposes changing household level behavior through focused community based interventions at the community, group and household levels in addition to mass media inputs.

The proposed community based BCC activities are:

1. MCHN Day
2. Home visits by ASHA to offer need specific BCC.
3. Group meetings by ASHA and ANM on specific topics
4. Swasthya Camps at the block level with video vans (Pilot basis)
5. Child to community BCC for hygiene behavior, routine immunization and prevention of
6. Mosquito breeding sites
7. Folk performances and Nukkad Nataks

Integrated Disease Surveillance Project

The Government of India is initiating a decentralized, state based Integrated Disease Surveillance Project (IDSP) in the country in response to a long felt need expressed by various expert committees. The project would be able to detect early warning signals of impending outbreaks and help initiate an effective response in a timely manner. It is also expected to provide essential data to monitor progress of on going disease control programs and help allocate health resources more optimally.

Objectives

The project development objective is *to improve the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors*. Specifically, the project aims at:

1. To establish a decentralized state based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the country at the state and national level.
2. To improve the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.

The project will assist the Government of India and the states and territories to:

1. Surveil a limited number of health conditions and risk factors;
2. Strengthen data quality, analysis and links to action;
3. Improve laboratory support;
4. Train stakeholders in disease surveillance and action;
5. Coordinate and decentralize surveillance activities;
6. Integrate disease surveillance at the state and district levels, and involve communities and other stakeholders, particularly the private sector.

Components

Component 1. Establish and Operate a Central-level Disease Surveillance Unit.

Under this component, Ministry of Health and Family Welfare (MOHFW) will establish a new Disease Surveillance Unit at the central level to help coordinate and decentralize disease surveillance activities. The new unit will support and complement the states' disease surveillance efforts. The unit will be staffed by existing permanent staff reassigned from within the MOHFW. This component will address the constraints of lack of coordination despite central control of surveillance activities and the need for changing the diseases included in the system. Effective coordination (as compared to control) of disease surveillance activities depends on establishing the appropriate processes and institutional arrangements at the central level. This will be done through the creation of a small disease surveillance unit to support the states disease surveillance efforts.

Component 2. Integrate and strengthen disease surveillance at the state and district levels.

This component addresses the constraints imposed by lack of coordination at the sub-national levels, the limited use of modern technology and data management techniques, the inability of the system to act on information and the need for inclusion of other stakeholders. It will integrate and strengthen disease surveillance at the state and district levels, and involve communities and other stakeholders, in particular, the private sector.

Component 3. **Improve laboratory support.** This component will consist of:
(i) upgrading laboratories at the state level, in order to improve laboratory support for surveillance activities. Adequate laboratory support is essential for providing on-time and reliable confirmation of suspected cases; monitoring drug resistance; and monitoring changes in disease agents;
(ii) introducing a quality assurance system for assessing and improving the quality of laboratory data.

Component 4. **Training for disease surveillance and action.** The changes envisaged under the first three components will require a large and coordinated training effort to reorient health staff to an integrated surveillance system and provide the new skills needed. Training programs will include representatives from the private sector, NGOs and community groups.

Project Highlights

1. It will monitor a limited number of conditions based on state perceptions including 13 core and 5 state priority conditions for which pubic health response is available.
2. District, State & Central Surveillance units will be set up so that the program is able to respond in a timely manner to surveillance challenges in the country including emerging epidemics.
3. It will integrate surveillance activities in the country under various programs and use existing infrastructure for its function.
4. Private practitioners / Private hospitals / Private laboratories will be inducted into the program as sentinel units.
5. Active participation of medical colleges in the surveillance activities.
6. The project will ensure uniform high quality surveillance activities at all levels by
   a. Limiting the total number of diseases under surveillance and reducing overload at the periphery
   b. Developing standard case definitions
   c. Developing formats for reporting
   d. Developing user friendly manuals
   e. Providing training to all essential personnel, and
   f. Setting a system of regular feed back to the participants on the quality of surveillance activity.
7. District Public Health Laboratory will be strengthened to enhance capacity for diagnosis and investigations of epidemics and confirmation of disease conditions.
8. Use of information technology for communication, data entry, analysis, reporting, feedback and actions. A national level surveillance network will be established up to the district level.

Diseases conditions under the surveillance program

(i) ***Regular Surveillance***:

Vector Borne Disease	: 1. Malaria
Water Borne Disease	: 2. Acute Diarrhoeal Disease (Cholera)
	: 3. Typhoid
Respiratory Diseases	: 4. Tuberculosis
Vaccine Preventable Diseases	: 5. Measles
Diseases under eradication	: 6. Polio
Other Conditions	: 7. Road Traffic Accidents (Linkup with police computers)

Other International commitments	: 8. Plague
Unusual clinical syndromes	: 9. Menigo-encephalitis/Respiratory (Causing death / hospitalization) Dengue Hemorrhagic fevers, other undiagnosed conditions

(ii) ***Sentinel Surveillance***

Sexually transmitted diseases/Blood borne	: 10 HIV/HBV, HCV
Other Conditions	: 11 Water Quality
	: 12 Outdoor Air Quality (Large Urban centers)

(iii) ***Regular periodic surveys:***

NCD Risk Factors	: 13 Anthropometry, Physical activity, Blood Pressure, Tobacco, Nutrition, Blindness

(iv) ***Additional State Priorities:*** Each state may identify up to five additional conditions for surveillance.

Note : GOI may include in a public health emergency any other unusual health condition.
Project funds could be used for such emergencies and reimbursed by IDA subject to agreement at the next joint project review mission.

Phasing

Phase I (commencing from FY 2004-05)
Andhra Pradesh, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharashtra, Uttaranchal, Tamil Nadu, Mizoram & Kerala

Phase II (commencing from FY 2005-06)
Chhatisgarh, Goa, Gujarat, Haryana, Rajasthan, West Bengal, Manipur, Meghalaya, Orissa, Tripura, Chandigarh, Pondicherry, Delhi

Phase III (commencing from FY 2006-07)
Uttar Pradesh, Bihar, Jammu & Kashmir, Jharkhand, Punjab, Arunachal Pradesh, Assam, Nagaland, Sikkim, A & N Nicobar, D & N Haveli, Daman & Diu, Lakshdweep.

Key performance indicators:
Key aspects of overall performance of the surveillance system will be assessed using the following indicators:

1. Number and percentage of districts providing monthly surveillance reports on time – by state and overall;
2. Number and percentage of responses to disease-specific triggers on time - by state and overall;
3. Number and percentage of responses to disease-specific triggers assessed to be adequate - by state and overall;
4. Number and percentage of laboratories providing adequate quality of information – by state and center;
5. Number of districts in which private providers are contributing to disease information;
6. Number of reports derived from private health care providers;

7. Number of reports derived from private laboratories;
8. # and % of states in which surveillance information relating to various vertical disease control programs have been integrated
9. # and % of project districts and states publishing annual surveillance reports within three months of the end of the fiscal year;
10. Publication by CSU of consolidated annual surveillance report (print, electronic, including posting on the websites) within three months of the end of fiscal year.

IDSP Reporting

1. Form S (Suspect Cases) by Health Workers (Sub Centres)
2. Form P (Probable Cases) by Doctors (PHC, CHC, Hospitals)
3. Form L (Lab Confirmed Cases) from Laboratories

Frequency of reporting – weekly (Monday to Sunday)

Data compilation/analysis and response should be at all levels. Presently at State/District/Block level 12- 15 Outbreaks reported every week.

Expectations

By setting up a decentralized, action oriented, integrated and responsive program, it is expected that IDSP will avert a sufficient number of disease outbreaks and epidemics and reduce human suffering and improve the efficiency of all existing health programs. Such a program will also allow monitoring of resource allocation and form a tool to enhance equity in health delivery.

Year wise project costs:

Year	**Total**
2004-05	700.0
2005-06	880.0
2006-07	1020.0
Sub Total (X Plan)	**2600.0**
2007-08	840.0
2008-09	643.6
Sub Total (XI Plan)	**1483.6**
Grand Total	**4083.6**

Components-wise Project Costs	
Non-Recurring :	***Rs. in Millions***
Renovation & Furnishing	243.6
Laboratory Equipments	641.9
Computer Hardware & Accessories	432.6
Office Equipments	102.5
Application Software	220.0
Furniture & Fixtures	142.5
IEC Activities	360.1
Training of Personnel	204.3
Consultancy (Procurement, Software, Evaluation Studies etc)	158.6
Sub-total Non Recurring Costs	**2506.2**

Recurring (for 5 years):	
Laboratory consumables	310.5
Personnel Costs	561.2
Networking Costs	125.2
Operational & Maintenance Costs	580.6
Sub-total Recurring Costs	**1577.5**
Grand total	**4083.6**

New initiatives under IDSP

1. Alerts through IDSP call center

- Call Centre operational with 1075 toll free number since February 2008
- Call received as on 8th October 2008 : 18,872
- No. of Health Alerts : 60
- Led to detection of 5 outbreaks (Cholera, Acute Diarrhoeal Disease and Chickenpox)

2. e-learning

- The objective of e-learning is to enhance the skills to a wide arena of health personnel.
- Proposed components:
  - Discussion Forums
  - Online Survey & Assessment
  - Feedback
  - FAQs
- Currently e-learning modules are being prepared.

3. Media Scanning Cell

- Objective:
  - To provide the supplemental information about outbreaks
- Method:
  - National and local newspapers, Internet surfing, TV channel screening for news item on disease occurrence.
- Benefits of Media Scanning:
  - Increases the sensitivity & strengthen the surveillance system
  - Provide early warning of occurrence of clusters of diseases

Epidemic Preparedness and Outbreak Investigation

By and large the term outbreak and epidemics have been used interchangeably in public health for the thin line that differentiates the two. By definition epidemics refer to a situation which is clearly in excess to the normal expectation, often measured as endemic level. The outbreaks also could be defined based on the same, the only difference being that outbreaks hav a sudden onset meaning thereby that the diseases which qualify for outbreaks hav a relatively short incubation period.

The epidemic somehow, based on the epidemiological forecasting (we need data on endemic levels on a regular basis for such forecast) can often be managed with advanced preparedness but then the effective surveillance system has to be in place. Since the system needs to be prepared in advance it is imperative to understand the procedural details.

Why do outbreaks occur?

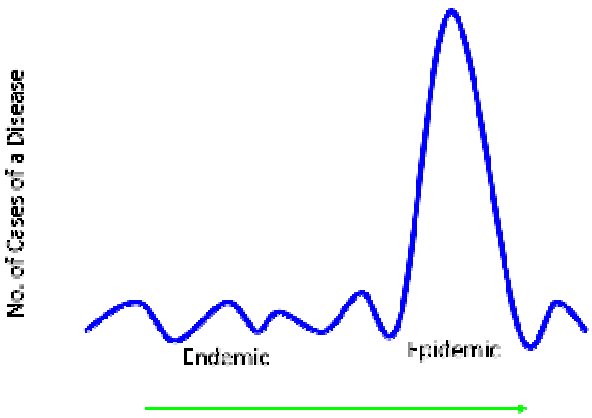
- Single lapse in infection control in hosp.
- Lapse in surveillance
- A hidden pocket of infection
- Smuggled animals
- Single volume of international air traffic
- Rapid mutation & Adoptation in microbial world
- Emergence of New risk groups
- Modes of transmission can change
- Drug resistance – effect on treatment and prophylaxis

Outbreak management....involves...

Anticipating, preventing, preparing for, detecting, responding and controlling disease outbreaks with the whole purpose of preventing or minimizing health and economic impacts of possible outbreaks

Why preparedness in advance?

- Emergencies caused by epidemics are frequent
- Epidemics require urgent action and
- Epidemics may often lead to panic if preparedness is not adequate
- Response can be delayed, with possibility of fast spread, and avoidable loss to human lives, and economy



Why Investigate?

- Control and prevention measures
- Knowledge of an agent
- Training
- Public concerns

Concepts in Outbreak Investigation

- Quantifying the epidemic (Descriptive epidemiology)
- Getting at the source (Analytic epidemiology)

Basic steps for communicable disease outbreak investigation

1. Preparation
    a. Health coordination meetings
    b. Use data from surveillance system

c. Review local directives or plans for each disease
d. Assemble your team –
    - Epidemiologist
    - Laboratory workers
    - Environmental health specialists
    - Local health department
e. Identify and contact Key community contacts
f. Arrange supplies, equipment
g. Sample questionnaires
h. Plans for isolation wards
i. Laboratory support

2. Detection
    a. Surveillance system with early warning system (EWS) for epidemic prone diseases.
        - Clustering of cases or deaths in time and/or space
        - Unusual increase in cases or deaths
        - Acute haemorrhagic fever
        - Severe dehydration following diarrohoea (usually with vomiting) in patients >5 years of age
        - Acute fever with altered sensorium
        - Acute fever with renal involvement
        - Acute flaccid paralysis in a child
        - Acute fever with painful lymphnodes
        - Acute febrile severe illness of unknown aetiology
        - Occurrence of two or more epidemiologically linked cases of meningitis
        - Even a single case of measles or any other epidemic prone diseases from a tribal or other poorly accessible area
        - Unusual isolates
        - Shifting in age distribution of cases
        - High vector density
        - Natural disasters
    b. Notify ministry of health and WHO in case of outbreaks of specific diseases.
    c. Take appropriate specimens (stool, CSF or serum) for laboratory confirmation.
    d. Include case in the weekly report.
3. Response
    a. Confirm the outbreak
        i. Determine if disease incidence is higher than background level
        ii. How do you determine background level? -surveillance
        iii. Reasons for Observed >Expected
            - Change in case definition
            - Change in reporting procedures
            - Increased awareness or interest
            - Improved diagnostics
            - New clinician
            - Change in Population
            - True increase
            - Activate the outbreak control team
            - Investigate the outbreak

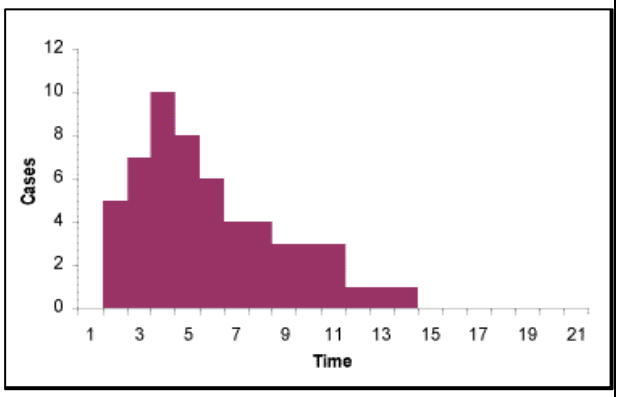
- Control the outbreak

b. Define and identify cases in terms of time, place and person distribution
c. Establish Case Definition and classify as confirmed, propable, suspect
d. Identify Population At Risk (that would serve as denominator to calculate attack rate)

4. Evaluation
   a. Assess appropriateness and effectiveness of containment measures.
   b. Assess timeliness of outbreak detection and response.
   c. Change public health policy if indicated.
   d. Write and disseminate outbreak report.

Epidemic Curves: Time

- Plot number of cases by onset date
- Index case: first case of outbreak
- Determine time course and future course, exposure period



Point Source Outbreaks

1. All exposed at one time
2. Cases occur suddenly after minimum incubation time
3. All cases occur within one incubation period
4. Outbreak stops unless secondary spread
5. Curves have steep upslope, more gradual down slope

Continuous Common Source

1. May begin suddenly or gradually
2. Does not have an early peak (v/s Point source)
3. Cases do not disappear because of secondary exposure
4. Curves have gradual or steep upslope, plateau trickling down slope, and may repeat

Propagated Outbreaks

- Typical of person-to-person outbreaks
- Secondary cases appear, at intervals corresponding to average incubation period after peak of first wave
- Taller successive waves of cases

Evaluate Hypothesis via Analytical Epidemiology

- Determine exposure variables. Compare ill to not ill.
- Construct a 2 X 2 table
- Perform Cohort or Case Control Study
- Use Cohort study when:
  - Population at risk is known
  - (you have a denominator)
  - Interview “ill” and “not ill”
  - Calculate attack rates - “ate” v/s “didn’t eat”
  - Put on food-specific attack rate table

Calculation of Attack Rate for Food "X"

Ate the food				Did not eat the food			
Ill	Well	Total	Attack Rate	Ill	Well	Total	Attack Rate
10	3	13	76%	4	7	11	64%

Attack Rate = Ill / (Ill + Well) x 100 during a time period

Attack rate = (10/13) x 100 = 76%

(4/11) x 100 = 36%

Calculating Risk Ratios

Attack rate of ill and exposed a/ (a+ b)

Attack rate of ill, not exposed c/ (c+ d)

A risk ratio of >1.0 means increased risk whereas RR 1.0 indicates no correlation, on the other hand if the RR is less than 1.0, it can be safely interpreted that the risk gets decreased on account of the factor present.

Additional Studies

Clinical Specimens

- Clinical Specimens
- Identifies agent and confirms cases
- Obtain results if already collected
- Collect specimens if necessary
- Type of specimen depends on suspected agent, nature of outbreak

Collect Clinical Specimens

- Specimens must be labeled with patient's name and collection date
- Indicate on form that specimen is related to investigation
- Submission form (s) must be completed and enclosed with specimen
- Local health department should collect and transport specimens to lab

Environmental Investigation

- Help explain why outbreak occurred
- Begins when suspected mode of transmission identified
- Identifies vehicle of transmission
- Samples: food, water, air

Implement Control Measures

Control Measures: (**Aim at weakest link in infection cycle of agent – host - environment)**

- Post-exposure prophylaxis/treatment
- Recalling/destroying food

- Providing educational information
- Closing an establishment
- Exclusion (work, daycare, school)
- Making public announcements

Possible control measures for different communicable diseases:

1. **ARI**
    a. Early recognition and treatment
    b. All children with cough carefully assessed
    c. Assess signs of malnutrition
    d. Refer severely malnourished to hospital
    e. Manage pneumonia with antibiotics
    f. Follow national treatment protocols
    g. Supportive measures
    h. Vaccination against measles, diphtheria and whooping cough
2. **Cholera**
    a. Prompt diagnosis and management
    b. Establish treatment centers with barrier nursing.
    c. Fecal material and vomit properly disinfected and disposed.
    d. Health Education on hygiene, safe water, safe food and hand washing.
    e. Funerals to be held quickly and near the place of death.Meticulous hand washing for those who handle the body.
    f. Promote washing hands with soap and water when food is being handled.
3. **Typhoid**
    a. Health education, clean water, food inspection, proper food handling and proper sewage disposal.
    b. Early detection and control are important in prevention of spread.
    c. Laboratory services are essential to know the outbreak strain and the anti microbial sensitivity pattern.
4. **Viral Hepatitis**
    a. Enforcement of water and food sanitation.
    b. For Hepatitis B and C, all blood products should be screened for the two (and for HIV).
    c. Vaccination of target population groups for Hepatitis A recommended.
5. **Diarrhea**
    a. Provision of safe water supply
    b. Supply of adequate quantities of reasonably clean water is more important than supply of small quantities of microbiologically clean water
    c. Food safety
6. **Conjunctivitis**
    a. personal hygiene and hand washing.
    b. Vector control measures to reduce fly population.
    c. Disinfect articles contaminated by nasal and conjunctival discharges.
    d. In health facilities vigorous hand washing to avoid cross contamination and proper disposal of infected material.
7. **Dengue**
    a. Eliminate habitats of Aedes mosquitoes.
    b. Personal protection against mosquito bites during day time (clothes, repellants).
    c. In an outbreak use larvicide on all potential habitats of Aedes aegypti.

d. Insecticides to reduce vector population.
e. Social mobilization to eliminate breeding sites.

8. Japanese Encephalitis (JE)

a. Personal protection against mosquito bites.
b. Screen the sleeping and living areas.
c. House pigs away from the living quarters.
d. Vaccines are available for travelers.
e. Vaccination of pigs and fogging with insecticide although effective are expensive.

9. Malaria

a. Rapid diagnosis and effective case management.
b. Use of insecticide treated nets.
c. Indoor Residual Spraying.
d. Chemo prophylaxis to non-immune expatriates and Intermittent Presumptive Therapy for pregnant women.

10. Measles

a. Routine vaccination
b. Measles outbreak response.
c. Mass vaccination with measles vaccine is priority in emergency situations. The ideal target population being 6 month to 14 years old although age groups from 6 months to four years is still acceptable.
d. Measles vaccine should be accompanied with vitamin A administration in children 9 months to 5 years of age.

11. Meningococcal Meningitis

a. Early detection and control of the outbreak.
b. Diagnosis and management of cases.
c. Mass vaccination
d. Highest risk group for meningococcal meningitis is children aged 2-10 years and this should be the priority group during vaccination campaigns.

12. Tuberculosis

a. Need for integration with the national TB control Program and involve local TB coordinators.
b. Use the national TB treatment protocols.
c. Cover the local population also.
d. Refer seriously ill patients to local hospitals.
e. Laboratory services for sputum smears.
f. Procedures in place for follow up of cases.
g. Program evaluation.

13. HIV/AIDS

a. Reduce sexual and mother to child transmission.
b. Ensure blood safety
c. Universal precautions to be used.
d. Physical protection especially of women and children.
e. Protect health care workers.
f. Counseling and voluntary testing programs.
g. Vaccination of asymptomatic HIV infected children with EPI vaccines.
h. Symptomatic HIV infected children should not be given BCG or yellow fever vaccine.

14. H1NI (Swine Flu)

a. Entry screening, aircraft disinsection, isolation of suspects, sample collection/transportation, contact tracing, quarantine, prophylaxis and case management
b. Active search for contacts and cases
c. PPEs use
d. Public health – mass prophylaxis
e. Social distancing, PPEs etc.
f. SOPs
    i. Self reporting on Sign and Symptoms of Swine Flu
    ii. Details for Contact Tracing
    iii. Examination of Suspect
    iv. Referral system for suspects
    v. Flight Disinsection
g. SOPs for confirmed cases
    i. Guidelines for the case and relatives
    ii. Movement & Visiting restrictions
    iii. Use of PPEs when required
    iv. Personal protective measures to be followed
    v. Food and other arrangements at the facility
    vi. Watch for symptoms and complications
    vii. Treatment with Tamiflu
    viii. Prophylaxis for immediate contacts
    ix. MOHFW guidelines to be followed for treatment and discharge
    x. Fumigation of the room and belongings
h. IEC for Communication
    i. Signs and symptoms
    ii. Risk groups
    iii. Transmission of outbreak
    iv. Risks of Late detection & late reporting
    v. Where to report, what to report
    vi. Health facilities available
    vii. Co-morbid conditions
    viii. Preventive health practices

Coordination and Communication during outbreak between

a. State/National and international
    - MOHFW
    - DGHS/DM&HS
    - National IHR focal point
    - JMG
b. Health Functionaries
c. National IHR focal points
d. Interdepartmental and intra-departmental
e. Mass Media
f. Public

Communicate Findings

Investigation Report

- Outlines investigation
- Write report

Purpose of Report

1. Prevent similar outbreaks
2. Identify trends/causal factors
3. Justify resources used
4. Serves as public record

Report Format

- Cover page in memo format
- Background
- Epidemiologic investigation
- Environmental assessment
- Laboratory results
- Conclusions

Media Calls

- Confirm investigation underway
- Provide only confirmed or statistically proven information
- Be careful mentioning businesses
- Never speculate or provide identifiers
- Remain calm and do not be rushed

Real-Life Examples

On June 30 2009, the local health officer of Jaipur, reported the occurrence of an outbreak of acute gastrointestinal illness to the District Health Officer. Dr.X, epidemiologist-in-training, was assigned to conduct an investigation. When Dr. X arrived in the field, he learned from the health officer that all persons known to be ill had attended a dinner at Hotel on June 30 2009. Family members who had not attended the Dinner had not become ill. Accordingly, the investigation was focused on the circumstances related to the supper. Interviews regarding the presence of symptoms, including the day and hour of onset, and the food consumed at the Dinner, were completed on 75 of the 80 persons known to have been present. A total of 46 persons who had experienced gastrointestinal illness were identified. The epidemiologist started questioning himself

1. Is this an Outbreak?
2. What might be the agent?
3. How is this agent transmitted?
4. What am I looking for?

Select the correct case definition and find the error in the others:

1. All Invitees in Dinner held in Hotel on June 30 2009between 8:00 PM and 11:00 PM; whether they attended Dinner or not; whether they participated in food preparation, transport, or distribution or not; whether they ate or not. **. Missing definition of sickness**
2. Persons who developed acute gastrointestinal symptoms within 72 hours of eating supper and who were among Invitees in Dinner held in Hotel on June 30 2009. **Correct definition**
3. Invitees who developed acute gastrointestinal symptoms within 24 hours of the Dinner held in Hotel on June 30 2009 between 8:00 PM and 11:00 PM **Does not specify whether the invitees went to the dinner**

The Dinner was held at Hotel. Food was prepared by Chefs of the Hotel. The Dinner began at 8:00 PM and continued until 11:00 PM. Food was spread out upon a table and consumed over a period of several hours. The food items served were: Baked Vegetable, Malai paneer , Dum Aaloo, Cabbage salad, Paneer Khumb, Raita, Raj bhog, Cream salad, Ice cream (van), Ice cream (choc) and Fruit salad

Which menu item (s) is the potential culprit? In order to find that, we need to calculate attack rates.

The foods that have the greatest difference in attack rates may be the foods that were responsible for the illness.

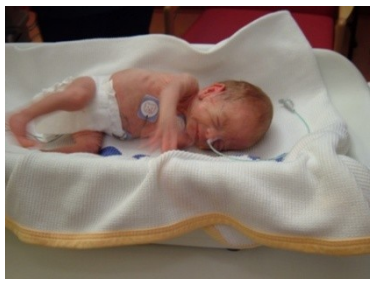
	Number of persons who ate specified item				Number of persons who did not eat specified item			
	Ill	Well	Total	Attack rate (%)	Ill	Well	Total	Attack rate %
Baked Veg.	29	17	46	**63**	17	12	29	**59**
Malai paneer	26	17	43	**60**	20	12	32	**62**
Dum Aaloo	23	14	37	**62**	23	14	37	**62**
Cabbage salad	18	10	28	**64**	28	19	47	**60**
Paneer Khumb	16	7	23	**70**	30	22	52	**58**
Raita	21	16	37	**57**	25	13	38	**66**
Raj bhog	2	2	4	**50**	44	27	71	**62**
Cream salad	27	13	40	**67**	19	16	35	**54**
Ice cream (van)	43	11	54	***80***	3	18	21	**14**
Ice cream (choc)	25	22	47	**53**	20	7	27	**74**
Fruit salad	4	2	6	**67**	42	27	69	**61**

And that brings the epidemiologist to the conclusion that vanilla ice cream (attack rate 80%) was the food that contributed to the illness.
This emphatically proves that for an outbreak investigation, following steps is a must

- Collect good descriptive data
- Be observant -- Be objective
- Keep Authority informed
- Be sure to collect data on both the “ill” and the “not ill”
- Ask for help
- Disease prevention

Only work in the field can uncover the way in which an *agent* links to a *host* in the real world (Environment) outside of the laboratory.
Jhon Snow discovered the ***waterborne*** route as a major mode of communication of disease, which turned out to apply not only to *cholera*, but also to *typhoid fever* and other infections.

Integrated Management of Neonatal and Childhood Illnesses (IMNCI)



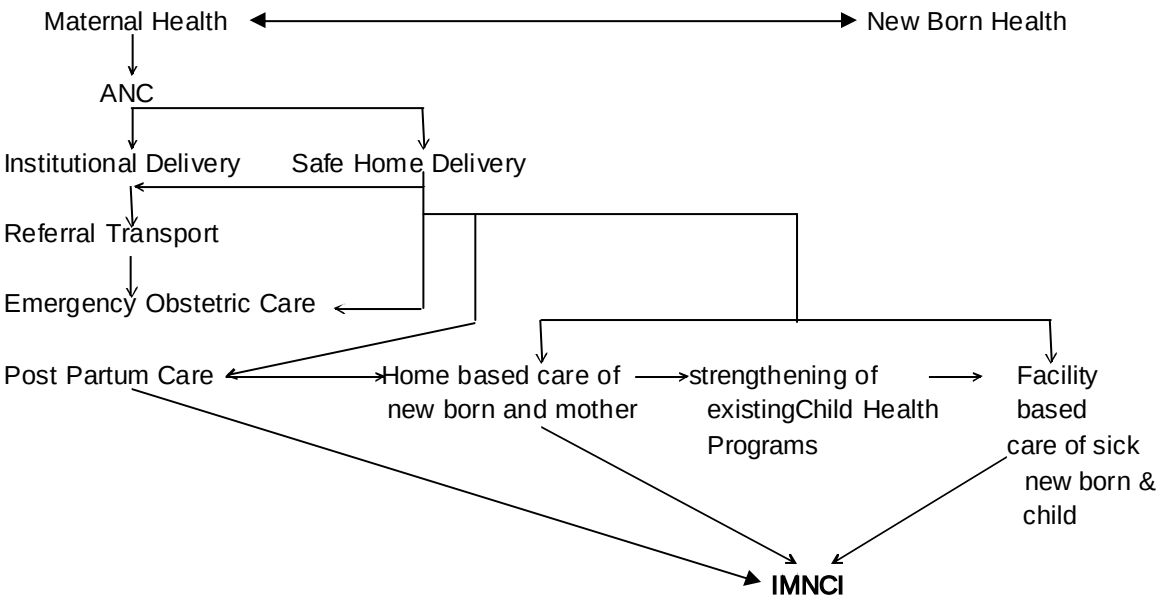
Child health programs/ schemes in India:

1978- Expanded Programme of immunization (EPI)
1984- Universal Immunization Programme (UIP) For prevention of deaths due to 6 VPDs
1985- Oral Rehydration Therapy Programme for prevention of deaths due to diarrhoea
1990- UIP and ORT universalized in all districts
1990- ARI Programme taken up as a pilot in 26 districts
1992- CSSM
1997- RCH-1
2005- NRHM and RCH II

Under RCH-II, various strategic approaches have been put in place to address child health, like-

Integrated Management of Neonatal and Childhood Illnesses **(IMNCI)**
Home Based Newborn and Childhood Care
Facility Based Care – SNCUs
Infant & Young Child Feeding & Nutrition Rehabilitation Centres
Micronutrient supplementation – Vitamin A & Iron folic acid

Conceptual frame work of Maternal and New born health under NRHM: Implementation of IMNCI in the districts has to be seen as part of the Child Health Strategy under the National rural health mission/Reproductive and Child Health Program- Phase II.



IMNCI

Bringing down Infant and Child Mortality Rates and improving Child Health & Survival has been an important goal of the Family Welfare Programs in India. During the period 1977 to 1992

programs like universal immunization program; oral rehydration therapy (ORT) program and program for prevention of deaths due to acute respiratory infections (ARI) were implemented as vertical programs. These programs were integrated in 1992 under the Child Survival and Safe Motherhood Programs and have continued to be a part of the Reproductive & Child Health Program implemented since 1997.

As a result of these efforts, the Infant Mortality Rate (IMR) has come down significantly over the years from 114 in 1980 to 53 in 2008(SRS bulletin, Oct. 2009)though the decline has not been uniform across all States over the years. 20 states have achieved the IMR goal of 2007, 10 have already achieved the goals laid for 2012 while 8 states including Rajasthan are below the national average.

It has to be remembered that malnutrition and low birth weight (LBW) are contributors to the about 50% deaths among infants and children under 5 years of age and post natal care has not received adequate attention until recently. According to NFHS-II Survey only 6% of recently delivered women were visited by a health worker during the first week of life. Efforts have therefore to be made during the coming years to ensure that the numbers of home visits during the post natal care are increased significantly.

WHO/UNICEF have developed a new approach to tackling the major diseases of early childhood called the Integrated Management of Childhood Illnesses (IMCI).

The IMNCI Package

	Generic IMCI	**India IMNCI**
0-6 days coverage	No	Yes (except care at birth)
Training days for newborn & YI care	2/11 (18%)	4/8 (50%)
Training sequence	Child → Newborn	NB/YI → Child
Home visits for newborn & YI	No	Yes
Home-based training	No	Yes

The package includes the following interventions:-

Care of Newborns and Young Infants (infants under 2 months)

1. Keeping the child warm.
2. Initiation of breastfeeding immediately after birth and counseling for exclusive breastfeeding and non-use of pre lacteal feeds.
3. Cord, skin and eye care.
4. Recognition of illness in newborn and management and/or referral).
5. Immunization
6. Home visits in the postnatal period.

Home visits are an integral part of this intervention. Home visits by health workers (ANMs, AWWs, ASHAs and link volunteers) help mothers and families to understand and provide essential newborn care at home and detect and manage newborns with special needs due to low birth weight or sickness.

Three home visits are to be provided to every newborn starting with first visit on the day of birth (day 1) followed by visits on day 3 and day 7. For low birth weight babies, 3 more visits (total of six visits) are to be undertaken before the baby is one month of age. The details of these visits are given in the training package.

In addition the opportunity of home visit is to be used for the care of mothers during the post-partum period. This will help mothers and families on how to recognize and manage minor conditions and will ensure timely referral of severe cases.

Care of Infants (2 months to 5 years)

1. Management of diarrhoea, acute respiratory infections (pneumonia) malaria, measles, acute ear infection, malnutrition and anemia.
2. Recognition of illness and at risk conditions and management/referral)
3. Prevention and management of Iron and Vitamin A deficiency.
4. Counseling on feeding for all children below 2 years
5. Counseling on feeding for malnourished children between 2 to 5 years.
6. Immunization

After neonatal period, IMNCI package is accessed by the family for their newborns/children from the health workers in the community (ANM, AWW, ASHA or link volunteer) or providers at the facility (PHC/CHC/FRU).

IMNCI Components and Intervention areas

Improve health worker skills	Improve health systems	Improve family & community prectices
Case management standards & guidelines	District & Block planning and management	Appropriate Care seeking
Training of facility-based public health care providers	Availability of IMNCI drugs	Nutrition
IMNCI roles for private providers	Quality improvement and supervision at health facilities – public & private	Home case management & adherence to recommended treatment
Maintenance of competence among trained health	Referral pathways & services	Community services planning & monitoring
	Health Information System	

Components of IMNCI

1. **Training**

   IMNCI is a skill based training in both facility and community settings.

   Broadly, two categories of training are included, one for medical officers and a second for front-line functionaries including ANM's and Anganwadi Workers (AWW's).

   For ASHA and link volunteers if any, a separate package consistent with IMNCI focusing on the home care of newborn and children is in preparation keeping in mind their educational status.

   While training is an important input for implementation of IMNCI, this is not the only one. Effective implementation of IMNCI in a district also involves the following components.

   a. **Improvements to the health system.** The essential elements include:

i. Ensuring availability of the essential drugs with workers and at facilities covered under IMNCI.
ii. Improve referral to identified referral facility.
iii. Referral mechanism to ensure that an identified sick infant or child can be swiftly transferred to a higher level of care when needed. Every health worker must be aware of where to refer a sick child and the staff at appropriate health facilities must be in position to identify and acknowledge the referral slips and give priority care to the sick children.
iv. Functioning referral centres, especially where healthcare systems are weak, referral institutions need to be reinforced or private/public partnerships established
v. Ensuring availability of health workers / providers at all levels
vi. Ensuring supervision and monitoring through follow up visits by trained supervisors as well as on-the-job supportive supervision

b. **Improvement of Family and Community Practices**

Counseling of families and creating awareness among communities on their role is an important component of IMNCI. This includes-

i. Promoting healthy behaviors, such as breastfeeding, illness recognition, early case seeking etc.
ii. IEC campaigns for awareness generation.
iii. Counseling of care givers and families as part of management of the sick child, when they are brought to the health worker/health facility.
iv. During Home Visits- Home Visits provide an opportunity for identification of sickness and focused BCC for improving newborn and child care practices.

2. Collaboration/coordination with other Departments, PRIs, Self Help Groups, MSS

Implementation of IMNCI in an effective way in any district would be possible only with the total involvement of ANM and Anganwadi workers of ICDS, and grass-root functionaries of other sectors. Community ownerships and participation is of paramount importance. Therefore active involvement of PRI, self help groups and women's groups is a must. Special effort will thus be required on the part of the district CMOs to involve the concerned departments.

For training of health staff and follow-up and supervision of IMNCI activities in the district, the involvement of pediatrics units/departments of District Hospitals will be necessary. The involvement of the Departments of Pediatrics and Preventive and Social Medicine of the local or regional medical colleges should be sought.

The referral care for sick children and newborns is to be provided at the upgraded PHC's and FRU's which are being developed as a part of the RCH program phase-II .The guidelines for services at these facilities have been developed.

F-IMNCI

From November 2009 IMNCI has been re-baptized as F-IMNCI, wherein F stands for Facility based management; with added component of

a. Asphyxia Management and

b. Care of Sick new born at facility level, besides all other components included under IMNCI

Institutional Arrangements-

IMNCI is a Child Health Intervention to be implemented as part of NRHM/RCH-II. Training for IMNCI will therefore be part of the overall training plan under RCH-Phase II.

A. State Level

1. **Appoint a nodal officer for IMNCI.** The State RCH Program Director could take up the responsibility himself. The nodal officer will be responsible for the institutional arrangements listed below.
2. **Set up a co-ordination Group,** including the donor agencies, other Departments like ICDS, Panchayati Raj, department of medical education are important as medical colleges will be involved not only in IMNCI implementation but also education of medical and nursing students. The coordination committee should be linked to the State Health Mission of the NRHM.
   Meeting quarterly, the role of the coordination group would be to
   a. Provide any technical support needed for state and district level implementation,
   b. Coordinate financial inputs,
   c. Review logistics and dugs supply and
   d. Review progress in the implementation of imnci training and implementation activities. Involvement of departments like icds, panchayati Raj, Medical Education will all have essential and specific contributions to make in scaling up IMNCI.
3. **Arrange translation, printing and supply of training material.** Requirement of funding for these activities may be reflected as part of State PIPs.
4. **Create pool of State level trainers.** These trainers are required for training of trainers (TOT) of district trainers as defined earlier and also to monitor quality of training in the districts. These trainers will be trained at the National Institutes at Delhi.
5. **Select priority districts for IMNCI implementation**' First phase may therefore be restricted to 3-4 districts along with regional training centers (preferably medical colleges) in the first phase. Each state should however; strive to complete implementation of IMNCI in at least 25-30% of the districts over the next 2-3 years.
6. **Monitoring, follow-up and review of implementation of IMNCI**
7. **Identify the state nodal institute for IMNCI training.**
8. **Improvement in family and community practices**

B. District Level

Many of the institutional arrangements at the State level need to be developed at district level, though emphasis is less on overall direction and quality control and more on the day-to-day activities to make IMNCI successful.

1. Appoint District Coordinator for IMNCI.
2. Set up an IMNCI Coordination Group.
3. Train District Trainers.
4. Develop a detailed plan for IMNCI Implementation in the District.
5. Ensure timely supplies & logistics, supervision and follow-up
6. IEC activities for improvement in family and community practices

Training in IMNCI-

Focus on Skill Development

The training under IMNCI is focused on applied skill development. Around 50% of training time is spent building skills by ***"hands-on training"*** involving actual case management and counselling, the remaining 50% is spent in classroom sessions, building theoretical understanding of essential health interventions. The hands-on training is undertaken through clinical training sessions in hospitals and in the community. Physicians spend 6 days in hospital and 1 day in community; workers spend 3 days in hospital and 4 days in community settings.

The hands on practice are to be undertaken through:

1. Visits to hospitals and
2. In the case of Health workers in addition to hospital based practice, the participants are to be trained through field visits and visits to the homes of sick children.

Skill development is critical to the implementation of IMNCI.

Training at two levels:

In-service training for the existing staff – The existing staff in the districts will have to be provided in-service training in a phased manner. The objective of the training effort would be to ensure that all medical officers and health worker are trained in IMNCI.

Pre-Service Training – for including IMNCI in the pre-service teaching of doctors, nurses, ANM's, LHV's and others. ***The State Governments will need to issue instructions in this regard.***

Personnel to be Trained

There are 2 types of trainings under IMNCI*

Type of Training	Personnel to be trained	Duration	Package to be used	Place of Training
Clinical skills training	Medical Officer and Pediatricians	8 days	Physicians Package	Medical college /District Hospital
	Health Workers, ANMs, LHVs, Mukhya Sevikas, CDPO's and AWWs	8 days	Health Workers Package	District Hospital
Supervisory Skills Training	Medical Officers, Pediatricians, CDPO's LHVs and Mukhiya Sevikas)	2days#	Supervisory Skills package	Medical college /District Hospital

To be clubbed Preferably with clinical skills training. Where this is not possible the two days training should be conducted within 4-6 weeks of the clinical skills training. Experience has shown that it is difficult to call back people within 6 weeks again for another training.

* An orientation meeting of 1 to 2 days may be organized in some districts for planners and key personnel such as people from PRI, CDPO's and other senior health functionaries and other stake holders to orient them about IMNCI and its implementation plan.

Training of Trainers

For training of the district staff it would be essential to have adequate number of trainers within the districts. The trainers at district level includes all pediatricians in the district, selected medical officers from CHCs and block PHCs, selected staff nurses and LHVs and CDPO's and Mukhiya Sevikas from ICDS. **Experience has shown that about 40-50 trainers are required for undertaking training of the health staff on a continuous basis. This is because in every district around 200 doctors and 200 supervisors along with 1200- 1600 workers need to be trained.** Total training time is 10 days: 8 days (Clinical skills training) + 2 days for supportive supervision. The TOT for Physicians is facilitated by National IMNCI facilitators; the TOT for Health/ICDS workers is facilitated by State IMNCI facilitators ideally with participation of national IMNCI facilitators. Candidates for the all TOTs and ultimately the district training pool would ideally include all pediatricians in the district, plus selected CHC/Block PHC medical officers, staff nurses, LHVs, CDPOs, and ICDS supervisors. Additional TOT candidates might include faculty of HFWTC, ANMTC, GNMTC, MPW (M) TC, junior faculty of medical colleges, and NGOs. *All candidates should have good communication skills.* Districts with limited manpower might also consider including freelance facilitators.

Number to be trained

1. It is estimated that in a district of average size about 1800 health staff will need to be trained. The exact numbers will however have to be calculated for each district will be taken up for implementation of IMNCI.
2. Since the staff of other departments like ICDS etc is also to be trained, their numbers should be carefully included in consultation with the concerned district officers.
3. Since meaningful implementation of IMNCI will need adequate numbers of trained staff, it will be better if the staff belonging to a PHC areas may be taken up fully before moving to another PHC area.

Training Institutions:

1. **State Level**
    a. Identify a Regional Training Centre.
    b. The Departments of Pediatrics and Preventive & Social Medicine in each college will have to take up this responsibility. Another benefit of selecting the medical colleges as regional training centre would be in the pre-service training of undergraduate students. In addition to medical colleges, other centres including private centres can also be used for training provided they have the requisite clinical material and facilities for training available.

2. **District Level**
    The following issues need consideration before selecting the institutions for training of district staff:
    a. The selected institution for training should have sufficient load of inpatient newborns to provide case material for hands on training.
    b. Health workers have to be given the opportunity for practice on cases in home situations. Therefore at-least 4 visits have to be organized to nearby field areas during their training.
    c. Ensure adequate number of class rooms (Preferably two) with sitting capacity of 12-15 participants each.
    d. Batch size not more than 25 participants with 6-7 facilitators.

e. HFW TCs/ANM schools can perform this task only jointly with a hospital/health institutions. District hospital will thus be an obvious choice for training of medical officers. For training of health workers CHCs/operational FRUs etc can be considered. Where institutions with enough case load are not available in public sector – involvement of hospitals/health centres of local bodies/public sector enterprises or even private sector. In rare cases even facilities of adjoining districts should be considered

Follow-up Training (FUT)

The Follow-up Training is designed to improve supportive supervision skills such as methods for skill reinforcement, records review, and assessment of facility functioning for 2 days which may either be clubbed with Clinical skills training or conducted within 6-8 weeks of the initial Clinical skills training.

Pre-service Training

Following the initial experiences in implementation IMNCI in several districts, States should plan early for the expansion to remaining districts. Pre-service training in medical colleges will need to include training on IMNCI in the training schedules of undergraduate students and interns, during their postings in the Departments of Paediatrics and Preventive & Social Medicine. ANM, AWW, and Staff Nurses' training schools will need to include training on IMNCI in their training schedules. State Governments will need to issue instructions in this regard to be implemented by teaching institutions by respective directorates.

Funding arrangements for IMNCI Trainings

National Level training:

For the national level training of the faculty of Medical Colleges of different States at Kalawati Saran Children Hospital and Safdarjung Hospital at Delhi, the States need not provide for budget in their NRHM/RCH-II-Program Implementation Plans (PIPs) as the funding for this training will be entirely provided by the Government of India. This will include all costs such as TA/DA, stay and other training expenses.

State Level training (at the Medical Colleges identified as training centres):

The States need to project their funding requirements for the following in their NRHM/RCH-II-PIPs:

1. Equipments for imparting training such as:
    a. One Computer with in-built CD RW/ROM
    b. One LCD Projector with display screen
    c. Other miscellaneous training/ teaching accessories.
2. TA/DA and honorarium to the trainees and trainers as per RCH norms.
3. Vehicle hiring for field visits for trainees as per State Government norms.

District Level training:

1. **At District Training Cell (in the District Hospital):**
   The States need to project their funding requirements for the following in their NRHM/RCH-II-PIPs:
    a. Equipments for imparting training such as:
        i. One Computer with in-built CD RW/ROM
        ii. One LCD Projector with display screen

iii. Other miscellaneous training/ teaching accessories.

b. TA/DA and honorarium to the trainees and trainers as per RCH norms.
c. Vehicle hiring for field visits for trainees as per State Government norms.

2. **At other Training Centres within the District (Maximum two in identified CHCs/PHCs):**
   The States need to project their funding requirements for the following in their NRHM/RCH-II- PIPs:
   a. Equipments for imparting training such as:
      i. One television (which is CD player compatible)
      ii. One CD player
      iii. Other miscellaneous training/ teaching accessories.
   b. TA/DA and honorarium to the trainees and trainers as per RCH norms.
   c. Vehicle hiring for field visits for trainees as per State Government norms.

3. **Translation, printing and supply of training material**

4. **Field-level Monitoring Support, Follow up and Coordination**

Navjat Shishu Suraksha Karykram(NSSK):

The trainings under IMNCI shall take a long time to deliver the desired to all, for which GoI has come out with another program –Navjat Shishu Suraksha Karykram(NSSK) ON September 15, 2009;which focuses on-

a. **Prevention of Hypothermia**
b. **Prevention of Infection**
c. **Early initiation of Breast feeding and**
d. **Basic Newborn Resuscitation.**

The objective is to have one trained person at institutional facility, where deliveries take place. The NSSK will train healthcare providers at the district hospitals, community health centres and primary health centres in the interventions at birth with the application of the latest available scientific methods aimed at significantly reducing the infant mortality ratio.

Limitations of IMNCI

- Outpatient Facility Based
- Community activities not given adequate focus
- Training centre of attention
- Vertical initiatives in Non IMNCI districts sorely lacking

Integrated Child Development Services (ICDS) Scheme

Introduction

India is the home to the largest child population in the world. As per 2001 census, India has around 157.86 million children, constituting 15.42% of India's population, who are below the age of 6 years. Of these 157.86 million children, 75.95 million children are girls and remaining 81.91 million children are boys. The sex ratio among children (0-6 years) as per Census 2001 is 927. A significant proportion of these children live in economic and social environment which impedes the child's physical and mental development. These conditions include poverty, poor environmental sanitation, disease, infection, inadequate access to primary health care, inappropriate child caring and feeding practices etc.

National Policy on Children in August 1974 provided the required framework for assigning priority to different needs of the child. The program of the **Integrated Child Development Services (ICDS)** was launched in 1975 seeking to provide an integrated package of services in a convergent manner for the holistic development of the child.

Integrated Child Development Scheme

Launched on ***2nd October 1975 in 33 Community Development Blocks***, ICDS today represents one of the world's largest program for early childhood development providing pre-school education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality, on the other.

It is an inter-sectoral program which seeks to directly reach out to children, below six years, especially from vulnerable and remote areas and give them a head-start by providing an integrated program of early childhood education, health and nutrition.

Objectives:

1. Lay the foundation for proper psychological development of the child
2. Improve nutritional & health status of children 0-6 years
3. Reduce incidence of mortality, morbidity, malnutrition and school drop-outs
4. Enhance the capability of the mother and family to look after the health, nutritional and development needs of the child
5. Achieve effective coordination of policy and implementation among various departments to promote child development

Services-

The Scheme provides an integrated approach for converging basic services through community-based workers and helpers. The services are provided at a centre called the 'Anganwadi'. The Anganwadi, literally a courtyard play centre, is a childcare centre, located within the village itself. A package of following six services is provided under the ICDS Scheme:

1. Supplementary nutrition
2. Growth Monitoring and nutrition surveillance
3. Non-formal pre-school education
4. Immunization
5. Health Check-up
6. Referral services
7. Nutrition and Health Education

The three services namely immunization, health check-up and referral are delivered through public health infrastructure viz. Health Sub Centres, Primary and Community Health Centers under the Ministry of Health & Family Welfare.

Target Groups & Service Provider

Services	*Target Group*	*Services Provided By*
Supplementary Nutrition	Children below 6 years; pregnant and lactating mothers	Anganwadi Workers (AWW) & Anganwadi Helper (AWH)
Immunization*	Children below 6 years; pregnant and lactating mothers	ANM/MO
Health Check-ups*	Children below 6 years; pregnant and lactating mothers	ANM/MO/AWW
Referral	Children below 6 years; pregnant and lactating mothers	AWW/ANM/MO
Pre-School Education	Children 3-6 years	AWW
Nutrition & Health Education	Women (15-45 years)	AWW/ANM/MO

Population Norms

The revised Population norms for setting up a Project, Anganwadi Centre and Mini-AWC are as under:

Projects:

(i) Community Development Block in a State should be the unit for sanction of an ICDS Project in rural/tribal areas, irrespective of number of villages/population in it.

(ii) The existing norm of 1 lakh population for sanction of urban project may continue.

Further to this, for blocks with more than two lac population, States could opt for more than one Project (@ one per one lac population) or could opt for one project only. In the latter case, staff could be suitably strengthened based on population or number of AWCs in the block. Similarly, for blocks with population of less than 1 lac or so, staffing pattern of CDPO office could be less than that of a normal block.

Anganwadi Centres

For Rural/Urban Projects

400-800 1 AWC

800-1600 - 2 AWCs

1600-2400 - 3 AWCs

Thereafter in multiples of 800 1 AWC

For Mini-AWC

150-400 1 Mini-AWC

For Tribal /Riverine/Desert, Hilly and other difficult areas/ Projects

300-800 - 1 AWC

For Mini- AWC

150-300 1 Mini AWC

Supplementary Nutrition Norms:

Financial norms:- The Government of India has recently, revised the cost of supplementary nutrition for different category of beneficiaries vide this Ministry's letter No. F.No. 4-2/2008-CD.II dated 07.11.2008, the details of which are as under:-

Sl.No.	Category	Pre-revised rates	Revised rates (per beneficiary per day)
1.	Children (6-72 months)	Rs.2.00	Rs.4.00
2.	Severely malnourished children (6-72 months)	Rs.2.70	Rs.6.00
3.	Pregnant women and Nursing mothers	Rs.2.30	Rs.5.00

Nutritional Norms:- Revised vide letter No. 5-9/2005-ND-Tech Vol. II dated 24.2.2009

Sl. No.	Category	[Pr-revised]		[Revised] (per beneficiary per day)	
		Calories (K Cal)	Protein (g)	Calories (K Cal)	Protein (g)
1.	Children (6-72 months)	300	8-10	500	12-15
2.	Severely malnourished children (6-72 months)	600	20	800	20-25
3.	Pregnant women and Nursing mothers	500	15-20	600	18-20

Budgetary Allocation : Alongside gradual expansion of the Scheme, there has also been a significant increase in the Budgetary allocation for ICDS Scheme from Rs.10391.75 crore in 10th Five Year Plan to Rs.44,400 crore in XI Plan Period.

The ICDS Team

The ICDS team comprises the Anganwadi Workers, Anganwadi Helpers, Supervisors, Child Development Project Officers (CDPOs) and District Programme Officers (DPOs). Anganwadi Worker, a lady selected from the local community, is a community based frontline honorary worker of the ICDS Programme. She is also an agent of social change, mobilizing community support for better care of young children, girls and women. Besides, the medical officers, Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) form a team with the ICDS functionaries to achieve convergence of different services.

ICDS Training Programme

Training and capacity building is the most crucial element in the ICDS Scheme, as the achievement of the programme goals largely depends upon the effectiveness of frontline workers in improving service delivery under the programme. Since inception of the ICDS scheme, the Government of India has formulated a comprehensive training strategy for the ICDS functionaries. Training under ICDS scheme is a continuous programme and is implemented through 35 States/UTs and National Institute of Public Cooperation and Child Development (NIPCCD) and its four regional centres.

During the 11th Five Year Plan, the Government of India has laid much emphasis on strengthening the training component of ICDS in order to improve the service delivery mechanism and accelerate better programme outcomes. An allocation of Rs. 500 crore has been kept for the ICDS Training Programme during the 11th Five Year Plan.

Financial norms relating to training of various ICDS functionaries and trainers have been revised upwardly with effect from 1 April 2009.

1. **Types of Training Courses:** Three types of regular training are imparted to AWWs, AWHs, Supervisors, CDPOs/ACDPOs and Instructors of AWTCs and MLTCs, viz.:

   - Induction Training (*on initial engagement/appointment*) mainly to AWWs
   - Job/Orientation Training (*once during service period*)
   - Refresher Training (*in-service, once in every two years)*

Also, specific need based training programmes are organized under the 'Other Training' component, whereby the States/UTs are given flexibility to identify state specific problems that need specialized issue based training and take up such training activities.

1. **Training Infrastructure:** There is a countrywide infrastructure for the training of ICDS functionaries, *viz.*

   - **Anganwadi Workers Training Centres (AWTCs)** for the training of Anganwadi Workers and Helpers.
   - **Middle Level Training Centres (MLTCs)** for the training of Supervisors and Trainers of AWTCs;
   - **National Institute of Public Cooperation and Child Development (NIPCCD)** and its Regional Centres for training of CDPOs/ACDPOs and Trainers of MLTCs. NIPCCD also conducts several skill development training programmes.

[Govt. of Tamil Nadu has established a State Training Institute (STI) at the State level for the training of Trainers of MLTCs and CDPOs/ACDPOs]

Based on the needs, State Governments identify and open up AWTCs and MLTCs after due approval by the Government of India. As on 31.3.2009, 490 AWTCs and 31 MLTCs were operational across the country. About 80% of the AWTCs and 70% MLTCs are run by State/District based NGOs.

Monitoring & Supervision of Training Programme: A separate ICDS Training Unit within the Ministry of Women and Child Development headed by a Director/Dy. Secretary level officer is responsible for overall monitoring, supervision and evaluation of the training programme. The following measures are undertaken for monitoring and supervision:

- Physical and financial progress are captured through Quarterly Progress Reports (QPRs) in a standardized format, that are submitted by the States/UTs to GoI at the end of every quarter;
- A detailed analysis of the QPRs is carried out by the ICDS Training Unit and based on the same, quarterly review meetings are organized with the States at the central level;
- Monthly/quarterly review meeting with the Training Centres at the state level;
- Necessary feedback and guidelines are issued to the States after each of the review meetings;
- Field visits to AWTCs/MLTCs by Nodal Officer or the District Programme Officers (DPOs)/CDPOs; and also by the officials from the Ministry of WCD and NIPCCD.
- Annual meeting of State Training Task Force (STTF) for the approval of STRAP and review of past performance and chalking out future actions.

Existing Monitoring System under ICDS Scheme:

Central Level

Ministry of Women and Child Development (MWCD) has the overall responsibility of monitoring the ICDS scheme. There exists a Central Level ICDS Monitoring Unit in the Ministry which is responsible for collection and analysis of the periodic work reports received from the States in the prescribed formats. States have been asked to send the State level consolidated reports by 17th day of the following month.

The existing status of monitoring of these six services is as under :

(i) Supplementary Nutrition : No. of Beneficiaries (Children 6 months to 6 years and pregnant & lactating mothers) for supplementary nutrition;

(ii) Pre-School Education: No. of Beneficiaries (Children 3-6 years) attending pre-school education;

(iii) Immunization, Health Check-up and Referral services : Ministry of Health and Family Welfare is responsible for monitoring on health indicators relating to immunization, health check-up and referrals services under the Scheme.

(iv) Nutrition and Health Education: This service is not monitored at the Central Level. State Governments are required to monitor up to State level in the existing MIS System.

(v) No. of ICDS Projects and Anganwadi Centres (AWCs) w.r.t. targeted no. of ICDS Projects and AWCs are taken into account for review purpose.

Analysis & Action

The information received in the prescribed formats is compiled, processed and analysed at the Central level on quarterly basis. The progress and shortfalls indicated in the reports on ICDS are reviewed by the Ministry with the State Governments regularly by review meetings/ letters.

State Level

Various quantitative inputs captured through CDPO's MPR/ HPR are compiled at the State level for all Projects in the State. No technical staff has been sanctioned for the state for programme monitoring. CDPO's MPR capture information on number of beneficiaries for supplementary nutrition, pre-school education, field visit to AWCs by ICDS functionaries like Supervisors, CDPO/ ACDPO etc., information on number of meeting on nutrition and health education (NHED) and vacancy position of ICDS functionaries etc.

Block Level

At block level, Child Development Project Officer (CDPO) is the in-charge of an ICDS Project. CDPO's MPR and HPR have been prescribed at block level,. These CDPO's MPR/ HPR formats have one-to-one correspondence with AWW's MPR/ HPR. CDPO's MPR consists vacancy position of ICDS functionaries at block and AWC levels. At block level, no technical post of officials have been sanctioned under the scheme for monitoring. However, one post of statistical Assistant./ Assistant is sanctioned at block level to consolidate the MPR/ HPR data.

In between CDPO and AWW, there exists a supervisor who is required to supervise 25 AWC on an average.

CDPO is required to send the Monthly Progress Report (MPR) by 7th day of the following month to State Government. Similarly, CDPO is required to send Half-yearly Progress Report (HPR) to State by 7th April and 7th October every year.

Village Level (Anganwadi Level)

At the grass-root level, delivery of various services to target groups is given at the Anganwadi Centre (AWC). An AWC is managed by an honorary Anganwadi Worker (AWW) and an honorary Anganwadi Helper (AWH).

In the existing Management Information System, records and registers are prescribed at the Anganwadi level i.e. at village level. The Monthly and Half-yearly Progress Reports of Anganwadi Worker have also been prescribed. The monthly progress report of AWW capture information on population details, births and deaths of children, maternal deaths, no. of children attended AWC for supplementary nutrition and pre-school education, nutritional status of children by weight for age, information on nutrition and health education and home visits by AWW. Similarly, AWW's Half yearly Progress Report capture data on literacy standard of AWW, training details of AWW, increase/ decrease in weight of children, details on space for storing ration at AWC, availability of health cards, availability of registers, availability of growth charts etc.

AWW is required to send these Monthly Progress Report (MPR) by 5th day of following month to CDPO' In-charge of an ICDS Project. Similarly, AWW is required to send Half-yearly Progress Report (HPR) to CDPO by 5th April and 5th October every year.

International partners

Government of India partners with the following international agencies to supplement interventions under the ICDS:

i. United Nations International Children' Emergency Fund (UNICEF)
ii. Cooperative for Assistance and Relief Everywhere (CARE)
iii. World Food Programme (WFP)

UNICEF supports the ICDS by providing technical support for the development of training plans, organizing of regional workshops and dissemination of best practices of ICDS. It also assists in service delivery and accreditation system where the capacity of ICDS functionary is strengthened. Impact assessment in selected States on early childhood nutrition and development, micro-nutrient and anemia control through Vit. 'A' supplementations and deworming interventions for children in the age group of 9-59 months is also conducted by UNICEF from time to time.

CARE is primarily implementing some non-food projects in areas of maternal and child health, girl primary education, micro-credit etc. Integrated Nutrition and Health Project (INHP)-III, which is a phaseout programme of INHP series would come to an end on 31.12.2009.

WFP has been extending assistance to enhance the effectiveness and outreach of the ICDS Scheme in selected districts (Tikamgarh & Chhattarpur in Madhya Pradesh, Koraput, Malkangir & Nabrangpur in Orissa, Banswara in Rajasthan and Dantewada in Chhattisgarh), notably, by assisting the State Governments to start and expand production of low cost micronutrient fortified food known as 'Indiamix'. Under this the concerned State Government are required to contribute to the cost of Indiamix by matching the WFP wheat contribution at a 1:1 cost sharing ratio.

Special Focus on North East : Keeping in view the special needs of North Eastern States, the Central Government sanctioned construction of 4800 Anganwadi Centres at a cost of Rs.60 crore in 2001-02, 7600 Anganwadi Centres at a cost of Rs.95.00 crore in 2002-03 and 7600 AWCs at a cost of Rs.95.00 crore in 2004-05. In the wake of expansion of ICDS Scheme in 2005-06, it was provided in the Scheme itself that GOI will support construction of AWCs in NE States. The cost of construction was also revised from Rs.1.25 lakh per centre to Rs.1.75 lakh per center. In 2006-07, 50% of funds have been released to all the NE States except the State of Manipur.

Recent Initiatives

- Revision in **Population norms** for setting up of AWCs/Mini-AWCs

- Universalisation and 3rd phase of expansion of the Scheme of ICDS for 792 additional Projects, 2.13 lakh additional Anganwadi Centres (AWCs) and 77102 Mini-AWCs, as per the revised population norms, with special focus on coverage of SC/ST and Minority population.
- Introduction of cost sharing between Centre & States, with effect from the financial year 2009-10, in the following ratio:

  a. 90:10 for all components including SNP for North East;

  b. 50:50 for SNP and 90:10 for all other components for all States other than North East.

- Budgetary allocation for ICDS Scheme increased from Rs.10391.75 crore in 10th Five Year Plan to Rs.44,400 crore in the 11th Plan Period
- Revision in financial norms of supplementary nutrition enhancing the unit cost per ben per day
- Revision of feeding and nutrition norms as under (vide letter No. 5-9/2005-ND-Tech Vol. II dated 24.2.2009)
- Revision in financial norms of other existing interventions to improve the service delivery.
- Enhancement of honoraria w.e.f. 1.04.2008 by Rs.500 of AWWs and by Rs.250 of Helpers of AWCs and Workers of Mini-AWCs. Prior to enhancement, AWWs were being paid a monthly honoraria ranging from Rs. 938/ to Rs. 1063/- per month depending on their educational qualifications and experience. Similarly, AWHs were being paid monthly honoraria of Rs. 500/-

Qualification/Year	1975-76	1.4.78	1.7.86	2.10.92	16.5.97	1.04.02	1.04.08
Non-Matriculate	100	125	225	350	438	938	1438
Matriculate	150	175	275	400	500	1000	1500
Non-Matriculate With 5 year exp	-	-	250	375	469	969	1469
Matriculate With 5 year exp	-	-	300	425	531	1031	1531
Non-Matriculate With 10 year exp	-	-	275	400	500	1000	1500
Matriculate With 10 year exp	-	-	325	450	563	1063	1563
Mini-Anganwadi Workers	-	-	-	-	-	500 (w.ef. 1.1.2007)	750

Honorarium of Helper:

Helper	35	50	110	200	260	500	750

- Introduction of World Health Organisations (WHO) Growth Standards for monitoring the growth of children.
- The GoI introduced `Anganwadi Karyakartri Bima Yojana' to AWW & AWH w.e.f.1.4.2004 under Life Insurance Corporation's Social Security Scheme. The amount of premium of Rs. 80/- payable by AWWs and AWHs has also been waived of w.e.f. 1.4.2007 for a period of two years.
- A scheme of award for AWWs has been introduced, both at the National and State Level. The Award comprises Rs.25,000/- cash and a Citation at Central level and Rs.5000/- cash and a Citation at State level.
- Provision of flexi funds at Anganwadi level.
- They have been allowed paid absence of 135 days of maternity leave.
- Provision for a Uniform (saree/suit @ Rs. 200/- per saree per annum) and a name badge to Anganwadi Workers and HelpersProvision of Uniform for AWWs and Helpers.
- Strengthening of Management Information System (MIS)
- Revision in cost norms of Training component of ICDS Scheme.
- BPL no longer a criteria

Achievements: There has been significant progress in the implementation of ICDS Scheme during X Plan both and during XI Plan (up to 2008-09), in terms of increase in number of operational projects and Anganwadi Centres (AWCs) and coverage of beneficiaries as indicated below:-

Year ending	No. of operational projects	No. of operational AWCs	No. of Supplementary nutrition beneficiaries	No. of pre-school education beneficiaries
31.03.2002	4608	545714	375.10 lakh	166.56 lakh
31.03.2003	4903	600391	387.84 lakh	188.02 lakh
31.03.2004	5267	649307	415.08 lakh	204.38 lakh
31.03.2005	5422	706872	484.42 lakh	218.41 lakh
31.03.2006	5659	748229	562.18 lakh	244.92 lakh
31.03.2007	5829	844743	705.43 lakh	300.81 lakh
31.03.2008	6070	1013337	843.26 lakh	339.11 lakh
31.03.2009	6120	1044269	873.43 lakh	340.60 lakh

VHSC, Role of PRIs and Community Monitoring

Village Health Sanitation Committee (VHSC):

The NRHM framework support decentralized planning & monitoring up to the grass root level. Therefore it was decided to entrust village level committees of the users group, community based organization for the planning monitoring & implementation of NRHM activities into the 41000 revenue villages of the State.

Village Health & Sanitation committee (VHSC) feed such groups, which is the fifth committee (Development Committee) of the Gram Panchayat. The VHSC will be the key agency for developing Village Health Plan & the entire planning of village Panchayat for NRHM. This committee comprises of Panchayat representatives, ANM, MTW, Aganwari workers, Teachers, Community health volunteers, ASHA.

Village Health Committees are the first step towards communitization of health care services and for making health as a people's movement. The Village Health Committees are constituted in all the 40479 habitat villages with elected member of Panchayti Raj Institution of the village as Chairperson. The other members of the committee are ASHA Sahyogini, Anganwadi Worker, ANM, Representative from SHG, NGO, MSS etc. ASHA Sahyogini is the Convener for this Committee. Village Health Committee will facilitate in addressing the health needs of the entire village with the help of health providers and health institutions. VHCs will play an important role in planning and monitoring of the health care services through community monitoring mechanisam.

Composition of the Village Health & Sanitation Committee

To enable the Village Health & Sanitation Committee to reflect the aspirations of the local community especially of the poor households and women, it has been suggested that:

a. At least ***50% members*** on the Village Health & Sanitation Committee should be **women**.
b. Every hamlet within a revenue village must be given due representation on the Village Health and Sanitation Committee to ensure that the needs of the weaker sections especially Scheduled Castes, Scheduled Tribes, Other Backward Classes are fully reflected in the activities of the committee.
c. A provision of at least ***30%*** representation **from the Non-governmental sector.**
d. Representation to women's self-help group etc. on these committees etc. will enable the Committee to undertake women's health activities more effectively.
e. Notwithstanding the above, the overall composition and nomenclature of the Village Health & Sanitation Committees is left to the State Governments as long as these committees were within the umbrella of PRIs.

Composition:

Gram Panchayat members from the village.
ASHA, Anganwadi Sevika, ANM
SHG leader, the PTA/MTA Secretary, village representative of any community based organization working in the village, user group representative.

Role of Village Health Committee

Activities

a. Create Public Awareness about the essentials of health programs.
b. Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community.
c. Analyze key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present annual health report of the village in the Gram Sabha.
d. Participatory Rapid Assessment: to ascertain the major health problems and health related issues in the village. Estimation of the annual expenditure incurred for management of all the morbidities may also be done. The mapping will also take into account the health resources and the unhealthy influences within village boundaries.
e. Maintenance of a village health register and health information board/calendar: The health register and board put up at the most frequented section of the village will have information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc.
f. Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW.
g. Get a bi-monthly health delivery report from health service providers during their visit to the village.
h. Take into consideration of the problems of the community and the health and nutrition care providers and suggest mechanisms to solve it.
i. Discuss every maternal death or neonatal death that occurs in their village, analyze it and suggest necessary action to prevent such deaths. Get these deaths registered in the Panchayat.
j. Managing the Village health fund.

Village Health Fund

Untied funds for VHCs- There is a provision of Rs.10,000/- as untied funds for each VHC per year. This untied fund is to be deposited in concerned Subcenters Account which is jointly operated by ANM and Sarpanch. The untied funds are utilized for demand generation for health care services, sanitation drives, emergency health care needs, rewards for exceptional work in health sector, publicity of MCHN days, RCH camps etc.

The untied funds are to be used for the community actions for improvement of health status of the community,for any of the following activities: -

a. As a revolving fund from which households could draw in times of need to be returned in installments thereafter.
b. For any village level public health activity like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc.
c. In extraordinary case of a destitute women or very poor household, the Village Health & Sanitation Committee untied grants could even be used for health care need of the poor household.
d. The untied grant is a resource for community action at the local level and shall only be used for community activities that involve and benefit more than one household. Nutrition, Education & Sanitation, Environmental Protection, Public Health Measures shall be key areas where these funds could be utilized.
e. Every village is free to contribute additional grant towards the Village Health & Sanitation Committee. In villages where the community contributes financial resources to the Village

Health & Sanitation Committee untied grant of Rs.10,000/-, additional incentive and financial assistance to the village could be explored. The intention of this untied grant is to enable local action and to ensure that Public Health activities at the village level receive priority attention.

Training-

As per the NRHM framework for implementation, all the members of VHCs are to be trained. The objective of training-

- To develop VHSC as strong Vibrant Group which will be responsible for improving the health status of fellow villagers
- To develop understanding on Health Issues, Health Problems, Health Services, Health Programmes
- To empower the VHSC members to plan, demand and monitor the health services
- To strengthen the group to work as active participants of society for the cause of Health.

The content of the training is developed with focus on the following issues-

1. Concept of Health and determinants of health.
2. Health institutions and health programmes
3. Social aspects impacting health status like child marriages, son preference etc.
4. Demand generation for health care services
5. Planning and monitoring of health care services
6. Team Building and networking
7. Operational issues - Constitution, monthly meetings, funds management, reporting
8. Roles and responsibility of VHC in improvement of health status of the community

The expected training load is of about 250,000 members. The training will be imparted at PHC/Block level and all the committee members of the cluster of villages will be trained in one batch. State Institute of Health and Family Welfare is the Apex body for the task of trainings. The support will be taken from the NGOs which have an experience in implementing the community level interventions in the health sector. The trainings will be completed in two years time span.

The pool of trainers will be developed at State, District and Block level. The cascade model will be used for these trainings. The trainers team will include identified and experienced trainers from DMHS, DWCD, PR and RD, NGOs and some free lancing trainers. SIHFW will carry out the state and district level trainings and will provide supportive supervision for block/ PHC level trainings. NGOs will be involved in the trainings of members of the committee and provision of the logistics support for the trainings.

Training of trainers

a. State level- 20 selected trainers at state level will be identified who are involved in the development of training module and reading material. The support of the NGOs who are involved in Community Monitoring Programme will be sought for development of reference material and state trainers group.
b. District Level- 6 selected trainers - 2 DMHS, 1 Panchayati Raj, 1 DWCD and 4 NGO and free lancer trainers- Total 10 per District will be trained at state level by SIHFW.
c. Block Level - 6 trainers per block- Constitution same as District Level Trainers- 6* 237 = 1422 trainers. These trainings will be conducted at District level, simultaneously in all the districts

Training of Village Health Committee Members- The training will be imparted to all the members of Village Health Committee. The total training load is of approximate 2,50,000 members. The trainings at grass root level will be contracted out to the NGOs which will be selected at district level to carry out the trainings. State level SIHFW will monitor and provide supportive supervision for the trainings.

IEC-

The component of VHSC is to be widely publicized, so that it could be robustly rooted in the institutional framework. The IEC can be done through posters, pamphlet and radio jingles. The issues like health rights, citizens charter of subcenter, PHC, CHC, roles and responsibilities of committees will be addressed through posters, radio jingles etc. The awareness campaign can be organized for all Sarpanchs at district or block level.

Monthly Meetings-

The monthly meetings of Village Health Committees are planned on each MCHN days which are facilitated by ASHA Sahyogini and ANM. As a convener ASHA Sahyogini will be responsible for conducting the monthly meetings, documenting the minutes, approval of the resolutions. ASHA Sahyogini will facilitate for the compliance on the decisions taken during the meeting. ASHA Sahyogini will support the ANM to collect all the members of the Committee and will ensure maximum attendance. An incentive of Rs. 100/- for ASHA Sahyogini is provided for convening the meeting from the budget head of ASHA Sahyogini- Selection and training. Format for the proceeding of the meeting are developed, printed and disseminated for facilitating the meetings.

The key for the success of Village Health Committees intervention is monthly meetings. The committees will become vibrant and active through the planned monthly meetings. For conducting the meetings, month wise agenda is developed and provided in the districts.

MIS-

The physical and financial reports are incorporated in the monthly progress report of the State. The MIS is developed on the basis of four measurable indicators. They are Constitution of Committees, Monthly Meetings held, monthly meeting through ASHA Sahyoginis and utilization of funds. The information on the trainings will also be included after initiation of the trainings.

Monitoring –

The constitution of Village Health Committees, making it vibrant and utilization of untied funds for VHCs will be incorporated as the permanent Agenda Point in the monthly review meetings at all levels i.e Executive Committee at State level, District Health Society at District Level and review meetings at block and PHC level.

Support System-

F. State level –

State Institute of Health and Family Welfare will provide technical backstopping to the programme at state level. The training modules, development of resource pool, state level trainings, supportive supervision for district and block level trainings will be provided by SIHFW. The support will also be provided in monitoring of the programme from State level.

G. District level-

The CMHO, DPM, District ASHA Coordinator are responsible for implementation of VHC programme in the district. The DPM, ASHA Coordinator in the district will facilitate the following components of Village Health Committees –

1. Constitution of VHCs in all the revenue villages
2. Making data base and profile of VHCs.
3. Facilitation of monthly meetings of VHC on each MCHN day at village level
4. Facilitation in Development of village health plans
5. Facilitation in incorporation of VHPs in to Block Health plans and Block Health Plans in to District Health Plans.
6. Addressing the issues identified by Village Health Committees and work for the emicable solutions.

The DPM and District ASHA Coordinator will facilitate the process of constitution and functioning of Village Health Committees.

H. **Block Level-** Block Chief Medical and Health Officer and Block Programme Manager will be responsible for the intervention related to Village Health Committees. They will provide support to PHC level factionaries. Block ASHA Coordinator will also be responsible for VHC intervention.

I. PHC Level -PHC Level Facilitator - The ASHA facilitator who will be coterminous with PHC will be responsible with the PHC medical Officer and LHV for following activities-

1. Constitution of Village Health Committees
2. Organizing Monthly Meetings
3. Providing support in trainings
4. Facilitation in development of Village Health Plans
5. Facilitation in conflict redressal
6. Other issues related to VHCs

J. Village Health Plans- The Village Health Plans have been developed with ten measurable indicators. The indicators are ANC, Institutional Delivery, PNC, Immunization, Control of TB and Malaria, Registration of Adolescent Girls in Anganwadis, Sterilization, IUCD and Prevention of Child Marriages.

The challenge is to strengthen the Village Health Committees to take the ownership of Health Status of the villagers. This could only be done through fruitful monthly meetings and intensive training programmes.

Expected Funds Inflow:

Every VHSC will receive an untied amount of Rs 10,000 every year which is to be used as per the guidelines issued in this regard.

Banking System: VHSC may open a joint bank account of (1) Gram Pradhan or Panchayat Secretary and (2) ASHA or ANGANWARI Worker in any scheduled bank/Grameen Bank/Post Offices.

Joint Signatories: ASHA/Health Link Worker/Anganwadi Worker along with the President of the VHSC/Pradhan of the Gram Panchayat.

Records: VHSC may maintain a simple register for 'Untied Grants to VHSC'. This register may be maintained by ASHA/MPW. This register can be verified by the Panchayat representative at the close of each month.

Submission of Statement of Expenditure (SoE): SoE may be submitted on half yearly basis by 5th October and 5th April respectively to the concerned ANM. It would be desirable if, at the time of submission of SoE, ASHA reconciles the expenditure with the bank statement. SoE can be submitted on a plain paper stating as below:

"Certified that an amount of Rs. ……. has been utilized during the half year ending 30th September…….. / 31st March …….. from out of untied funds released to the Village Health and Sanitation Committee for the village ……."The two joint signatories of the VHSC account should jointly certify this SoE.
Administrative Approval & Financial Sanction: The funds under Untied Grant should be spent after the approval of majority members of the Committee provided the expenditure is made for the activities approved by State Government.

Accountability of VHSC

1. Every Village Health & Sanitation Committee needs to maintain *updated Household Survey data* to enable need based interventions.
2. Maintain a register where complete details of activities undertaken, expenditure incurred etc. will be maintained for public scrutiny. This should be periodically reviewed by the ANM/Sarpanch.
3. The Block level Panchayat Samiti will review the functioning and progress of activities undertaken by the VHSC.
4. The District Mission in its meeting also through its members/block facilitators supporting ASHA [wherever ASHA's are in position] elicit information on the functioning of the VHSC.
5. A data base may be maintained on VHCSs by the DPMUs.

Community based Monitoring of Health services under NRHM

Community-based Monitoring of health services is a key strategy of National Rural Health Mission (NRHM) to ensure that the services reach those for whom they are meant, especially for those residing in rural areas, the poor, women and children. Community Monitoring is also seen as an important aspect of promoting community led action in the field of health.
Objectives of Community based Monitoring:

1. Create forums for community ownership
    a. VHSC, RKS,DHM,SHM
2. Collect systematic info about community needs
3. Provide feedback according to
    a. locally developed yardsticks
    b. key indicators.
4. Do with salary based systems what seems possible only with passion based systems.
5. Validate sector wide data from other sources
6. Triangulation

Organogram:

MOHFW
AGCA (Advisory Group on Community Action)
National secretariat
State Planning and Monitoring Committee
State Mentoring Group
State Nodal NGO
District Mentoring Group
District Nodal NGO
District Planning and Monitoring Committee
Block Nodal NGO
Block Planning and Monitoring Committee
PHC Planning and Monitoring Committee
Village Planning and Monitoring Committee

The NRHM proposes a monitoring and planning committee at the village, PHC, block, district and state level. The main functions of the committee are:

1. To create public awareness about the essentials of health programs, with focus on people's knowledge of entitlements to enable their involvement in the monitoring.
2. Conduct Participatory Rapid Assessment to ascertain the major health problems and health related issues
3. Discuss and develop a Health Plan based on an assessment of the situation and priorities identified by the community.
4. Presentation of the progress made at the village level, achievements, actions taken and difficulties faced followed by discussion on the progress of the achievements of the health facilities.
5. Taking cognizance of the reported cases of the denial of health care and ensuring proper redressal.
6. Report to the monitoring committee at the next level and collate information collected from the lower level committee.

Issues to be monitored:

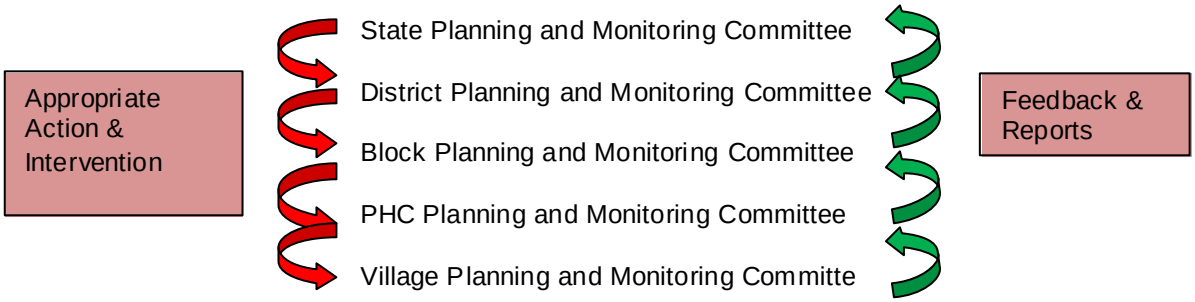
1. MCH, JSY, ASHA, VHSC
2. Untied funding
3. Disease Surveillance
4. Curative care
5. Service availability, Quality
6. Equipment, Supplies, Personnel
7. Charges, Corruption
8. RKS Functioning

Tools for community monitoring:

1. **Village Level**
   i. Village Health Register - Records of ANM - Public dialogue
   ii. Village Health Calendar- Infant and maternal death audit
2. **PHC level**
   i. Charter of Citizens Rights – IPHS - PHC Health Plan
3. **Block level**
   i. IPHS - Charter of Citizens Rights - Block Health Plan

4. **District level**
   i. Report from the PHC Health committees
   ii. Report of the District Mission committee
   iii. Public Dialogue (Jan Samvad)
5. **State level**
   i. Reports of the District Health committees
   ii. Periodic assessment reports by taskforces / State level committees about the progress made in formulating policies according to IPHS, NHSRC recommendations etc.

Flow of Report/Feedback & Necessary Action amongst the Monitoring and Planning Committees is shown below:



People Involved in Community Monitoring

1. State, District & Block Nodal NGOs
2. State Mentoring Group Members
3. State Resource Group
4. District Mentoring Group Members

Processes:

The implementation framework includes:

1. **Orientation of stakeholders & Strengthening of District /Block NGO's**
2. **Strengthening of District/Block NGO's**
3. **Mobilization of community**

Objective of community mobilization:

a. To make the communities aware of their health related entitlement within NRHM.
b. To have a shared understanding of the health issues of the community.
c. To facilitate the formation or expansion of the Village Health and Sanitation Committee.
d. Building ownership about public health service.
e. Developing awareness about determinants of health.

4. **Village Health Services Profile**

It is an outcome of the mobilization process. It should be used by the block facilitators and the VHSC members to familiarise themselves before they start with the monitoring process. It will help in comparing the changes that will be brought about after the community monitoring process.

5. **Formation & Strengthening of VHSC/PHC/Block/District Committees**
   There is formation or expansion of committees at village, PHC, block and district levels **Strengthening of Committees** Once the committees are formed there are trainings at each level for the monitoring exercise that the members will undertake.

6. **Community Level Enquiry**
   The monitoring committee members conduct the first round of monitoring by conducting beneficiary interviews, provider interviews, exit interviews, focus group discussions and observations. At the end of the first round of community monitoring a report card and a cumulative report card is generated at each level. The village report card consists of the issue and their status by means of traffic lights. Green suggests good performing village, yellow suggests there is a cause for concern and Red suggests that the village is performing badly. After the village report cards have been formed for each village, they are collated by the PHC, block, district and state level monitoring and planning committees. So according to the color code for each issue in each of the village health report card, the greens, yellows and reds are added at each level. The facility score card is a snapshot of the status of the health facility in the village/block/district. The color codes display the facility's level of performance. Green stands for good performance, Yellow stands for Cause for concern. After the facility score cards have been formed for each facility, they are collated by the PHC, block, district and state level monitoring and planning committees. So according to the color code for each issue in each of the facility score card, the greens, yellows and reds are added at each level.

7. **Sharing of Reports & Planning**
   a. **Village Sharing Meeting**
      i. Village Score Card and key findings of the Community Monitoring exercise
      ii. Adverse experiences and adverse outcome
      iii. To improve service delivery & not fault finding with health care service providers
      iv. To discuss key problems & suggest action points
   b. **Jan Samvad (Public Dialogue)**
      i. Conducted at Block and PHC level
      ii. Presentation of Cumulative Village Report Card & Facility Report Card
      iii. Presentation of Denial of Care / Adverse Outcomes
      iv. Discussion on implementation of outreach services, improving Facility level service utilization & support to denial of care/adverse outcome cases.

Health Management Information System

Information in Health care Planning:

The amount of information available to health policy-makers and planners at the time of the Declaration of Alma-Ata on primary health care was limited. The main sources of population-based health information were vital registration, censuses, national surveys, and research studies. Information was generated through routine reporting at facility level. However, data were rarely collated and used at national level, and feedback mechanisms from central to local levels were missing.

Substantial progress has been made since then in the field of health information. An increasing volume of data has become available on health status, health services utilization, and determinants of health through population-based health interview surveys.

Information, a vital input to planning and programming that is not available in tine and is not valid can put off the best of planning or policy processes. The amount of information and data available to policy makers and planners is always limited and **whatever is made available is often the result of ad hoc attempts in form of surveys out of "compliance".**

Which ever way we look at, it has gradually become evident that **Information is critical input** to the entire planning process in Health care.

Surveys, the most fashionable tool for secondary data, continue to rule the information base for the simple reason that they are **relatively more accurate** for the extra inputs but are **based purely on self-reporting**, which puts a question mark to their reliability, validity and comparability. Also the ***survey "efforts" in routine can't be sustained*** by the system.

Population-based household surveys have become the major source of health information. Much of the information generated by surveys is based on self-reporting, raising issues of reliability, validity and cross-population comparability.

We need to develop an "Information culture" in Health to measure Health System's performance Slow at pace, but this dimension has started getting attention particularly since late nineties. A good volume of data is now available on health status, service utilization, and determinants of health, still morbidity is not measured over a standard scale and only child mortality is documented on a limited level. Further, we do not have empirical evidence for coverage and cost of health care interventions.

Major issues that remain to be addressed are:

1. How to dovetail health information with operational management and strategic planning in the health care delivery system;
2. How to enhance the information management capacity in countries especially in area of human resources development; and
3. How to improve use of information technology to improve data collection and dissemination of information.

The need:

Primarily, Information in Health care delivery is required for the four distinct but still related purposes like-

1. Evidence based policy and strategic decision-making
2. Program management
3. Monitoring the process and outcomes
4. Evaluation of achievements

Issues in HMIS:

1. Is there a policy existing for Health Information system?
2. Does an organizational structure exist at the National level for HMIS?
3. Functional linkages between sub-systems for feedback, utilization, responsibility
4. Capacity building-potential, activities and resources
5. Is there a Fixed- frequency review of reports and records?
6. How are reports made and who makes them?
7. Is there a built in system for checking reliability of data generated at the lowest level

Terms used in Information System:

Data: Messages not evaluated for their worth in specific situations". Data could be-Primary or Secondary

Data Quality-

"Quality" is defined as ability to achieve desirable objectives using legitimate means
The data quality refers to what was initially intended and is objective, unbiased and complies with standards.
The attributes of data quality are-

1. Accuracy & Validity
2. Reliability
3. Completeness
4. Legibility
5. Timeliness
6. Accessibility
7. Usefulness
8. Confidentiality

Factors deciding Quality in Data collection:

1. Who collected for whom?
2. For what service
3. When and where
4. Why was it provided?
5. How effective the service was
6. What was the outcome?

Sources of Data-

The data for the above said purpose are usually available from different sources like-

1. Diaries
2. Family registers
3. Hospital registers / Records
4. Periodic reports
5. Rapid surveys
6. Exit interviews
7. National sample survey
8. Census
9. Special studies

Data may be defined as a **representation of facts or concepts or instructions in a formalized manner, suitable for communication, interpretation or processing by manual or electronic**

means. Data need to be **Accurate and Valid** at each point (Point of Entry, Point of Service delivery and Point of Decision making), besides being **Reliable, Timely, Complete, and Retrievable.**

Information:" Evaluated data"
"A resource with cost & benefit", "Potential knowledge"," An essential input for decision making"

Record:" A document of transaction between a client and service provider of who did what to whom, when and where", e.g. A bill, A prescription, A discharge ticket, A laboratory report, A register.

Information System: Comprehensive, coherent arrangement organized on an organizational or major program basis to collect, process and provide coordinated information to serve multiple needs of management system.

Health Information System: "an integrated effort to collect, process, report and use health Information & knowledge for influencing policy-making, program action, and research.

Objectives of HMIS:

1. To support the development of strategic plan for national health information systems
2. To encourage the establishment of communicable and non communicable disease surveillance systems
3. To promote the use of ICD-10 (International Classification of Diseases, Injuries and Causes of Death) and to improve data quality
4. To establish a National health database with indicators to monitor and assess health outcomes
5. To provide technical support to strengthen data analysis and use of information at all levels of health care delivery
6. To promote research related to health, such as research into human behavior, biomedical interventions and health systems
7. To facilitate the use of scientific evidence based on research

The other set of objectives could be-

1. Medical care-
    a. Quality assurance &
    b. Assessment of outcome
2. Cost control & productivity enhancement
3. Utilization analysis and demand estimation
4. Program planning & evaluation
5. Simplification of Records
6. Education
7. Clinical research

Components of the basic mgt. process in health care are-

1. **Establishing goals & Objective** for which information is required regarding-
    a. Problem indicators
        i. Mortality
        ii. morbidity
        iii. Social indicators
        iv. Economic data
        v. Health seeking behavior

   b. Data on services delivered by other community organizations
   c. Resources available

2. **Estimate demand for services** based on
   a. Data on utilization
   b. Demographic data
   c. Community projections

3. **Allocate resources to meet demands**, based on
   a. Data on work force
   b. Financial information
   c. Capital requirements
   d. Short term demand forecasts

4. **Control quality**, based on data on
   a. Output measure
   b. Quality control data
   c. Work sampling & measurement
   d. Medical audit

5. **Evaluate performance** through
   a. Changes in problem indicators
   b. Cost benefit analysis
   c. Changes in community's capability to provide services

The **major components of HMIS** are-

1. Identification
2. Collection
3. Classification
4. Processing
5. Communication
6. Interpretation
7. Storage and Retrieval

Use of Information in Health care planning:

1. Information for assessing need
2. Information for controlling utilization and standards (quality of services)
3. Information for controlling deployment of resources
4. Information for increasing effectiveness of services

Prerequisites of HMIS-

The following review activities may be contemplated in order to assess the current status of HMIS-

1. Existing formats, transmission system & channels, capacity of data handlers and analyzers and the resources (hard and soft) available.
2. Exploring possibilities of additions and deletion of parameters
3. Complimentary or contradictory nature of sub-systems of the System

"How do we determine ideal number of indicators and cost?" Collection of information is expensive and one really needs to prioritize the indicators.

The number of indicators on which information is to be collected depends on-

1. National Health policy & priorities
2. Relevance in view of Epidemiological transition
3. Resources at command
4. Capacity of Data generators and data handlers
5. System's overall responsiveness to data being used in planning

Levels at which we need information

1. Point of entry of client into the System
2. Point of Service
3. Point of decision-making

Who uses the information and for what-

1. National & State Ministries for
   a. Assessing impact
   b. Policy development
   c. Financial allocations
2. Health care professionals for
   a. Treatment in Hospitals/ CHC/ PHC
   b. Choosing alternatives between care lines
3. Legal bodies
   a. As documentary evidence of care
   b. Protect interests of Health care professionals and patients
4. Insurance companies for reimbursement of claims

Designing HMIS

1. **Design Requirements:**
   a. Clarity of Objectives
   b. Awareness of information need
   c. Flexibility to change
2. **Considerations in information system design**
   a. Identifying & listing of objectives and norms in hierarchy
   b. Identification of all decision points to be served by the system
   c. Determination of relative importance & priority of identified decisions
   d. Identifying information need for decision
   e. Identification of relationship among decision sets
   f. Specification of information system
   g. Installation
   h. Establishing a review mechanism
3. **Information requirements,** is governed by
   a. Decision structure of Program
   b. Levels of decision making
   c. Questions to be answered
   d. Economics of information management, based on these requirements decision shall be taken regarding type of information, which could be-
      i. Scientific& Technical (Related to problem & solution

ii. Situational (Program environment)
iii. Programmatic (Intervention system)

An answer to questions like-

1. What data is needed?
2. Who generates, in what form
3. Quality
4. Processing requirement
5. Types of formats for reporting
6. Frequency of reporting
7. Data storage system,
8. Devices for storage
9. What should be the channel for information flow;

shall determine the **basic steps in designing HMIS,** which are-

1. Determine organizational need for information
2. Identify sources of information
3. Decide on amount, form and frequency
4. Select means of information communication & processing

Application of HMIS-

A good HMIS that is **Reliable, Timely, Complete, and Retrievable** should facilitate decision making at different levels

HMIS should provide support to-

1. **Health Workers,** in
   a. Understand health needs (based on approaches like CNAA)
   b. Prioritizing clients
   c. Estimate requirements (based on Demographic profile, morbidity profile, coverage and /or Expectations)
2. **Program Mangers**, for
   a. Assessing quality & Coverage
   b. Allocating resources
   c. Reducing wastage and duplication
3. **Policy makers**, to
   a. Assess cost-effectiveness
   b. Decide content & mode of service delivery
   c. Develop norms
      i. Financial
      ii. Infrastructure
      iii. Staffing
      iv. Logistics

Problem areas in HMIS:

1. Unrealistic expectation of Managers
2. Addressing to –"Report to higher levels" rather than convincing workers about the benefits
3. Too much information asked
4. Poorly trained, Over worked staff, (30-40 % time in reporting)
5. Information collected is selective is directed to handle out of pressure ad hoc exigent requirements of Managers or System

6. Many reporting levels- Data lost in transmission
7. Performance indicators keep changing with-
    a. Shifting priorities within program
    b. New additions- NO deletions of irrelevant
8. Indicators-simply output oriented
9. Program priorities & timeliness of information flow do not match
10. Retrieval
11. Duplication
12. NO periodic review

Immunization

46% of total children in India are malnourished.

Pneumonia kills 2 million children every year followed by Diarrhea.

Rate of improvement 1% in the last decade. For child mortality, India ranks at 49th place in the World

Why immunization:

1. Immunization is a key strategy to child survival.
2. By protecting infants from VPDs, immunization significantly lowers morbidity and mortality rates in children. The security provided to families can lead to lower birth rates.
3. Immunization is an indicator of a strong primary health care system

Full immunization:

Means child has received one dose of BCG, three doses of DPT and OPV each and one dose of Measles before one year of age

1. 43.5% of children in India received all vaccinations as per NFHS-III 2005-06.
2. Very little improvement in full vaccination coverage between NHFS-2 & NFHS-3.

Reasons for low coverage in immunization:

1. Failure to provide immunization at planned outreach, sub centre or PHC sites.
2. Dropouts: children who receive one or more vaccination, but do not return for subsequent doses.
3. Unreached populations
    a. Children whose parents do not know about immunization or face socio-economic barriers to utilize services.
    b. Lack of geographic access: children who live too far away from a health centre or outreach site to realistically complete a full immunization schedule.
4. Resistant populations: Children whose parents do not believe in immunization services, even though a health centre is within reach.
5. Missed Opportunities: Children who visit the health centre for some other reason, but are not immunized by health workers.
6. Improper logistics management

Immunization Micro Plan

1. At SC level:
    a. Estimation of benefictiories
    b. Estimation of vaccine and logistics
    c. Work plan
        i. Who will provide services
        ii. Who wil assist (AWW, ASHA, PRI, NGO)
        iii. Where wil the services be provided (Site)
        iv. When will the services be provided (Session plan)
2. At SC/PHC level
    a. Area map at SC level
    b. Alternative vaccine delivery routes
3. At PHC/District level
    a. Supervision plan
    b. Budget plan (transport, social mobilization, meetings)
    c. IEC and training plan

Simple way to keep injections safe:

1. ***Keep hands clean before giving injections***
    a. Wash or disinfect hands prior to preparing injection material.
    b. Avoid giving injections if the skin of the recipient is infected or compromised by local infection (such as a skin lesion, cut, or weeping dermatitis).
    c. Cover any small cuts on the service provider's skin.

2. ***Use sterile injection equipment, every time***

3. ***Prevent the contamination of vaccine and injection equipment***

    a. Prepare each injection in a designated clean area where contamination from blood or body fluid is unlikely.
    b. If the injection site is dirty, wash with clan water
    c. Always pierce the rubber cap of the vial with a sterile needle.
    d. Do not leave the needle in the stopper of the vial.
    e. Follow product-specific recommendations for use, storage, and handling of a vaccine.
    f. Discard any needle that has touched any non-sterile surface.

4. ***Assume all used equipment is contaminated***

    a. Cut the used syringe at the hub immediately after use.
    b. Wash or disinfect hands prior to preparing injection material.
    c. Avoid giving injections if the skin of the recipient is infected or compromised by local infection (such as a skin lesion, cut, or weeping dermatitis).
    d. Cover any small cuts on the service provider's skin.

5. ***Practice safe disposal of all medical sharps waste***

    a. Used sharps (needles) must be deposited in a hub cutter and then carried to the PHC for safe disposal.

6. ***Prevent needle-stick injuries***

    a. Do not recap.
    b. Collect sharps in a puncture proof container (Hub cutter).
    c. Anticipate sudden movement of the child.

Adverse Events following Immunization

Programmatic Errors	Possible Adverse event that may occur
Non-Sterile injection:	
1. Improperly sterilizing syringe 2. Contaminated vaccine or diluents 3. Re-use of reconstituted vaccine at subsequent sessions 4. Wiping the needle with a swab **5.** Administering injection over clothes	1. Infection such as local abscess at site of injection sepsis, toxic shock syndrome or death.
Re-use of disposable syringe and needle	1. Transmission of blood-borne infections such as Heb B, HIV, Hep C
Reconstitution Error/ Wrong vaccine preparation 1. Reconstitution with incorrect diluents 2. Drug substituted for vaccine diluents **3.** Inadequate shaking for T-series vaccines	1. Vaccine ineffective 2. Negative effect of drug, e.g. insulin causing death **3.** Local abscess
Injection at incorrect site 1. BCG given sub-cutaneously 2. DPT/DT/TT given superficially **3.** Injection into buttocks	1. Local reaction or abscess 2. Local reaction or abscess **3.** Sciatic nerve damage
Vaccine transportation/storage	1. Local reaction from frozen vaccine **2.** Vaccine ineffective
Contraindications ignored	1. Avoidable serious reaction

When a severe adverse event occurs, the health worker should immediately contact the Medical Officer and if needed should accompany the patient.
All vaccines can cause minor vaccine reactions in some patients. These mild reactions are normal and do not need to be reported.

Mild vaccine reactions	Treatment	When to report
Local reaction (pain, selling, redness)	1. Cold cloth at injection site 2. Give Paracetamol	1. In case of an abscess
Fever > 38.5°C	1. Give extra fluids 2. Wear cool clothing 3. Give tepid sponging 4. Give Paracetamol	1. When accompanied by other symptoms
Irritability, malaise and systemic symptoms	1. Give extra fluids 2. Give Paracetamol	1. When severe or unusual

Why children drop out:

1. Anaphylaxis or a severe allergic reaction is an absolute contraindication to subsequent doses of a vaccine. Persons with a known allergy to a vaccine component should not be vaccinated. Parents are not told or forget when to return.
2. Parents are not aware of the reason of following an immunization schedule.
3. Parents do not know that immunization is important.
4. Parents develop misconceptions about immunization.
5. Families move to a new village.

Actions to be taken to reach the un-reached (instruct your health workers):

1. Develop a list of children who have never accessed immunization services in the area.
2. Look for migrant populations travelling through your service delivery area and reach out to them. Tell them about immunization and give them the date, time and place of the nearest session.
3. Visit several of these households to find out the reasons why they have never accessed immunization services. Use the opportunity to clear up any doubts expressed by the families and help them find ways to overcome any barriers that prevent them from bringing their child to the next session.
4. Take the help of the community workers such as ASHA, AWW and NGOs to talk to parents about the importance of full immunization and give them the date and time of the next session.

Actions to be taken for dealing with resistant populations

1. Find out the reasons by taking directly to them and address their misconceptions, doubts, and fears by listening to them, and offering support and care.
2. Request community leaders and other staff working to educate them about vaccination.
3. Spend more time talking with community leaders, religious leaders, and other key persons in the village about the benefits of immunization.
4. Always provide prompt and quality services.
5. Arrange for an interaction between resistant groups and satisfied beneficiaries in the area to promote immunization.
6. Community meetings
7. Discussion sessions at farmers' meetings, in the market place and other places
8. Loudspeaker messages for the community, use Radio and TV spots Newspaper and drama

National Immunization schedule:

Vaccine	***When to give***	***Dose***	***Route***	***Site***
For Pregnant Women				
TT-1	Early in pregnancy	0.5 ml	IM	Upper Arm
TT-2	4 weeks after TT-1*	0.5 ml	IM	Upper Arm
TT- Booster	If pregnancy occur within three yrs of last TT vaccination*	0.5 ml	IM	Upper Arm
For infants				
BCG	At birth (for institutional deliveries) or along with DPT-1	0.1 ml (0.05ml for infant up to 1 month)	ID	Left Upper Arm
OPV-0	At birth if delivery is in institution	2 drops	Oral	Oral
OPV- 1,2 & 3	At 6 weeks, 10 weeks & 14 weeks	2 drops	Oral	Oral
DPT- 1,2 & 3	At 6 weeks, 10 weeks & 14 weeks	0.5 ml	*IM*	Outer Mid-thigh (Antero-lateral side of mid-thigh)
Hep B 1,2 & 3	At 6 weeks, 10 weeks & 14 weeks**	0.5 ml	IM	Outer Mid-thigh (Antero-lateral side of mid-thigh)

Measles	9-12 months	0.5 ml	SC	Right upper Arm
Vitamin-A (1st Dose)	At 9 months with measles	1 ml (1 lakh IU)	Oral	Oral
For children				
DPT Booster	16-24 months	0.5 ml	IM	Outer Mid-thigh (Antero-lateral side of mid-thigh)
OPV Booster Vitamin-A (2nd to 9th Dose)	16-24 months • 16 months with DPT/OPV booster • Then, one dose every 6 months up to the age of 5 years.	2 drops 2 ml (2 lakh IU)	Oral Oral	Oral Oral
DT Booster	5 years	0.5 ml	IM	Upper Arm
TT	10 years & 16 years	0.5 ml	IM	Upper Arm

Cold Chain:

Cold Chain is a system of transporting and storing vaccines at recommended temperature from the point of manufacture to the point of use. All Vaccines tend to lose potency on exposure to heat above +80 C

Some Vaccines lose potency when exposed to freezing temperatures. The damage is irreversible

Essentials of cold chain-

1. Personnel to organize and manage vaccine distribution
2. Equipment for storage and transport of vaccines.
3. Transport facilities
4. Maintenance of equipment
5. Monitoring
6. It is the responsibility of district block managers to ensure the cold chain equipment are installed operated and maintained properly so as to keep it continuously functioning equipment.

How to be sure that the vaccine is still Potent?
VVM for Heat Damage-

A Vaccine Vial Monitor (VVM) is a label that changes colour when the vaccine vial has been exposed to heat over a period of time. Before opening a vial, the status of the VVM must be checked to see whether the vaccine has been damaged by heat. The VVM is printed on the vial label or cap. It looks like a square inside a circle. As the vaccine vial is exposed to more heat, the square becomes darker.

1. Use only vial with inner squares that are lighter in colour than the outside circle.
2. Vials with VVMs in which the inner square has begun to darken but is still lighter than the outer circle should be used before the vials with a lighter inner square.
3. VVMs do not measure exposure to freezing temperatures (for freeze- sensitive vaccines).

Shake test for Cold Damage

Shake test is designed to determine whether adsorbed vaccines (DPT, DT, TT or Hepatitis B) have been frozen. After freezing, the vaccine is no longer a uniform cloudy liquid, but tends to form flakes which gradually settle to the bottom after the vial has been shaken. Sedimentation occurs faster in a vaccine vial which has been frozen that in a vaccine from the same manufacturer which has never been frozen.

Step1 – Prepare a frozen control sample: Take a vial of vaccine of the same type and batch number as the vaccine you want to test, and from the same manufacturer. Freeze the vial until the contents are solid (at least 10 hours at -10°C) and then let it thaw. This vial is the control sample. Mark the vial clearly so that it is easily identifiable and will not be used by mistake.
Step2 – Choose a test sample: Take a vial (s) of vaccine from the batch (es) that you suspect has been frozen. This is the test sample.
Step3 – Shake the control and test samples: Hold the control sample and the test sample together in one hand and shake vigorously for 10-15 seconds.
Step4 – Allow to rest: Leave both vials to rest by placing the vials on a table and not moving them further.
Step5 – Compare the vials: View both vials against the light to compare the sedimentation rate. If the test sample shows a much slower sedimentation rate than the control sample, the test sample has most probably not been frozen and can be used. If the sedimentation rate is similar, the vial has probably been damaged by freezing and should not be used.

What are Vaccine Carriers?

Vaccine carriers are used by health workers for carrying vaccines (16-20 vials) to sub-centres or to villages. They maintain the cold chain for one day's use in the field. Vaccine carriers have thick walls and lids and are made of a special material that prevents heat from passing through and reducing the potency of vaccines. The inside temperature of a vaccine carrier is maintained between +2 to +8 degrees centigrade with 4 frozen ice packs for one day (if not opened frequently).

1. Only vaccine carriers with 4 ice packs should be used. Day carriers with 2 ice packs should not be used.
2. Do not leave vaccine carriers in the sunlight; this spoils vaccines that are sensitive to heat and light.
3. Do not open the lid unnecessarily as this can allow heat and light into the carrier, which can spoil vaccines

Ice lined Refrigerators (ILRs)

1. Capacity: 140 litres at PHC level(1200 vials)
2. Ideal Temperature: +2°C to 8°C (Effective with electricity supply of 8/24 hrs)
3. Safe Storage: Always in the basket section
    a. (Always T series, Hepatitis-B and Diluents)
    b. (OPV/Measles/BCG may be kept below basket in case space is not available)
4. Thermometer: Place in the ILR-basket

Deep Freezers:

1. Capacity: 140 litres at PHC level
2. Ideal Temperature: -18°C to -20°C (In case of power failure - maintain temperature for 18-20 hrs)

3. Ice Pack Freezing Capacity: freezes 20 ice packs every 24 hours

Cold Boxes:

1. Type: Insulated boxes of 5 litre capacity
2. Usage: Stores & transports vaccine. Also stores frozen Ice Packs
3. Capacity: 1500 doses (mixed antigen) or 5000 doses (only OPV) with 24 ice packs.
4. Holdover Time:3 days (Keep thermometer inside)
5. Vaccine Layout: Direct contact of frozen ice packs spoils the vaccine. Give carton spacers/surround vaccine by OPV vials.
6. Label Protection: Place vaccine in cartons or polythene bags.

Vaccine carrier:

1. Type: Insulated boxes used for carrying small quantities of vaccine.
2. Capacity: 16-20 vials
3. Holdover Time: Maintain +2 to+8^0 C for about 24 hours (one day)
4. Ice packs: A maximum of 4 frozen packs
5. Vaccine Layout: Keep vaccines in a plastic bag (not in direct touch with the ice packs)

Do not-

1. Leave vaccine carrier in sunlight; this spoils vaccines that are sensitive to heat and light.
2. Leave the lid open; this can allow heat and light into the carrier, which can spoil vaccines.
3. Drop or sit on the vaccine carrier: this can damage the carrier.
4. Carry vaccines in handbag as this can spoil vaccines that are sensitive to heat.
5. Keep the DPT, DT, TT and Hep. B vaccines on the Ice pack during the session

Ice packs:

1. Do not fill 100%.
2. Leave 10 mm room for expansion as water freezes.
3. Close the cap tightly
4. Clean the outer surface dry before freezing
5. Ice Packs to be frozen ROCK Solid
6. Freezing is faster & uniform if gap /breathing space is left between ice packs
7. Ice Packs are best frozen in Deep Freezers
8. Condition before use

Vaccine distribution:

1. Follow first-in-first - out rule (FIFO)
2. Also: first to expire - first out. (FEFO)
3. Vaccines are not stored at the sub-centre level and must be supplied on the day of use
4. Note manufacturer, batch no, VVM status
5. Use VVM stage-II vaccine near the cold chain point (do not distribute to remote areas)

Micro planning in Immunization

Micro-planning helps to answer-

1. What needs to be provided
2. Who will provide
3. Where to provide (including hard to reach)
4. When to provide
5. How to provide
6. How many to provide for (beneficiaries)
7. How much to provide (vaccines & logistics)

Steps for Supportive Supervision

Step 1: Set up a Supportive Supervision System

Right Supervisors | Right Tools | Right Resources

↓

Step 2: Plan regular Supervisory Visits

Where to conduct visits | When to conduct visits | What to do during visit

↓

Step 3: Conduuct supportive Supervision Visits

Collect information | Problem-solve and provide feedback | Provide on the job training | Record results of superrvision

↓

Step 4 : Follow up

Follow up on agreed actions | Analyze data regularly | Provide feedback to all stakeholders | Conduct follow up visits

Indian Public Health Standards (IPHS)

Why Standards:

1. Standards describe a level of quality that health care facilities are expected to meet.
2. Setting standards is a dynamic process
3. Revision of standards will occur as and when the facilities achieve a minimum functional grade.
4. Standards are also flexible, to be applied keeping in view the needs of the States.

Genesis of IPHS:

NRHM- launched on 12 April 2005 aimed at universal access to equitable, affordable and quality health care that is accountable and responsive to the people's needs. NRHM aims to reduce child and maternal Deaths, stabilize population and ensure gender and demographic balance. This requires a restructuring of delivery mechanism for health services for which it is proposed to up grade public health institutions from their present level to achieve a level of set standards called "Indian Public Health Standards (IPHS).

The "IPHS" have been prepared, keeping in mind the **minimum resources available** at the facilities. It mentions **the minimum functional level of institutions** in terms of space, building, manpower, instruments, equipments, drugs and health care services to be made available .The **IPHS will help the State and Central Governments, and PRIs** (where applicable), to monitor periodically how many of their health facilities are conforming to IPHS standards.

Need for Standards?

1. Functioning of Rural Health Care Institutions not satisfactory
2. Lack of comprehensive and realistic mandatory standards for Public Health Institutions in Indian context

Needed to ensure

1. Quality management
2. Quality Assurance
3. Effective, economical and accountable health care delivery system
4. Optimal level of services

Objectives for IPHS:

1. Describe benchmarks for quality expected from various components of health care organizations
2. Standards for quality of services, facilities, infrastructure, manpower, machines & equipment, drugs etc.
3. Main driver for continuous improvements in quality
4. Standards for assessing performance of health care delivery system

Process

1. Setting standards – a dynamic process
2. Current standards prepared keeping in view available resources
3. Minimum standards for functional requirements of buildings, manpower, instruments & equipments, drugs and other facilities

Existing Standards

1. Hospital Standards by Bureau of Indian Standards (BIS)
2. BIS Standards considered very resource intensive in current scenario
3. No such standards for primary health care institutions
4. National Rural Health Mission (NRHM) – opportunity to prescribe Indian Public Health Standards for rural health care

Process of Formulating IPHS

1. Constitution of Expert Committee under DGHS
2. Discussion with members comprised of ministry officials, State Governments representatives, academicians, management experts, economists, donor agencies, public health professionals, and other organizations such as NGOs etc.
3. Circulation of draft IPHS for public health institutions in rural areas
4. Putting drafts standard on website
5. Finalization of draft IPHS for public health institutions

Implementation and Monitoring

1. Under National Rural Health Mission (NRHM) States / UTs to upgrade CHCs, PHCs and Sub Centres up to IPHS levels
2. Govt. of India also provided funds @ Rs. 20 Lacs per CHCs for all CHCs to various States / UTs
3. Strengthening health infrastructure in terms of trained staff, infrastructure, equipment and supplies required
4. Prerequisite to obtain knowledge of existing situation at different levels of health facilities

Main objectives of IPHS Facility Survey

1. To assess existing facilities as per the norms under IPHS and identify gaps
2. To assess utilization of facilities provided
3. To assess quality of services using appropriate outcome indicators
4. Proforma designed and circulated among all States / UTs which could be used for conducting
   IPHS facility surveys
5. States / UTs in the process of conducting facility surveys
6. Reports of IPHS facility survey for identified CHCs received from 15 States / UTs
7. Monitoring Perform for Identifying Gaps for IPHS based on Facility Survey
    a. To properly analyze and monitor process of up gradation of CHCs to IPHS
    b. Proforma designed to highlight gaps
    c. To judge situation at a particular centre just by giving a look at proforma
    d. Monitoring Proforma to be kept as benchmark record for each centre
    e. Monitoring process for ensuring proper and effective implementation
8. Other requirements for IPHS
    a. Capacity Building at all levels
    b. Optimal Use of available infrastructure
    c. Quality Assurance & Accountability
    d. Standard Treatment protocols/ Standard Operating Guidelines
    e. Rogi Kalyan Samiti
    f. Charter of Patients' Rights (Citizen's Charter)
9. Monitoring mechanism
    a. Internal & External monitoring by PRIs and RKS/HMS

   b. Audits – Social, Economic, Medical & Technical
10. Checklist
   a. Checklist for minimum requirement for following components
   b. Services, Manpower, Physical infrastructure, Equipment, Drugs

IPHS for Sub Centers:

In the public sector, the Sub-Centre is the **most peripheral and first contact point** between the primary health care system and the community. Therefore, the success of any health program will depend on well functioning Sub-centres, providing **services of acceptable standards** to the people, through certain **available guidelines.** Thus, the necessary **first step is to lay down norms and standards for Sub Centres.**

Choosing location-

1. it is not too close to an existing sub centre/PHC
2. as far as possible, no person has to travel more than 3 km to reach the Sub-centre

Manpower-

One more ANM is proposed in addition to the **existing one ANM** and **one Male Health Worker.**

Drugs:

Elementary drugs for minor ailments such as **ARI, diarrhea, fever, worm infestation** etc

Services:

1. All “Assured Services” including routine, preventive, promotive, few curative and referral services and national health programs as applicable.
2. The assured package of services at SC level include
3. Full immunization and Vitamin A prophylaxis
4. Essential newborn care
5. Antenatal, natal and postnatal care
6. Prevention of malnutrition and common childhood diseases
7. Family planning services
8. Counseling.
9. community needs assessment
10. **Minimum laboratory services** to be made available are
   a. hemoglobin estimation,
   b. urine for albumin and sugar and
   c. Referral to PHC for blood grouping.
11. Others
   a. **Malaria prophylaxis** as per guidelines of` NVBDCP
   b. Provision of facilities under **Janani Suraksha Yojana (JSY)**
   c. **Adolescent health care** and **assistance to school health services**
   d. **Organizing VHND** in each village Anganwadi centre, at least once in a month, with the help of MO-PHC, ASHA, AWW, PRI, self help groups , PMU etc.
   e. Appropriate and prompt **referral services**
   f. Providing **treatment as per AYUSH** according to local need.
   g. **Training** of Traditional Birth Attendants and ASHA/Community Health Volunteers
   h. **Recording and reporting of vital events**
   i. **Syndromic surveillance** to be done and reported to PHC every week
   j. **Water Quality Monitoring**

k. **Disinfection of water** sources
l. **Promotion of sanitation** including use of toilets and appropriate garbage disposal.
m. **Field visits** for disease surveillance, community need assessment, family welfare services, including RTI/STI awareness

12. Norms for facility-
    a. **Residential Accommodation** should be available for the Health workers, especially the ANMs
    b. **Maintenance of equipment** is advised through preventive maintenance or prompt repair of non-functional equipment to ensure uninterrupted delivery of services, by making use of the untied funds
    c. Potable **water** for patients and staff and water for other use should be made available in adequate quantity.
    d. Wherever possible**, uninterrupted power supply** has to be ensured
13. Fund, Monitoring & Evaluation
    a. assistance from MOHFW to all Sub-centres in the country since April 2002
    b. **Untied funds** are provided (currently **Rs.10,000 per Subcentre** under NRHM)
    c. One Health Assistant (Female) / Lady Health Visitor (LHV) and one Health Assistant (Male) located at the PHC are entrusted with the task of supervision of all the Sub-centres (generally six sub centres) under a PHC.

IPHS for PHC:

The 6th Five year Plan (1983-88) proposed reorganization of PHCs on the basis of one PHC for every 30,000 rural population in the plains and one PHC for every 20,000 population in hilly, tribal and backward areas for more effective coverage**.A PHC serves as a first port of call to a qualified doctor in rural areas. On one hand it serves as a referral unit for 6 Sub-centres** and on the other hand, cases are referred from PHCs to CHCs/other higher secondary level institutions. It provides a range of curative, promotive and preventive health care services. Besides **minimum resources available** and minimum **functional standards** Constitution of RMRS (**Rogi Kalyan Samiti) / Management Committee with involvement of PRI** and **Citizens' Charter** are some of the innovative approaches incorporated under IPHS for PHC.

24 x 7 PHC should:

1. Provide 24-hour delivery services, both normal and assisted
2. Provide Obstetric First Aid and Referrals to First Referral Units (FRUs)/other hospitals, for high risk pregnancy cases beyond the capability of Medical Officer, PHC.
3. Provide 24 hours emergency services for management of injuries and accidents.
4. Provide emergency care of sick children

Genesis of IPHS

Minimum requirement for assured services at PHC under IPHS:

The requirements are projected based on an average case load of 40 patients per doctor per day, expected number of beneficiaries for maternal health ,child health and family planning services and 60% utilization of the available indoor/observation beds (6 beds).

It is a dynamic process - if utilization goes up, the standards are to be further upgraded.

Regarding manpower, one more Medical Officer (AYUSH or lady doctor) and two more staff nurses are to be added to the existing total staff strength of 15 in the PHC, if it is to be made into a 24x7 services delivery centre.

Minimum laboratory investigations should be provided as listed in the IPHS document on PHC

Assured services cover all the essential elements of preventive, promotive, curative and rehabilitative primary health care. This implies a wide range of services that include:

Medical care:

OPD services: 4 hours in the morning and 2 hours in the afternoon / evening. Time Minimum OPD attendance should be 40 patients per doctor per day.

24 hours emergency services: appropriate management of injuries and accident, First Aid, Stabilization of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions

Referral services

In-patient services (6 beds)

Maternal and Child Health Care including family planning:

1. Antenatal care:
2. Intra-natal care: (24-hour delivery services both normal and assisted)
3. Postnatal Care:
4. New Born care:
5. Care of the child:
6. Family Planning:
7. Medical Termination of Pregnancies using Manual Vacuum Aspiration (MVA) technique. (wherever trained personnel and facility exists)
8. Management of Reproductive Tract Infections / Sexually Transmitted Infections:
9. Nutrition Services (coordinated with ICDS):
10. School Health:
11. Adolescent Health Care:
12. Promotion of Safe Drinking Water and Basic Sanitation
13. Prevention and control of locally endemic diseases like malaria, Kalaazar, Japanese Encephalitis, etc.
14. Disease Surveillance and Control of Epidemics:
15. Collection and reporting of vital events
16. Education about health/Behavior Change Communication (BCC)
17. National Health Programs including Reproductive and Child Health Program (RCH), HIV/AIDS control program, Non communicable disease control Program - as relevant:
18. Revised National Tuberculosis Control Program (RNTCP): All PHCs to function as DOTS Centres to deliver treatment as per RNTCP treatment guidelines through DOTS providers and treatment of common complications of TB and side effects of drugs, record and report on RNTCP activities as per guidelines.
19. Integrated Disease Surveillance Project (IDSP):
20. National Program for Control of Blindness (NPCB):
21. National Vector Borne Disease Control Program (NVBDCP):
22. National AIDS Control Program:
23. Referral Services:
24. Appropriate and prompt referral of cases needing specialist care including:
25. Training:
26. Basic Laboratory Services: Essential Laboratory services including:
27. Monitoring and Supervision:
28. AYUSH services as per local people's preference (Mainstreaming of AYUSH)
29. Rehabilitation:

30. 24 hour delivery services and new born care, all seven days a week in order to increase the institutional deliveries which would help in reducing maternal mortality
31. Selected Surgical Procedures:
32. Record of Vital Events and Reporting:

Essential Infrastructure:

The PHC should have a building of its own. The surroundings should be clean. The details are as follows:

PHC Building

Location:

1. Easily accessible area.
2. Prominent board displaying the name of the Centre in the local language.
3. Facility for electricity, all weather road communication, adequate water supply, telephone. Well lit and ventilated with as much use of natural light and ventilation as possible.
4. The plinth area would vary from 375 to 450 sq. meters depending on whether an OT facility is opted for.
5. Entrance- well-lit and ventilated with space for Registration and record room,
6. Drug dispensing room, and waiting area for patients.
7. The doorway leading to the entrance should also have a ramp facilitating easy access for handicapped patients, wheel chairs, stretchers etc.

Waiting area:

1. This should have adequate space and seating arrangements for
2. waiting clients / patients
3. The walls should carry posters imparting health education.
4. Booklets / leaflets may be provided in the waiting area for the same purpose.
5. Toilets with adequate water supply separate for males and females should be available.
6. Drinking water should be available in the patient's waiting area.
7. Signage-displaying wings of the centre, available services, and names of the doctors, users' fee details and list of members of the RMRS/ Hospital Mgt Committee.
8. A locked complaint / suggestion box and complaints at regular intervals are addressed.
9. The surroundings should be kept clean with no water-logging in and around the centre and vector breeding places.

Outpatient Department:

1. The outpatient room should have separate areas for consultation and examination.
2. The area for examination should have sufficient privacy.
3. In PHCs with AYUSH doctors, necessary infrastructure such as consultation room for AYUSH Doctor and AYUSH Drug dispensing should be made available.

Wards 5.5x3.5 m each:

1. There should be 4-6 beds in a primary health centre. Separate wards/areas should be earmarked for males and females with the necessary furniture.
2. There should be facilities for drinking water and separate and clean toilets for men and women.
3. The ward should be easily accessible from the OPD so as to obviate the need for a separate nursing staff in the ward and OPD during OPD hours.

Nursing station:
Location should be easily accessible to

OT and labour room after regular clinic timings.

1. Clean linen should be provided and cleanliness should be ensured at all times.
2. Cooking should not be allowed inside the wards for admitted patients suitable arrangement with a local agency like a local women's group for provision of nutritious and hygienic food at reasonable rates may be made wherever feasible and possible.
3. Cleaning of the wards, etc. should be carried out at such times so as not to interfere with the work during peak hours and also during times of eating.

Operation Theatre: (Optional) to facilitate conducting selected surgical procedures (e.g. vasectomy, tubectomy, hydrocelectomy, Cataract surgery camps)

1. It should have a changing room, sterilization area operating area and washing area.
2. Separate facilities for storing of sterile and unsterile equipments /instruments should be available in the OT.
3. patient preparation area and Post-OP area. However, in view of the existing situation, the OT should be well connected to the wards.
4. The OT should be well-equipped with all the necessary accessories and equipment
5. Surgeries like laparoscopy / cataract / Tubectomy / Vasectomy should be able to be carried out in these OTs.

Labour Room (3800x4200mm):

1. There should be separate areas for septic and aseptic deliveries.
2. The LR should be well-lit and ventilated with an attached toilet and drinking water facilities.Plan has been annexed.
3. Dirty linen, baby wash, toilet, Sterilization

Minor OT/Dressing Room/Injection Room/Emergency:

1. This should be located close to the OPD to cater to patients for minor surgeries and emergencies after OPD hours.
2. It should be well equipped with all the emergency drugs and instruments.

Laboratory (3800x2700mm):

1. Sufficient space with workbenches and separate area for collection and screening should be available.
2. Should have marble/stone table top for platform and wash basins.

General store:

1. Separate area for storage of sterile and common linen and other materials/ drugs/ consumable etc. should be provided with adequate storage space.
2. The area should be well-lit and ventilated and should be rodent/ pest- free.

Dispensing cum store area: 3000x3000mm

Infrastructure for AYUSH doctor: Based on the specialty being practiced, appropriate arrangements should be made for the provision of a doctor's room and a dispensing room cum drug storage.

Immunization/FP/counseling area: 3000x4000mm
Office room 3500x3000mm
Dirty utility room for dirty linen and used items
Boundary wall with gate

Residential Accommodation: Decent accommodation with all the amenities likes 24-hrs. Water supply, electricity, etc. should be available for medical officers and nursing staff, pharmacist and laboratory technician and other staff.

Other amenities:

1. Electricity with generator back-up
2. Adequate water supply
3. Telephone: at least one direct line
4. Wherever possible garden should be developed preferably with the involvement of community.

Equipment and Furniture:

1. The necessary equipment to deliver the assured services of the PHC should be available in adequate quantity and also be functional.
2. Equipment maintenance should be given special attention.
3. Periodic stock taking of equipment and preventive/ round the year maintenance will ensure proper functioning equipment. Back up should be made available wherever possible.

Manpower: The manpower that should be available in the PHC s as follows:

Existing		Recommended
Medical Officer	1	2(one may be from AYUSH or Lady Medical Officer)
Pharmacist	1	1
Nurse-midwife (Staff	1	3 (for 24-hour PHCs)
(Nurse)		(2 may be contractual)
Health workers (F)	1	1
Health Educator	1	1
Health Astt. (Male &	2	2
Female)		
Clerks	2	2
Laboratory Technician	1	1
Driver	1	Optional/vehicles may be out-sourced.
Class IV	4	4
Total	15	17/18

Drugs:

1. All the drugs available in the Sub-centre should also be available in the PHC.
2. In addition, all the drugs required for the National health Programs and emergency management should be available in adequate quantities so as to ensure completion of treatment by all patients.
3. Adequate quantities of all drugs should be maintained through periodic stock-checking, appropriate record maintenance and inventory methods. Facilities for local purchase of drugs in times of epidemics / outbreaks / emergencies should be made available
4. Drugs required for the AYUSH doctor should be available in addition to all other facilities.

The Transport Facilities: The PHC should have an ambulance, which can be outsourced.
Referral Transport Facility: The PHC should have an ambulance for transportation of emergency patients, can be outsourced.
Transport for Supervisory and other outreach activities: The vehicle can also be outsourced for this purpose.

Laundry and Dietary facilities for indoor patients: These facilities can be outsourced.
Waste Management at PHC level: GOI guidelines to be followed.
Quality Assurance: Periodic skill development training of the staff of the PHC in the various jobs/ responsibilities assigned to them can ensure quality. Standard Treatment Protocol for all national Programs and locally common disease should be made available at all PHCs, regular monitoring is another important means.

A few aspects that need definite attention are:

1. Interaction and Information Exchange with the client/ patient:
   a. Courtesy should be extended to patients / clients by all the health providers including the support staff
   b. All relevant information should be provided as regards the condition / illness of the client/ patient.
2. Attitude of the health care providers needs to undergo a radical change so as to incorporate the feeling that client is important and needs to be treated with respect.
3. Cleanliness should be maintained at all points

Monitoring: This is important to ensure that quality is maintained and also to make changes if necessary.

Internal Mechanism: Record maintenance, checking and supportive supervision
External Mechanism: Monitoring through the PRI / Village Health Committee / RMRS (as per guidelines of State Government). A format for conducting facility survey for the PHCs on Indian Public Health Standards to have baseline information on the gaps and subsequently to monitor the availability of facilities is to be developed.

Accountability: To ensure accountability, the Charter of Patients' Rights should be made available in each PHC.Every PHC should have a RMRS / Primary Health Centre's Management Committee for improvement of the management and service provision of the PHC. This committee will have the authority to generate its own funds (through users' charges, donation etc.) and utilize the same for service improvement of the PHC. The PRI/Village Health Committee / RMRS will also monitor the functioning of the PHCs.

Indian Public Health Standard for CHC

Objectives of Indian Public Health Standards (IPHS) for CHCs:

1. To provide optimal expert care to the community
2. To achieve and maintain an acceptable standard of quality of care
3. To make the services more responsive and sensitive to the needs of the community.

Service delivery in CHCs: *Assured Services:*

1. Care of routine and emergency cases in surgery: This includes Incision and drainage, and surgery for Hernia, hydrocele, Appendicitis, hemorrhoids, fistula, etc.
2. Handling of emergencies like intestinal obstruction, hemorrhage, etc.
3. Care of routine and emergency cases in medicine:
4. Specific mention is being made of handling of all emergencies in relation to the National Health Programs as per guidelines like Dengue Hemorrhagic fever, cerebral malaria, etc. Appropriate guidelines are already available under each Program, which should be compiled in a single manual.
5. 24-hour delivery services including normal and assisted deliveries
6. Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions
7. Full range of family planning services including Laparoscopic Services
8. Safe Abortion Services
9. New-born Care
10. Routine and Emergency Care of sick children
11. Other management including nasal packing, tracheostomy, foreign body removal etc.

All the National Health Programs (NHP) should be delivered through the CHCs

Other facilities:

1. Blood Storage Facility
2. Essential Laboratory Services
3. Referral (transport) Services

Minimum requirement for delivery of the above-mentioned services: The following requirements are being projected based on the assumption that there will be average bed occupancy of 60%. The strength may be further increased if the occupancy increases with subsequent up gradation.

Clinical Manpower:

Personnel	Minm. requirement	Proposed	Desirable qualifications	Justification
General Surgeon	1	1	MS/DNB, (General Surgery)	
Physician	1	1	MD/DNB, (General Medicine)	
Obstetrician/ Gynecologist	1	1	MD/DNB/DGO (OBG)	
Pediatrics	1	1	MD/DNB/D.Ch (Pediatrics)	
Anesthetist	-	1	MD/DNB/DA(Anesthesia)/ Certificate course in Anesthesia for one year	Essential if there is to be utilization of the surgical specialties. They may be on contractual appointment or hiring of services from private sectors on case-to case basis.

Public Health Program Manager. He/she will be also designated as Block Surveillance Officer.	-	1	MD/DNB/ DPH/ Social science with public health background/ any other recognized course	Will be responsible for surveillance, coordination of NHPs, management of ASHAs, Training, etc. The appointment will be on contractual basis.
Eye surgeon	-	1	MD/MS/DOMS/DNB/(Ophthal)	For every 5 lakh population as per Vision 2020 approved Plan of Action.
Total	**4**	**6/7**		

Certain suggestions for offsetting the deficiencies in the availability of required manpower:

1. **Anesthetists:**
    a. Diploma and MD seats for post graduation in Anesthesia to be increased across the country. However care should be taken to only include institutions with assured quality and able to provide adequate clinical training.
    b. Certificate course for one year in Anesthesia by the National Board of Examinations

2. **Public Health Program Manager:**
    a. Diploma and MD seats for post graduation in Public Health to be increased across the country. However care should be taken to only include institutions with assured quality and able to provide adequate field and community-based training.
    b. Persons with DNB degrees in Family Medicine, Hospital Administration, Public Health, Maternal and Child health are to be recognized for the post.
    c. Persons who have completed the Professional Development Course of 3 months with a 9-month field training in recognized training institute may also be eligible for the same. This may also be seen as a career advancement avenue for Medical Officers serving in PHCs who may be eligible for the post after a stint of 3-4 years in PHC and completion of this course.

Support manpower:

Personnel	**Existing**
*Nurse-midwife	7+2
Dresser (certified by Red Cross/ St.Johns Ambulance)	1
Pharmacist/compounder	1
Lab. Technician	1
Radiographer	1
**Ophthalmic Assistant	0-1
Ward boys/ nursing orderly	2
Sweepers	3
Chowkidar	5***
OPD attendant	
Statistical Assistant/Data entry operator	
OT attendant	
Registration clerk	
Total Essential	21/22+2

*1 ANM and 1 PHN for family welfare will be appointed under the ASHA scheme
** Ophthalmic assistant may be placed wherever it does not exist through redeployment or contract basis.
*** Flexibility may rest with the state for recruitment of personnel as per needs.

Equipment:

The list of equipment provided under the CSSM may be referred to.

10-15% of the annual budget to be kept for Maintenance

Refrigerators - one for the ward and one for OT. Sharing of Refrigerator with the lab should be possible.

Appropriate standards for equipments are already available in the Bureau of Indian Standards.

Drugs:

The essential & emergency drugs to be maintained as per list. Program specific drugs are detailed in the Guidelines under each Program.

Investigative facilities at the CHC:

Routine along with ECG.

Physical Infrastructure:

The CHC should have

1. 30 indoor beds
2. one Operation theatre,
3. labor room,
4. X-ray facility and
5. Laboratory facility.

Location of the centre: at the centre of the block head quarter in order to improve access to the patients. This may be applicable only to centres that are to be newly established.

However, priority is to be given to operationalize the existing CHCs.

The building should have areas/ space marked for the following:

1. Entrance zone:
   a. Prominent display boards in local language providing information regarding the services available and the timings of the institute.
   b. Registration counters.
   c. Pharmacy for drug dispensing and storage
   d. Clean Public utilities separate for males and females
   e. Suggestion/ complaint boxes for the patients/ visitors and also information regarding the person responsible for redressal of complaints.
2. Outpatient department:
   a. Clinics for Various Medical Disciplines
      i. general medicine,
      ii. general surgery,
      iii. dental (optional),
      iv. obstetric and gynecology,
      v. pediatrics and
      vi. Family welfare.
      vii. Separate cubicles for general medicine and surgery with separate area for internal examination (privacy) can be provided
      viii. Family Welfare Clinic
      ix. Waiting room for patients
      x. Drug Dispensary
3. Emergency Room/ Casualty:
   a. The emergency cases may be attended by OPD during OPD hours and in inpatient units afterwards.

4. Treatment Room:
   a. Minor OT
   b. Injection Room and Dressing Room
5. Wards: Separate for males and females
   a. Nursing Station– Centralized location, spacious, work counters, trash cans.
   b. It should have provision for:
      i. Injections,
      ii. Dressings,
      iii. Examination and dressing table,
      iv. Bins for waste material,
      v. Wash basins,
      vi. Syringe destroyer
      vii. Needle cutter.
6. Patient Area:
   a. Enough space between beds.
   b. Toilets; separate for males and females.
   c. Separate space/ room for patients needing isolation
7. Ancillary rooms:
   a. Nurses rest room
   b. There should be an area separating OPD and Indoor facility.
8. Operation theatre/ Labour room:
   a. Patient area
   b. Pre-operative and Post-operative(recovery)room
9. Staff area:
   a. Changing room separate for males and females
10. Storage area for sterile supplies
    a. OT/ Labor room area:
    b. Operating room/ labor room
    c. Scrub area
    d. Instrument sterilization area
    e. Disposal area
11. Public utilities: Separate for males and females
    a. Physical infrastructure for Support services:
    b. CSSD:
    c. Sterilization and Sterile storage
12. Laundry:
    a. Storage: separate for Dirty linen and clean linen
    b. Outsourcing is recommended after appropriate training of washer man regarding separate treatment for infected and non-infected linen.
13. Services:
    a. Electricity/ telephones/ water/ civil engineering: May be outsourced.
    b. Maintenance of proper sanitation in Toilets and other Public utilities should be given utmost attention.
    c. Sufficient funding for this purpose must be kept and the services may be outsourced.
14. Water Supply:
    a. 10,000 liters of potable water per day
    b. Storage capacity for 2 days requirements
    c. Round the clock water supply
    d. Separate reserve emergency overhead tank for operation theatre.

e. Necessary water storage overhead tanks with pumping/boosting arrangement shall be made. The laying and distribution of the water supply system shall be according to the provisions of IS: 2065-1983*.

15. Geyser in O.T. / L.R. and one in ward also should be provided.
16. Emergency lighting:
    a. Emergency portable/fixed light units in the wards and departments
    b. Generator backup
    c. Use of solar energy wherever feasible.
17. Telephone: minimum two direct lines with intercom facility should be available.
18. Administrative zone:
    a. Separate rooms should be available for Office
    b. Stores

Capacity building:
Training of all cadres of worker at periodic intervals is an essential component. Multi-skill training for paramedical workers.

Quality Assurance in Service delivery:
Quality of service should be maintained at all levels. Standard treatment protocol for all national Programs and locally common diseases should be made available at all CHCs.

Standard Treatment protocol:

Diet: Diet may either be outsourced or adequate space for cooking should be provided in a separate space.

CSSD:
Adequate space and standard procedures for sterilization and sterile storage should be available.

Laundry:
Storage: separate for Dirty linen and clean linen
Outsourcing is recommended after appropriate training of washerman regarding separate treatment for infected and non-infected linen.

Services: Electricity/ telephones/ water/ civil engineering: may be outsourced.

Blood Storage Units: as per GOI guidelines

Waste disposal: As per National guidelines on hospital waste management as applicable to 30 bed CHCs or may be outsourced to agencies trained in this.

Charter of Patient Rights: It is mandatory for every CHC to have the Charter of Patient Rights prominently displayed at the entrance.

Quality Control:

1. Internal monitoring:
    a. Social Audit: through **Rogi Kalyan Samitis (RMRS in Rajasthan)/ Panchayati Raj Institution, etc**
    b. Medical audit

c. Others like technical audit, economic audit, disaster preparedness audit, etc.
d. Patient care:
    i. Access to patients
    ii. Registration and admission procedures
    iii. Examination
    iv. Information exchange
    v. Treatment
    vi. Other facilities: waiting, toilets, drinking water
    vii. Indoor patients:
        - Linen/ beds
        - Staying facilities for relatives
        - Diet and drinking water
        - Toilets

2. External Monitoring: Gradation by PRI(Zilla Parishad)/ Rogi Kalyan Samitis
3. Monitoring of laboratory

Record maintenance

Computers are to be used for accurate record maintenance.

Suggested innovations:

1. Water harvesting should be introduced in all new buildings
2. Computerization is a must and would be essential for record maintenance and surveillance.
3. To maintain the hospital landscaping, a room to store garden implements; seeds, etc, should be provided.

Checklist for minimum requirement of CHCs

Services	Existing	Remarks
Population covered		
Specialist services available		
Medicine		
Surgery		
OBG		
Pediatrics		
NHPs		
Emergency services		
Laboratory		
Blood Storage		

Check list for Infrastructure

Infrastructure (As per specifications)	Existing	Remarks
Area of the Building		
OPD rooms/cubicles		
Waiting room for patients		
No. of beds: Male		
No. of beds: Female		
Operation theatre		
Labour room		

Laboratory		
X-ray Room		
Blood Storage		
Pharmacy		
Water supply		
Electricity		
Garden		
Transport facilities		

Checklist for Equipment

Equipment (As per list)	Available	Functional	Remarks

Checklist for Drugs:

Drugs (As per Essential Drug list)	Available	Remarks

Checklist for Audit:

Particulars	Available	Whether functional as per norms
Patient's charter		
Rogi Kalyan Samiti		
Internal monitoring		
External Monitoring		
Availability of SOPs/STPs*		

Public Private Partnership

It is widely accepted that the deficiencies in public sector health system can only be overcome by significant reforms. The need for reforms in India's health sector has been emphasized by successive plan documents since the Eighth Five-Year Plan in 1992, by the 2002 national health policy and by international donor agencies. The proposed reforms are not cheap, but the cost of not reforming is even greater.

Health Sector Reform (HSR) is defined as a sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector' (Berman 1995). The World Health Organization (1997) defined health sector reform as a sustained process of fundamental change in policy and institutional arrangements of the health sector, usually guided by the government.

Reform strategies include:

1. alternative financing (user-fees, health insurance, community financing, private sector investment);
2. institutional management (autonomy to hospitals, monitoring and management by local government agencies, contracting);
3. Public sector reforms (civil service reforms, capacity building, productivity improvement); and
4. Collaboration with the private sector (public/private partnerships, joint ventures)

In an effort to bring in desired reforms into Health Care Delivery System, particularly so in wake of-

1. Rising costs,
2. Changing political situations, and
3. Social contexts (expectations of people from System);

The Public sector Health services are finding it difficult to sustain the services without extra inputs that need to be pumped in. Many of the functions of health care systems depend on adequate financing. If sustainable financing mechanisms are not put in place, innovative ideas for strengthening the primary health care base of health care systems will not yield results. But then where are those extra resources. One needs to look into the alternatives and explore the possibility of applying economics for financing Health sector.

Hitherto, governments were responsible for providing and financing health care, but rapid increase of health care expenditure requires more resources than those at the command of the governments. As a result, government participation in health care financing has been declining which affects the poor and marginalized sections of society, the most.

The expenditure pattern:

The public **health investment as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999.** The **aggregate expenditure (2000) in the Indian Health sector was 5.2 percent of the GDP**, of which **only 17% was public health expenditure**, rest being Out of Pocket Expenditure.

Different recommendations at different times were made with regard to the percentage of GDP/ plan allocations that should be spent on health sector, like Alma-Ata-5%, CSSR-ICMR-6%, CCHFW (1989)-7% of Plan; actual for 1990 was only 1.3% of GDP

CCHFW (2001) suggested 2% of GDP from the then current level of 0.9%.

If we look into per capita health expenditure it was Rs.320/- per annum in 1990-91 with the following break up
Primary care-58.7%
Secondary/ Tertiary-38.8%
Non-service expenditure-2.5%

The options available for Health care financing are-

1. Health insurance
2. Regulation and Legislation.
3. National Health Accounts (NHA)
4. Resource allocation
5. Cost - effectiveness and benefits
6. **Partnership collaboration**

Given their respective strengths and weaknesses, neither the public sector nor the private sector alone can operate in the best interest of the health system.
Recent estimates indicate that 93% of all hospitals, 64% of beds, 85% of doctors, 80% of outpatients and 57% of inpatients are in the private sector (World Bank 2001) and private hospitals are relatively less urban-biased than the public hospitals. The presence of the private sector in health has prompted various state governments in India to explore the option of involving the private sector and creating partnerships to meet the growing health care needs.

The private sector is not only India's most unregulated sector but also its most potent untapped sector. Besides punctuations like inequitable, expensive, over-indulgent in clinical procedures and without quality standards or public disclosure of practices, the private sector is perceived to be easily accessible, better managed and more efficient collaboration in the form of Public/Private Partnership would improve equity, efficiency, accountability, quality and accessibility of the entire health system. Partnerships are expected to ameliorate the resource constraints of the public sector by reducing investments in expensive tertiary care services.

What is Public/Private Partnership?

The definition adopted by GOI defines PPP as "collaborative efforts, between private and public sectors, with clearly identified partnership structures, shared objectives, and specified performance indicators for delivery of a set of health services (MOHFW,GOI)".

Advantages:

The advantages with public sector are-

1. Improvement in Health is the primary objective
2. Economies of Scale
3. More Equitable

The private sector offers a different set of advantages-

1. Market/Choice and Access
2. Efficiency
3. Flexibility

The overall **objective of PPP** are-

1. Improving access to essential services
2. Improving the quality of services available
3. Exchange of expertise
4. Mobilize additional resources for activities
5. Improve efficiency
6. Better Management of Health services
7. Increasing scope and scale of services
8. Increasing community ownership of programs.
9. Ensuring optimal utilization of govt. investment and infrastructure

The basics of PPP are-

1. Problem
2. Profile of Partners
3. Process of Building a partnership
4. Profit – Mutual Benefit
5. Phase – start small & build
6. Proliferate –Grow, Expand, & Sustain
7. Priorities & Preferred group
8. Policing–Mechanism of Monitoring & Transparency
9. Politics–Governance, Administration, People's audit
10. Protection/proof: A security system
11. Price: A cost share in terms of money/kind
12. Professional Network
13. Platform
14. Prize: Acknowledgement/recognition

Factors influencing PPP-

1. Clarity of Purpose
2. Creation of value
3. Congruency of Mission, Strategy and Values
4. Connection with purpose and people
5. Communication between partners
6. Continual learning
7. Commitment to the partnership

Models of PPP

1. Social Franchising
2. Branded Clinics
3. Contracting
4. Social Marketing
5. Build, Operate and Transfer
6. Joint Venture Companies
7. Voucher System
8. Donations from individuals
9. Involvement of Corporate sector
10. Partnership with Professional Associations
11. Capacity Building of Private Providers
12. Autonomous Institutions

13. Mobile Health Vans
14. Health Insurance
15. Partnerships with Social Clubs and Groups (e.g. Rotary Club)

The STRAIGHT approach to PPP-

1. Identifying the **Scope** of partnership
2. Identifying the appropriate **Target** Population
3. Selecting the **Right** Partners and Model of PPP
4. Ensuring **Accountability** of private providers
5. Ensure active **Involvement** of the government
6. **Generate** Support of all the key stakeholders through IEC, advocacy and rapport building
7. **Highlight** achievements of the partnerships
8. Build **Trust** of all the partners and clients

Some PPP models in India:

Conventional Contracting in	SMS Hospital, Jaipur Bhagajatin Hospital Kolkata	Radiology & Drug store Diet, Cleaning, Laundry, security	**Private Company/ Individual Entrepreneurs**
Contracting out	Karuna Trust, Karnataka Shamlaji Hospital Gujarat Rajiv Gandhi Hospital, Raichur	PHC Mgt. CHC Mgt. Tertiary care hospital	**Charitable NGO** **Charitable NGO** **Private company**
Performance Management Contracts	APUHS Project, Adilabad, AP Chiranjeevi Yojana, Gujarat	RCH Services RCH/MH services	**Charitable NGO** **Private clinics** **Charitable NGO**
Community/ Health Insurance	Yeshashvini Scheme,Karnataka	Surgical Care	**Private Hospitals consortium**
Voucher Scheme	Arogya Raksha Scheme, AP SIFPSA, Agra UP SCOVA, Haridwar, UK	Hospitalization Maternity Care/ Institutional Delivery	**Private Hospitals/ PSU insurance** **Private Hospitals**
Hospital Autonomy	RKS, Bhopal / & Other Places	Patient welfare committee	**Public Hospital**
Franchising	Merri Tarang; Merri Silver; Merri Gold; Life Spring- HLFPPT/ SIFPSA' Janani, Bihar	M CH / Other curative services	**Franchised private entrepreneurs**

Rajasthan Medic-care Relief Society (RMRS):

First started (1996) in a tertiary level hospital, SMS hospital, Jaipur and replicated in other medical colleges, district hospital and sub-divisional hospitals. The success of this initiative has led the Rajasthan State government to support the setting up of such societies Rajasthan Medical Relief Societies (RMRS) at all hospitals having 30 beds or more, including Community Health Centres (CHC) and recently it has also been introduced in all model Primary Health Care Centres (PHCs).

Action:

Seed money: INR. 12 lacs was given to the medical college hospitals; 2 lacs to district hospitals. Guidelines and orders were issued to ensure effective functioning of these societies.
Allowed to collect the revenue of user fees from patients' hospitalized and out-patient department and laboratory, as well as from donations, and contracting out of space.
Purchase of hospital equipment was permitted and the government contributed half the cost if the other half was obtained through public contributions.

In 1998 guidelines were issued for utilization of revenue generated by the societies; 50% could be used for purchase of equipment, while the other half had to be spent on provision of facilities to patients, cleanliness, and purchase of instruments. Detailed guidelines for purchase, maintenance and repair works were also issued.
In 1996, the RMRS was scaled up to cover all hospitals with 100 beds.

All equipment used under the auto finance scheme was transferred to a society which would be responsible for its maintenance.

Amendments were also made to the Rajasthan civil service (Medical Attendance) Rules, 1970, so as to allow re-imbursement of the charges paid by government employees to the RMRS for diagnostic tests and investigations.

A regular audit of accounts was also ordered, along with the exemption of donations received from income tax.

The management structure of the societies is autonomous and consists of 9 to 11 officials and non-officials at State, Regional and district levels. The Society functions outside the purview of the State, the General Financial Rules (GFR) do not apply and it can purchase equipment according to its own requirements.

Funds used - maintenance and renovation of buildings, maintenance and repair of equipment, purchase of new equipment, improving sanitation and cleanliness, improving other facilities for patients and attendants, computerization of various systems and provision of free medicines for below poverty line (BPL) families.

The source of funds for the Society includes seed money from the State Government and transfer of operational control of diagnostic machines.

Free services provided to families living below the poverty line, widows, freedom fighters, destitute people, and citizens over 70 years and retired government servants.
Charges are as follows i) Average OPD charge INR 2. ii) Inpatient charges INR 5 . iii) In-patient referral by private practitioner INR 10. iv) Bed charges for private rooms, cubicles or cottage wards from INR 50 to 600 depending upon the type of facility.

Management training has been organized for RMRS senior managers on guidelines, stock keeping and accounting. The training program was coordinated by State Institute of Health Family Welfare.

Results: In 2003 CHC Sadri, Pali constituted an RMRS with seed money from the European commission.

Place:

All public health facilities above Sub-centre level in Rajasthan.

Time Frame - One year.

Advantages- Revenue generation: Increased availability of financial resources to hospitals from renting of parking areas, auditoriums, contracting out the administration of canteens. Financial Autonomy: Each society is authorized to purchase items ranging from INR 1000 to10,000 though the State's guidelines suggest that institutional heads have authority to make decisions regarding expenses less than INR 5000. Improved efficiency in the system: The society can follow the State's established government financial and accounting rules or their own purchasing procedures. Cost recovery: Multiple sources of supplementary financing are available and user charges are levied for a full range of services. Exemptions are judicious.

Challenges- Management skills: Continuous enhancement of the management capabilities of hospital administrators, systems and procedures of procurement, maintenance of equipment and hospital buildings as well as contracting and outsourcing is necessary for smooth functioning of RMRS. Maintenance: A lack of clear policy regarding with whom rests the decision-making authority for repair and maintenance. A study found 53% societies report difficulty in repairing and maintaining equipment. User charges: Procedures for exemption of user charges to vulnerable groups are usually informal and discretionary. Increase in proportion of patients visiting the health facility will make it difficult for RMRS to spend money on upgrading services. Utilization of RMRS funds: Hospital managers fail to spend the generated revenue efficiently, as most of spending is on equipment in absence of trained personnel to operate the machines. So there is under-utilization of machines.

Subsidy: The government subsidies to hospitals have not declined because of the transfer of matching grants to participating hospitals. So, it has not relieved the state's burden. Monitoring: Regular systemic monitoring of the RMRS has to be undertaken at all levels.

Prerequisites Training of society officials regarding objectives of the society, guidelines governing the societies, budgeting, accounting, management information systems, pricing and needs assessment. Managerial guidelines should be in place. Facilitation of purchase of equipment, rationalizing pricing schemes. Expert committee to resolve issues and problems. Continuous monitoring of the functioning of RMRS.

Risks:

Sustainability- The program is sustainable. Under NRHM, each year now INR 1 lakhs will be transferred to these societies as untied funds.

Chances of Replication-

The innovative scheme was started in Rajasthan in one government hospital and later replicated in other facilities up to CHC level. (By March 2003, the number of RMRS in Rajasthan has reached to 301 which includes 16 RMRS in the Medical College Hospitals, 58 in the District Hospitals and 217 at the level of CHCs).Now government is going to start such societies in Model PHC across Rajasthan as on March 31, 2009 1500 PHCs are having functional RMRS

Rashtriya Swasthya Bima Yojana

Background

The workers in the unorganized sector constitute about 93% of the total work force in the country. The Government has been implementing some social security measures for certain occupational groups but the coverage is miniscule. Majority of the workers are still without any social security coverage. Recognizing the need for providing social security to these workers, the Central Government has introduced a Bill in the Parliament.

One of the major insecurities for workers in the unorganized sector is the frequent incidences of illness and need for medical care and hospitalization of such workers and their family members. Despite the expansion in the health facilities, illness remains one of the most prevalent causes of human deprivation in India. It has been clearly recognized that health insurance is one way of providing protection to poor households against the risk of health spending leading to poverty. However, most efforts to provide health insurance in the past have faced difficulties in both design and implementation. The poor are unable or unwilling to take up health insurance because of its cost, or lack of perceived benefits. Organizing and administering health insurance, especially in rural areas, is also difficult.

In the past Government have tried to provide a health insurance cover to selected beneficiaries either at the State level or National level. However, most of these schemes were not able to achieve their intended objectives. Often there were issues with either the design and/ or implementation of these schemes.

Keeping this background in mind, Government of India decided to design a health insurance scheme which not only avoids the pitfalls of the earlier schemes but goes a step beyond and provides a world class model. A critical review of the existing and earlier health insurance schemes was done with the objective of learning from their good practices as well as seeks lessons from the mistakes. After taking all this into account and also reviewing other successful models of health insurance in the world in similar settings, Rashtriya Swasthya Bima Yojna was designed.

Objective

Recognizing the diversity with regard to public health infrastructure, socioeconomic conditions and the administrative network, the health insurance scheme aims to facilitate launching of health insurance projects in all the districts of the States in a phased manner for BPL workers. The definition of BPL is the one prescribed by the Planning Commission.
The main is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization.

Salient Features of the Scheme

Funding Pattern

1. GoI Contribution: 75% of the estimated annual premium of Rs.750, subject to a maximum of Rs. 565 per family per annum. The cost of smart card will be borne by the Central Government.
2. State Contribution: 25% of the annual premium, as well as any additional premium.
3. Beneficiary Contribution: Rs. 30 per annum as registration/renewal fee.
4. The administrative and other related cost of administering the scheme would be borne by

the respective State Governments

Implementing Agency & Formulation of Projects

The State Government while formulating the pilot project will determine the implementing agency on behalf of the State Government.

Eligibility

Unorganized sector workers belonging to BPL category and their family members (a family unit of five) shall be the beneficiaries under the scheme.

It will be the responsibility of the implementing agencies to verify the eligibility of the unorganized sector workers and his family members who are proposed to be benefited under the scheme.

The beneficiaries will be issued smart cards for the purpose of identification.

Benefits

The beneficiary shall be eligible for such in-patient health care insurance benefits as would be designed by the respective State Governments based on the requirement of the people/ geographical area. However, the State Governments are advised to incorporate at least the following minimum benefits in the package / scheme:

a. Family unit of 5
b. Total sum insured - Rs. 30,000/- per family per annum on a family floater basis.
c. Cashless attendance to all covered ailments
d. Hospitalization expenses, taking care of most common illnesses with as few exclusions as possible
e. All pre-existing diseases to be covered
f. Transportation costs (actual with maximum limit of Rs. 100 per visit) within an overall limit of Rs.1000.

Formulation of the Projects

The State Government shall formulate project/projects for providing health insurance benefits, taking into account the aforementioned points, for the workers and their families in the unorganized sectors for a defined geographical area, preferably a district. While formulating the project/projects, the following aspects may be considered:

1. Clearly defined institution (autonomous body, State Government Department, a Cooperative Society or even an NGO) capable of organizing a health insurance programme.
2. The organization should have
    a. the technical skills
    b. should be able to design a programme that is technically sound,
    c. should have skills to be able to discuss with the community and
    d. should have the administrative capacity to organize the programme.
3. There must be a network of health care providers (public and private). The Project should incorporate use of private and all public healthcare providers, including ESI hospitals.
4. There should be some basic data available regarding the demographic profile of the District.
5. The cost of the scheme, i.e., total premium per year, along with the procedure adopted to arrive at the premium.
6. The procedure for collecting the registration/renewal fee from the beneficiary should be outlined in the proposal.

Setting up of Technical Cell

A Cell would be constituted in the Ministry, administering the scheme, to assist the State Governments in formulating projects. The Cell would be headed by a Sr. Advisor who would be assisted by two Advisors. The expert would be hired on contract basis or on deputation. The Cell would perform following functions:

1. Plan the insurance scheme based on the requirements of State;
2. Workout financial implication and other details;
3. Assist the State Governments in the preparation of pilot projects d) Assist in the effective implementation of the Scheme.
4. Monitor and evaluate the implementation of the project.

The proposal for launching health insurance project would be submitted to the Administrative Ministry for approval along with all the financial implications and details.

Selection of insurance provider:

The selection of the health insurance provider shall be done by the state/implementing agency through tendering process inviting both Public and Private Insurers for better terms of reference. The State Government would formulate the projects and determine the implementing agency such as Insurance Trust/ Insurance Cell/ Mother NGO etc. to monitor/supervise the scheme and integrate with insurance company. This would be further monitored at State and Central level.

Approval and Monitoring Committee:

i) Joint Secretary/Director General Labour Welfare, Ministry of Labour & Employment	Convener
ii) Representatives of Ministry of Finance	Member
iii) Representatives of Ministry of Health and Family Welfare	Member
iv) Representatives of Planning Commission	Member

The Committee will also periodically monitor and review the progress of the projects.

Release of funds:

On the approval of the project, the State Government will, from time to time, intimate the Central Government about the payment of the premium to the Insurance Company. The Central Government, on receipt of this information, shall release its share of premium.

Operationalizing the scheme

- Signing of MOU between the Central and the State Government.
- Contract between the State Government and the Insurance Provider.
- Delivery of Smart Card to commence
- Setting up of a Central Key Management system (KMS) for a secure system
- Development of a Uniform application
- Availability of a Robust Backend system for data transmission & MIS
- Defining a process for system conformonce of Smart Card product
- Designate a Central Nodal officer to deal with complete smart Card system
- Evaluate the various Smart Card vendors & their capabilities

- Ensure Tight contracts with Smart Card vendor for Seamless & Uninterrupted Operation & Maintenance of the system
- Set up systems of checks & balances of the smart card product to ensure conformance to Government guidelines.

Smart card

Basic purpose for induction of Smart Cards as RSBY card is to provide

- Capability to store data on-board into the chip for field usage
- Capability to perform authentic field transactions
- Providing correct entitlement details for service delivery
- Ease of handling
- Inbuilt mechanism to verify the authenticity of card after issuance, thereby checking the fake duplication
- Smart cards to be provided by the selected Insurance Company. The Insurance Company can outsource this task.
- BPL family details will be provided in a predefined electronic format by the respective State Governments to the Insurance Company for the Districts selected for health insurance coverage.
- A detailed village-wise schedule will be worked out by the State Government in consultation with the selected Insurance Provider.
- Representatives of the respective State Governments and the Insurance Provider to visit each village jointly in the selected District(s).
- Advance publicity of these visits by the State Governments
- Photograph of the head of the family and thumb impressions of all the family members to be taken during the visit to the village.
- Collection of Rs.30 from the beneficiary as registration fee by the Insurance Service Provider. (This would be adjusted against the amount of premium to be paid to the Insurance Company.)
- Handing over the smart card and insurance related pamphlet, in local language, by the Insurance Provider to the beneficiary.
- The smart card would entitle the beneficiary at the time of the delivery of the card.

Features of Smart Card

- Unique Identification
    - Fool proof Authentication of Beneficiary
    - Instant Validation of Mediclaim Balance available
    - Multiple levels of Security
- Claims Processing
    - Least inconvenience to Beneficiary
    - Reduction in administrative costs for Hospitals & Insurance agencies
- Enable product innovation
    - Fast availability of MIS for analysis & fraud control
    - Possible to Store customer's health history
    - Other Government Schemes for the same set of beneficiaries can make use of available Card real estate.

- Stores
  - Data
  - Images
  - Codes
  - Security Keys
  - Algorithms
- Supports
  - Authentication
  - Validation
  - Verification
  - Encryption
  - Business Logic
  - Non Repudiation

Enrollment Process

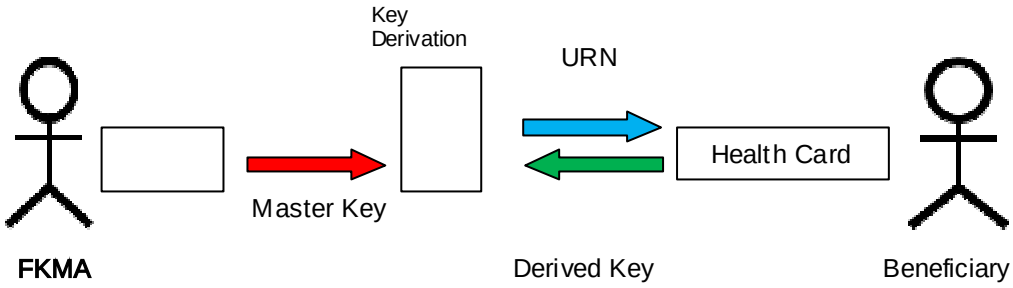
Customer	Data - Deduping	UID (Unique Identification) 17 digit number
An application to capture beneficiary data, Personalise Cards, Conduct transactions , Transmit Data & provide MIS	Various methodologies used like demographic, Biometric (finger, face, etc.) - Fingerprint most effective from technical & cost perspective	Sr no(5) + Birth Yr (2)+ Gender(1) + State(2) + Location(6) + Checksum(1)
Uniform Application Across states & Insurance Providers	Possible state of the art technology for de-duping	This number can be and should be shared across several entities

Key Management System

- KMS is the basic requirement for implementing Smart Card Security. It provides following:
- Establishing Authenticity of Card that verifies the authenticity of card at field.
- Protection against un-authorized tampering of data which means provide a mechanism for card modification only by authorized agencies or persons.

Issuance of RSBY card

- Rashtriya Swasthya Bima Yojna Cards are generated with the help of Master Issuance cards (MIC).
- Is the ultimate point of usage of Master Issuance card for issuance.
- Field Key Officer (FKO) is the entity which is responsible for safe keeping and safe usage of these cards, while they are in use.
- Responsibility is to ensure and see to it that all the defined security guidelines are strictly being followed at the field by various trusted authorities which are using authority cards for various functionalities.



FKMA: Field Key Management Authority, **URN**: Universal Registration Number

Monitoring and evaluation:

The State Government will put in place a well defined mechanism for monitoring and evaluation of the pilot project at the time of its implementation. At the Central Government level, the Cell constituted for examining project proposals shall also periodically monitor and evaluate the performance of each pilot project with a view to evolving workable models which can be up-scaled for wider application.

Policies & Legislations

National Health Policy-2002

Health per se had a fragmented approach till 1978 when Global concern dictated in favor of HFA-2000 and, with a little longer latent period at last, a National Health Policy (1983) was formulated. It took us 36 years to formulate a Health Policy for the first time in 1983.

The basic **issues** involved in **NHP-1983** formulation were-

1. Re-orientation of Medical education
2. Re-structuring and Re-organizing the then existing health care services
3. Population stabilization
4. Re-orientation of existing health personnel
5. Role of practitioners of ISM in Health care delivery

These issues were addressed through incorporation of certain key areas for action, in the policy. The **basic elements** identified were-

1. Nutrition
2. Preventing food adulteration and maintaining drug quality
3. Water supply and sanitation
4. Environmental protection
5. Immunization
6. Mother and Child health services
7. School health
8. Occupational health
9. Health education
10. Management information System
11. Medical industry
12. Health insurance
13. Health legislations, and
14. Medical research.

The **NHP-1983** gave a general exposition of the policies, which required recommendation in the circumstances then prevailing in the health sector.
The noteworthy **initiatives under that policy were: -**

1. A phased, time bound program comprehensive for setting up a well-dispersed network of primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves;
2. Intermediation through 'Health volunteers' having appropriate knowledge, simple skills and requisite technologies;
3. Establishment of a well-worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level;
4. An integrated net-work of evenly spread specialty and super-specialty services; encouragement of such facilities through private investments for patients who can pay, so that the draw on the Government's facilities is limited to those entitled to free use.

The **National Health Policy of 1983** laid down certain **Goals and Indicators** which were expected to be achieved in a prescribed time frame. These were-

Indicator		Current level	Goals		
		(year)	1985	1990	2000
Infant mortality rate		122 (1978)	106	87	< 60
Perinatal mortality rate		76 (1976)			30-35
Crude death rate		14	12	10.4	9.0
Maternal mortality rate/1000		4-5	3-4	2-3	< 2
Child mortality rate		24 (1976-77)	20-24	15-20	10
Life expectancy at birth		52.6 Male 51.6 Female	55.1 54.3	57.6 57.1	64 64
Babies with birth weight <2500 gms.		30%	25%	18%	10%
Crude birth rate		35	31	27	21
Couple protection rate		23.6 (March, 1982)	37	42	60
Net reproduction rate		1.48(1981)	1.34	1.17	1.0
Annual growth rate		2.24 (1971-81)	1.90	1.66	1.20
Family size		4.4 (1975)	3.8	-	2.8
Percentage of pregnant women receiving ANC		40-50	50-60	60-75	100
Percentage of deliveries by TBA		30-35	50	80	100
% of Immunization coverage	TT (PW)	20	60	100	100
	TT (10yrs.)		40	100	100
	TT (16 yrs.)	20	60	100	100
	DPT (<3 yrs.)	25	70	85	85
	OPV (Infants)	5	50	70	85
	BCG	65	70	80	85
	DT	20	80	85	85
	Typhoid	2	70	85	85
Leprosy-% of disease arrested cases		20	40	60	80
TB--% of disease arrested cases		50	60	75	90
% Of Blindness (Incidence/100000)		1.4	1.0	0.7	0.3

Government initiatives in the pubic health sector have recorded some remarkable **successes over time. Smallpox and Guinea Worm Disease have been eradicated** from the country; **Polio is on the verge of being eradicated**; **Leprosy, Kala Azar, and Filariasis are waiting for elimination,** in the foreseeable future. There has been a **substantial drop in the Total Fertility Rate and Infant Mortality Rate.** The success of the initiatives taken in the public health field is reflected in the progressive improvement of many demographic / epidemiological / infrastructural indicators over time.

Somehow odds kept challenging the system. **Malaria staged resurgence** in the1980s before stabilizing at a fairly high prevalence level during the 1990s.

TB, continues to be a problem, and there has been a distressing trend in the increase of drug resistance to the type of infection prevailing in the country; **HIV/AIDS - has emerged** on the health scene since the declaration of the NHP-1983.

The common water-borne infections – **Gastroenteritis, Cholera, and some forms of Hepatitis – continue to contribute to a high level of morbidity** in the population, even though the mortality rate may have been somewhat moderated.
Increase in mortality through **'life-style' diseases**- diabetes, cancer and cardiovascular diseases. Increase in life expectancy has increased the requirement for **geriatric care**. Similarly, the increasing burden of **trauma** cases is also a significant public health problem.

The policy, under the spirit of HFA-2000, stressed on universal provision of comprehensive primary health care services but the financial resources and public health administrative capacity was far short of that necessary to achieve such an ambitious and holistic goal.

Against this backdrop, it was felt to pitch **NHP-2002** at a level consistent with our realistic expectations about financial resources, and about the likely increase in Public Health administrative capacity.

Some how what was envisaged could not be achieved and a revisit to the policy resulted in another revision in Health Policy in 2002

The Considerations that were accounted for in NHP-2002:
The public **health investment as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999.**

The **aggregate expenditure in the Health sector is 5.2 percent of the GDP**, of which **only 17% was public health expenditure**, rest being Out of Pocket Expenditure.

The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while that in the States has declined from 7.0 percent to 5.5 percent. The current annual **per capita public health expenditure** in the country is **no more than Rs. 200.**

The **contribution of Central resources** to the overall public health funding has been limited to **about 15 percent.** The fiscal resources of the State Governments are known to be very inelastic. This is reflected in the declining percentage of State resources allocated to the health sector out of the State Budget.

If the decentralized pubic health services in the country are to improve significantly, there is a need for the injection of substantial resources into the health sector from the Central Government Budget.

With wide differences between the attainments of health goals in the better performing States as compared to the low-performing States. It is clear that national **averages of health indices hide wide disparities in public health facilities and health standards in different parts of the country.**

The infrastructure facilities as envisaged in the 1983 policy also fell short. Applying current norms to the population for the year 2000, it is estimated that the **shortfall in the number of SCs/PHCs/CHCs is of the order of 16 percent.** However, this shortage is as high as **58 percent when disaggregated for CHCs only.**

It is a principal **objective of NHP-2002 to evolve a policy structure, which reduces these inequities** and allows the disadvantaged sections of society a fairer access to public health services.

NHP-2002 attempts to define the role of the Central Government and the State Governments in the public health sector of the country.

Over a period it has been realized that **'vertical' implementational structure is not going to work** as for the major disease control program it has created a situation where if there is no separate vertical structure, there is no identifiable service delivery system at all.

With general **shortage of medical personnel** in the country and the disproportionate shortage in rural and less developed areas and the efforts to deploy Doctors on contractual appointment has proved to be fighting a losing battle, NHP-2002 also takes cognizance of formally trained **manpower in Indigenous Medical System** and their possible role in health care delivery.

NHP-2002 is based on an objective assessment of the quality and efficiency of the existing public health machinery which is far from satisfactory. It has been estimated that **less than 20 percent of the population, which seek OPD services, and less than 45 percent of that which seek indoor treatment, avail of such services in public hospitals**, at the cost of other essential expenditure for items such as basic nutrition.

The other areas which were under consideration of NHP-2002 formulation exercise are-

1. Need based allocation and implementation through Panchayat Raj Institutions (PRIs).
2. Norms for manpower in relation to services
3. Medical education to be more meaningful for delivery of primary health care
4. Development of relevant specialties under changing epidemiological profile and National Goals
5. Need for Public health specialists and Family Medicine
6. Use of Generic drugs.
7. Urban health infrastructure
8. Mental Health
9. IEC
10. Health research
11. Private sector participation
12. Disease surveillance
13. Women health
14. Medical ethics
15. Quality standards for food and drugs
16. Regulation of Standards in Paramedical disciplines
17. Environment and Occupational health

18. Medical facility to overseas users on package basis
19. Synchronized implementation of NHP-2002 and NPP-2000

The NHP-2002 **Objective:**

1. To achieve an acceptable standard of good health amongst the general population of the country.
2. To ensure a more equitable access to health services across the social and geographical expanse of the country
3. To increase the aggregate public health investment through a substantially increased contribution by the Central Government.

The **approach** would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions.

Goals that NHP-2002 laid are -

Eradicate Polio and Yaws	2005
Eliminate Leprosy	2005
Eliminate Kala Azar	2010
Eliminate Lymphatic Filariasis	2015
Achieve Zero level growth of HIV/AIDS	2007
Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
Reduce Prevalence of Blindness to 0.5%	2010
Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
Increase utilization of public health facilities from current Level of <20 to >75%	2010
Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005

Policy Prescriptions-NHP-2002**:**

1. To **increase health sector expenditure** to 6 percent of GDP, with 2 percent of GDP being contributed as public health investment, by the year 2010 (The State Governments would also need to increase, in the first phase, by 2005, to 7 percent of the Budget and by 2010, to increase it to 8 percent).
2. **Increased allocation** of 55 percent of the total public health investment **for the primary health sector**; the secondary and tertiary health sectors being targeted for 35 percent and 10 percent respectively.
3. **Gradual convergence of all health programs** under a single field administration.(Vertical programs for control of major diseases like TB, Malaria, HIV/AIDS, as also the RCH and Universal Immunization Programs, would need to be continued till moderate levels of prevalence are reached.
4. Program **implementation** to be effected through **autonomous bodies** at State and district levels.(presence of State Government officials, social activists, private health professionals and MLAs/MPs on the management boards of the autonomous bodies will facilitate well-

informed decision-making.

5. **Developing the capacity** within the State Public Health administration for scientific designing of public health projects, suited to the local situation.
6. **All rural health staff** should be **available for** the entire gamut of **public health** at the decentralized level, irrespective of whether these activities relate to national programs or other public health initiatives.
7. Some **essential drugs** under Central Government funding through the decentralized health system
8. **Frequent in-service training** of public health medical personnel, at the level of medical officers as well as paramedics.
9. **Strengthening of the primary health structure** for the attaining of improved public health outcomes on an equitable basis. besides committing additional aggregate financial resources.
10. Levying reasonable **user-charges** for certain secondary and tertiary public health care services, for those who can afford to pay.
11. **Contract employment** in order to provide trained medical manpower in under-served areas.
12. All State Governments to consider **decentralizing the implementation** of the programs **to Local Self Government**, by 2005
13. Minimal statutory **norms for the deployment of doctors and nurses** in medical institutions need to be introduced urgently under the provisions of the Indian Medical Council Act and Indian Nursing Council Act, respectively.
14. Setting up of a **Medical Grants Commission** for funding new Government Medical and Dental Colleges in different parts of the country, besides funding up gradation of existing Govt. colleges.
15. Need to **modify the existing curriculum**- A need-based, skill-oriented syllabus, with a more significant component of practical training.
16. The Policy envisages the progressive implementation of mandatory norms to **raise** the proportion of **postgraduate seats in discipline of Public Health & Family Medicine** in medical training institutions, to reach a stage wherein **¼ th of the seats** are earmarked for these disciplines.
17. **Improvement in the ratio of nurses** vis-à-vis doctors/beds besides improving the **skill -level of nurses,** and on increasing the ratio of degree- holding nurses vis-à-vis diploma-holding nurses.
18. Basing treatment regimens, in both the public and private domain, on a limited number of **essential drugs of a generic nature**, for cost-effective public health care, to be enforced by **prohibiting the use of proprietary drugs**, except in special circumstances.
19. **Not less than 50% of the requirement of vaccines/sera be sourced from public sector institutions**
20. Organized **urban primary health care structure- a two-tiered one**, the first-tier covering a population of one lakh, and a second-tier at the level of the Government general hospital, where reference is made from the primary centre. Funding from local self-government institutions and State and Central Governments**.**
21. Decentralized **mental health services** for diagnosis of common disorders, and the prescription of common therapeutic drugs, by general duty medical staff and Upgrading of the physical infrastructure so as to secure the human rights of this vulnerable segment of society.
22. **IEC** with targets for association with NGOs/PRIs for bringing change in behavior
23. **Government-funded health research** to a level of 1 percent of the total health spending by 2005; and thereafter, up to 2 percent by 2010.
24. Enactment of suitable **legislation for regulating minimum infrastructure and quality**

standards in clinical establishments/medical institutions by 2003. Also, statutory guidelines for the conduct of clinical practice and delivery of medical services are targeted to be developed over the same period.

25. **Disease control programs** should earmark not less than **10% of the budget** in respect of identified program components, to be exclusively **implemented through NGOs.**
26. Full operationalization of an **integrated disease control network** (including installation of data-base handling hardware, IT inter-connectivity between different tiers of the network, and in-house training for data collection and interpretation for undertaking timely and effective response) from the lowest rung of public health administration to the Central Government, by 2005.
27. Completion of **baseline estimates** for the incidence of the common diseases – TB, Malaria, Blindness – by 2005 and also **for non-communicable diseases**, like CVD, Cancer, Diabetes; and accidental injuries, **and communicable diseases**, like Hepatitis and JE.
28. Establish **national health accounts**, conforming to the `source-to-users' matrix structure.
29. **Highest priority** of the Central Government to the funding of the identified programs relating **to woman's health**. Also, the policy recognizes the need to review the staffing norms of the public health administration to meet the specific requirements of women in a more comprehensive manner.
30. Contemporary **code of ethics** be notified and rigorously implemented by the Medical Council of India.
31. **Food and drug administration** will be **progressively strengthened**, in terms of both laboratory facilities and technical expertise so that ultimately **food standards will be close, if not equivalent, to Codex specifications**; and that drug standards will be at par with the most rigorous ones adopted elsewhere.
32. Independently -stated policies and programs of the **environment -related sectors be smoothly interfaced with the policies and the programs of the health sector**. Also, periodic screening of the health conditions of the workers, particularly for high- risk health disorders associated with their occupation.

Despite the best of intentions that the policy has, the basic financial input levels stay stagnant and all claims and declarations have made mockery of intents. Besides finances, Public health and Epidemiology continue to be neglected though we keep airing our concern towards the role of Public health in achieving the desired.

National Population Policy-2000

Some developments-

Milestones in the evolution of the population policy of India
1946-Bhore Committee Report

1952-Launching of Family Planning Program

1976-Statement of National Population Policy

1977-Policy Statement on Family Welfare Program
Both statements were laid on the Table of the House in Parliament, but never discussed or adopted.
1983-The National Health Policy of 1983 emphasized the need for "securing the small family norm, through voluntary efforts and moving towards the goal of population stabilization". While adopting the Health Policy, Parliament emphasized the need for a separate National Population Policy.

1991-The National Development Council appointed a Committee on Population with Shri Karunakaran as Chairman. The Karunakaran Report (Report of the National Development Council (NDC) Committee on Population) endorsed by NDC in 1993 proposed the formulation of a National Population Policy (Planning Commission, 1992).

1993- An Expert Group headed by Dr. M.S. Swaminathan was asked to prepare a draft of a national population policy that would be discussed by the Cabinet and then by Parliament.

1994- Report on a National Population Policy by the Expert Group headed by Dr. Swaminathan.

1997- During Nov. 97 Cabinet approved the draft National Population Policy with the direction that this be placed before Parliament, but was not done.

1999- during 1998, and another draft National Population Policy was finalized and placed before the Cabinet in March 1999. Cabinet appointed a Group of Ministers to examine the draft Policy. The GOM finalized a draft population policy, and placed the same before Cabinet. Several suggestions were made during the deliberations. On that basis, a fresh draft was submitted to Cabinet.

2000-National Population Policy came in existence

1952, India was the first country in the world to launch a national program, emphasizing
Family planning to the extent is necessary for reducing birth rates "to stabilize the population at a level consistent with the requirement of national economy".
Subsequently, sharp declines in death rates were not accompanied by a similar drop in birth rates.
Health Policy, 1983 stated that replacement levels of total fertility rate **(TFR) should be achieved by the year 2000.**
On **11 May, 2000 Indian population crossed 1 billion (100 crores**) mark which meant 16 percent of the World's population on 2.4 percent of the globe's land area.
While global Population has increased threefold **during this century**, from 2 billion to 6 billion, the population of **India has increased nearly five times from 238 million (23 crores) to 1 billion** in the same period. India's current annual increase in population of 15.5 million is large enough to neutralize

efforts to conserve the resource endowment and environment.
Stabilizing population is an essential requirement for promoting sustainable development with more equitable distribution. Under this back drop for the first time a National Population Policy was formulated in year 2000 (The earlier one of 1976 (April, 16) and 1977(June) were simply the statements on population policy put before the Parliament).

The **salient features of statement on Population Policy made on April, 16, 1976** are-

1. Implementation of minimum needs program
2. Education and Economic development are crucial but waiting for the change on this account is not practical for time constraint.
3. Family planning has not made desired progress
4. Raising age of marriage has demonstrable demographic impact
5. Adoption of small family norm is vital
6. Voluntary organizations can contribute effectively
7. Research in Reproductive health and contraceptive technology can strengthen cafeteria approach
8. Multi-media motivational strategy can work.

Based on these features, a few **suggestions for the approach** were made-

1. Freezing the representation of States in Parliament till 2001 based on population of 1971 census
2. Year 1971 becomes the basis for Central assistance, Devolution of taxes and Grant in aid till 2001
3. 8% of Central assistance to be linked to State's performance in Family Planning
4. Monetary compensation to couples adopting terminal methods to be linked to no. of children
5. Compulsory sterilization after 3 children if State feels it has sufficient legislative power and infrastructure for enforcement
6. Rising the marriage age (Girls-18 yrs. and Boys-21 yrs.)
7. Research in reproductive biology and contraception
8. Introduction of group incentives in a bold and innovative manner to make Family Planning a people's movement.
9. Promotion of multi media, rural oriented communication strategy
10. Inclusion of population education in education system
11. Increasing level of female education through formal & non-formal education.
12. Involvement & support of voluntary organizations.

The later statement of June 1977, with the change in Political governance, in conformance to the earlier statement but doing away with "compulsion" factor, stressed on the following-

1. Voluntary nature of program
2. Re-naming the program to Family Welfare
3. Political commitment
4. Amending constitution for freezing State's representation at 1971 levels
5. Continuing 8% central assistance linked to Performance in Family Welfare.

Subsequently, realizing the need for SFN and, NRR-1 for population stabilization, a committee on Population was appointed by National Development Council in 1991, which recommended having a population policy formulated and approved.
July, 1993 and this task was assigned to an expert group chaired by MS Swami Nathan. Group

submitted draft policy on May 23, 1994 to MOHFW the contents of which were said to be pro-poor, pro-women, pro-nature and emphasized on-

1. Setting up of a Population and Social Development Commission (PSDC)
2. Freezing to continue till 2001 at 1971 levels
3. 1/3 Representation of women and poor section in Panchayat and Nagar Palika to increase community participation

The basic premise of the draft was over all social development placing greater demands on statistical system by Planners and Policy makers fore which it was suggested to upgrade the Office of Registrar General to Dept. of Census, SRS and CRS under ministry of Home.

Better late than never, and the policy makers and Political system woke up to the need and incorporating the basic features approved of the National Population Policy in the year 2000.

The National Population Policy, 2000 (NPP-2000) affirms the commitment of government towards-

1. voluntary and informed choice and consent of citizens while availing of reproductive health care services
2. Continuation of the target free approach in administering family planning services.

Policy Objectives-

1. **Immediate**
    a. To address the unmet needs for
        i. Contraception,
        ii. Health care infrastructure, and
        iii. Health personnel, and
    b. To provide integrated service delivery for basic reproductive and child health care
2. **Medium**
    a. To bring the TFR to replacement levels by 2010
3. **Long term**
    a. To achieve a stable population by 2045

National Socio-Demographic Goals for 2010:

1. Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
2. Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 percent for both boys and girls.
3. Reduce infant mortality rate to below 30 per 1000 live births.
4. Reduce maternal mortality ratio to below 100 per 100,000 live births.
5. Achieve universal immunization of children against all vaccine preventable diseases.
6. Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
7. Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.
8. Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.
9. Achieve 100 per cent registration of births, deaths, marriage and pregnancy.
10. Contain the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organization.

11. Prevent and control communicable diseases.
12. Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.
13. Promote vigorously the small family norm to achieve replacement levels of TFR.
14. Bring about convergence in implementation of related social sector programs so that family welfare becomes a people centered program

Some Projections made-.
If the NPP 2000 is fully implemented, anticipated population will be1107 million (110 crores) in 2010, instead of 1162 million (116 crores) projected by the Technical Group on Population Projections:

Anticipated Growth in Population (million)

Year	If current trends continue		If TFR 2.1 is achieved by 2010	
	Total Population	Increase in Population	Total Population	Increase in Population
1991	846.3	-	846.3	-
1996	934.2	17.6	934.2	17.6
1997	949.9	15.7	949.0	14.8
2000	996.9	15.7	991.0	14.0
2002	1027.6	15.4	1013.0	11.0
2010	1162.3	16.8	1107.0	11.75

Similarly, the anticipated reductions in the birth, infant mortality and total fertility rates are:

**Projections of Crude Birth Rate, Infant Mortality Rate, and TFR,
If the NPP 2000 is fully implemented.**

Year	Crude Birth Rate	Infant Mortality Rate	Total Fertility Rate
1997	27.2	71	3.3
1998	26.4	72	3.3
2002	23.0	50	2.6
2010	21.0	30	2.1

(Source: Ministry of Health and Family Welfare)

Population growth in India continues to be high on account of:

1. **The large size of the population in the reproductive age-group** (Estimated contribution- 58 percent). An addition of 417.2 million between 1991 and 2016 is anticipated despite substantial reductions in family size in several states, including those, which have already achieved replacement levels of TFR.
2. **Higher fertility due to unmet need for contraception** (estimated contribution 20 percent). India has 168 million eligible couples, of which just 44 percent are currently effectively protected. Urgent steps are currently required to make contraception more widely available, accessible, and affordable. Around 74 percent of the population lives in rural areas, in about 5.5 lakh villages, many with poor communications and transport. Reproductive health and basic health infrastructure and services often do not reach the villages, and, accordingly, vast numbers of people cannot avail of these services.

3. **High wanted fertility due to the high infant mortality rate (IMR)** (estimated contribution about 20 percent). Repeated childbirths are seen as an insurance against multiple infant (and child) deaths and accordingly, high infant mortality stymies all efforts at reducing TFR.

Under this background, a National Population Policy-2000 identified 12 basic strategic themes and operational strategy to accomplish each one of them.

Strategic themes of NPP-2000:

The NPP-2000 has 12 basic themes-

1. Decentralized Planning and Program Implementation
2. Convergence of Service Delivery at Village Levels
3. Empowering Women for Improved Health and Nutrition
4. Child Health and Survival
5. Meeting the Unmet Needs for Family Welfare Services
6. Under-Served Population Groups
7. Diverse Health Care Providers
8. Collaboration With and Commitments from Non-Government Organizations and the Private Sector
9. Contraceptive Technology and Research on Reproductive and Child Health
10. Mainstreaming Indian Systems of Medicine and Homeopathy
11. Providing for the Older Population
12. Information, Education, and Communication

1) Decentralized Planning and Program Implementation

The 73rd and 74th Constitutional Amendments Act, 1992, entrusted the responsibility of health, family welfare, and education to village Panchayats which need strengthening by further delegation of administrative and financial powers, including powers of resource mobilization.

The other approaches suggested are-

a. **33 percent** of elected Panchayat seats are **reserved for women**
b. **Promotion of a gender sensitive, multi-sectoral agenda** for population stabilization
c. **Identify area-specific unmet needs** for reproductive health services
d. **Prepare need-based, demand-driven, socio-demographic plans** at the village level
e. **Panchayats with exemplary performance be nationally recognized and honored.**

(for compulsory registration of births, deaths, marriages, and pregnancies, universalizing the small family norm, increasing safe deliveries, bringing about reductions in infant and maternal mortality, and promoting compulsory education up to age 14)

2) Convergence of Service Delivery at Village Levels

Efforts at population stabilization will be effective only if an **integrated package of essential services** at village and household levels can be delivered. Meaningful decentralization will result only if the convergence of the national family welfare program with the ICDS program is strengthened.

Somehow, hitherto this was punctuated with-

a. Poor and inadequate infrastructure below district levels. Current health Infrastructure (MOHFW-1998) includes-
    a. 2,500 community health centers,
    b. 25,000 primary health centers (each covering a population of 30,000), and 1.36 lakh

sub centers (each covering a population of 5,000 in the plains and 3,000 in hilly regions); which is far from adequate

b. An unmet need of 28 percent for contraception services,
c. Gaps in coverage and outreach.
d. Over-burdened Health care centers
e. Limited personnel and equipment.
f. Absence of supportive supervision,
g. Lack of training in inter-personal communication, and
h. Lack of motivation to work in rural areas

Taking cognizance of these constraints, **NPP-2000 proposes to-**

a. Promote a more flexible approach, by extending basic reproductive and child health care through mobile clinics and counseling services.
b. Involvement of the voluntary sector and the non-government sector in partnership with the government is essential.
c. A one-stop, integrated and coordinated service delivery should be provided at village levels, for basic reproductive and child health services.
d. At least two trained birth attendants, per village to universalize coverage and outreach of antenatal, natal and post-natal health care.
e. Have a equipped maternity hut in each village should be set up to serve as a delivery room, with functioning midwifery kits, basic medication for essential obstetric aid, and indigenous medicines and supplies for maternal and new born care.
f. Registration at village levels, of births, deaths, marriage, and pregnancies.
g. Each village should maintain a list of community midwives and trained birth attendants, village health guides, Panchayat sewa sahayaks, primary school teachers and aanganwadi workers who may be entrusted with various responsibilities in the implementation of integrated service delivery.
h. Involving community opinion leaders to-
   I) Communicate the benefits of smaller, healthier families, the significance of educating girls,
   II) Promoting female participation in paid employment
   III) Monitoring the availability, accessibility and affordability of services and supplies

To operationalize the said propositions, **operational strategies** have been identified as follows-

a. **Utilize village self help groups**
b. **Organize neighborhood acceptor groups**, and provide them with a revolving fund that may be accessed for income generation activities.
   Train and motivate the village self-help acceptor groups to become the primary contact at household levels. Once every fortnight, these **acceptor groups will meet, and provide at one place 6 different services for-**
   i) Registration of births, deaths, marriage and pregnancy;
   ii) Weighing of children under 5 years, and recording the weight on a standard growth chart;
   iii) Counseling and advocacy for contraception, plus free supply of contraceptives;
   iv) Preventive care, with availability of basic medicines for common ailments: antipyretics for fevers, antibiotic ointments for infections, ORT /ORS 1 for childhood diarrheas, together with standardized indigenous medication and homeopathic cures;
   v) Nutrition supplements; and
   vi) Advocacy and encouragement for the continued enrolment of children in school up to age of 14 yrs.

c. Wherever these village self-help groups have not developed for any reason community midwives, practitioners of ISMH, retired school teachers and ex-defense personnel may be organized into neighborhood groups to perform similar functions
   At village levels, the aanganwadi center may become the pivot of basic health care activities, contraceptive counseling and supply, nutrition education and supplementation, as well as pre-school activities. The aanganwadi centers can also function as depots for ORS/basic medicines and contraceptives
d. **A maternity hut** to serve as the village delivery room, with storage space for supplies and medicines. The Panchayat may appoint a competent and mature mid-wife, to look after this village maternity hut. Volunteers may assist her.
e. **Trained birth attendants** as well as the vast pool of **traditional dais** should **be made familiar with emergency and referral procedures**.
f. Each village may **maintain a list** of community **midwives,** village **health guides**, **Panchayat sewa sahayaks**, **trained birth attendants**, **practitioners** of indigenous systems of medicine, primary **school teachers** and other relevant persons, as well as the **nearest institutional health care facilities** that may be accessed for integrated service delivery

3) Empowering Women for Improved Health and Nutrition

The NPP-2000 stays fully informed of –

a. The complex socio-cultural determinants of women's health and nutrition that has cumulative effects over a lifetime.
b. Discriminatory childcare leading to malnutrition and impaired physical development of the girl child.
c. Under nutrition and micronutrient deficiency in early adolescence are crucial to a woman's well being, and through her, to the well being of children.
d. Malnutrition, frequent pregnancies, unsafe abortions, RTI and STI, all combine to keep the maternal mortality ratio in India among the highest globally. The extent of maternal mortality is an indicator of disparity and inequity in access to appropriate health care.
e. Early childbearing compounds impaired health and nutrition, and consequent risk of serious pregnancy related complications.
f. Role of Integrated Reproductive and Child Health Program, which also includes promoting management of STIs and RTIs.
g. The role and reach of voluntary non-government sector and the private corporate sector ;
h. in view of which the following operational strategies have been framed under NPP-2000

The operational strategies-

a. **Create an enabling environment** for women and children
b. **Cluster services** for women and children at the same place and time.
c. **Open more child care centers** in rural areas and in urban slums, where a woman worker may leave her children
d. I**mprove** district, sub-district and Panchayat-level **health management** with coordination and Collaboration between district health officer, sub-district health officer and the Panchayat for Planning and implementation activities
e. **Strengthen the referral network** between the district health office, district hospital and the community health centers, the primary health centers and the sub centers in management of obstetric and neo-natal complications.
f. **Strengthen community health centers** to provide comprehensive emergency obstetric and neo-natal care.

g. **Strengthen primary health centers** to provide essential obstetric and neo-natal care.
h. **Strengthen sub centers** to provide a comprehensive range of services, with delivery rooms, counseling for contraception, supplies of free contraceptives, ORS and basic medicines, together with facilities for immunization.
i. **Establish rigorous problem identification mechanisms** through maternal and peri-natal audit, from village level upwards.
j. **Ensure adequate transportation** at village level, sub center levels, zila parishads, and primary health centers and at community health centers.
k. **Improve supervision** by developing guidance and supervision checklists
l. To empower women, pursue programs of –
    i. Social afforestation to facilitate access to fuel wood and fodder.
    ii. Similarly, pursue drinking water schemes for increasing access to potable water. (This will reduce long absences from home, and the need for large numbers of children to perform such tasks.)
m. **Monitor performance** of maternal and child health services at each level by using the maternal and child health local area monitoring system, which includes monitoring the incidence and coverage of ante-natal visits, deliveries assisted by trained health care personnel and post-natal visits, among other indicators.
n. **Improve technical skills** of maternal and child health care providers
o. **Program development with Partnership** in family health and nutrition
p. **Convergence, strengthening, and universalisation** of the nutritional programs of the Department of Family Welfare and the ICDS run by the Department of Women and Child Development,
q. Provide **quality care in family planning**, including information
r. Develop a health package for adolescents
s. Ensure **availability of safe and legal abortion services** by-
    i. Increasing geographic spread;
    ii. Enhancing affordability;
    iii. Ensuring confidentiality and
    iv. Providing compassionate abortion care, including post-abortion Counseling.
t. Adopt updated and simple technologies that are safe and easy, e.g. manual vacuum extraction not necessarily dependant upon anesthesia, or non-surgical techniques which are non-invasive
u. Promote **collaborative arrangements** with private sector health professionals, NGOs and the public sector
v. **Formulate and notify standards for abortion services**. Strengthen enforcement mechanisms at district and sub-district levels to ensure that these norms are followed.
w. **Eliminate the current cumbersome procedures for registration of abortion clinics** & Formulate and notify standards for abortion services
x. Follow **norms-based registration of service** provision centers
y. Ensure services for **termination of pregnancy at primary health centers** and at community health centers.
z. Develop maternity hospitals at sub-district levels and at **community health centers to function as FRUs** for complicated and life-threatening deliveries
aa. Formulate and **enforce standards for clinical services in the public, private, and NGO sectors**, and Focus on distribution of **conventional contraceptive** through free supply, social marketing as well as commercial sales.
bb. Create a **national network** consisting **of public, private and NGO centers**, identified by a

common logo, for delivering reproductive and child health services free to any client (**Provider shall be compensated for service** through a coupon signed by beneficiary, Compensation same for all sectors, beneficiary to choose provider, **review mechanism to avoid misuse**)

4) Child Health and Survival

The NPP-200 also takes a note of the following facts-

a. Infant mortality is a **sensitive indicator** of human development.
b. High mortality and morbidity among infants and children below 5 years occurs on account of-
    i. Inadequate care,
    ii. Asphyxia during birth,
    iii. Premature birth,
    iv. Low birth weight,
    v. Acute respiratory infections,
    vi. Diarrhea,
    vii. Vaccine preventable diseases,
    viii. Malnutrition and deficiencies of nutrients, including Vitamin A., and
c. That **Infant mortality rates have not significantly declined in recent years**
d. **Need to intensify neo-natal care** on priority

And proposes a few **action areas-**

a. The Baby Friendly Hospital Initiative (BFHI) should be extended to all hospitals and clinics, up to sub center levels
b. Promoting breast-feeding and complementary feeds
c. Updating of skills of trained birth attendants to improve new born care practices to reduce the risks of hypothermia and infection.
d. Child survival interventions

Operational strategies for Child health & survival-

a. **Support community activities**, from village level upwards to monitor early and adequate antenatal, natal and post-natal care. Focus attention on neo-natal health care and nutrition.
b. Set up a **National Technical Committee** on neo-natal care, to align program and project interventions with newly emerging technologies in neo-natal and peri-natal care.
c. Pursue compulsory **registration of births** in coordination with the ICDS Program.
d. After the birth of a child, provide **counseling and advocacy** about contraception, to encourage adoption of a reversible or a terminal method.
e. **Improve capacities** at health centers in basic midwifery services, essential neo-natal care, including the management of sick neonates outside the hospital.
f. Sensitize and **train health personnel in the integrated management** of childhood illnesses.
g. **Standard case management** of diarrhea and acute respiratory infections must be provided at sub centers and primary health centers, with appropriate training, and adequate equipment. Besides, training in this sector may be imparted to health care providers at village levels, especially in indigenous systems.
h. **Strengthen critical interventions** aimed at bringing about reductions in maternal malnutrition, morbidity and mortality, by ensuring availability of supplies and equipment at village levels, and at sub centers.
i. Pursue rigorously the **pulse polio campaign** to eradicate polio.
j. Ensure **100 percent routine immunization** for all vaccine preventable diseases, in particular tetanus and measles.

k. As a child survival initiative, explore promotional and motivational measures for couples below the poverty line who marry after the legal age of marriage, to have the **first child after the mother reaches the age of 2**1, and adopt a **terminal method** of contraception **after the birth of the second child.**
l. Children form a vulnerable group and certain sub-groups merit **focused attention** and intervention, such as **street children and child laborers.**
m. Encourage voluntary groups as well as NGOs to formulate and implement special schemes for these groups of children.
n. **Explore the feasibility** of a **national health insurance** covering hospitalization costs for children below 5 years, whose parents have adopted the small family norm, and opted for a terminal method of contraception after the birth of the second child.
o. Expand the **ICDS to include children between 6-9 years of age,** specifically to promote and ensure 100 percent school enrolment, particularly for girls.
p. Promote **primary education** with the help of aanganwadi workers, and encourage **retention in school till age 14**. Provide vocational training for girls, and **gradually raise the average age of marriage**.
q. Involve NGOs, the voluntary sector and the private sector to target employment opportunities.

5) Meeting the Unmet Needs for Family Welfare Services

The needed support for meeting un-met needs includes-

a. Supplies and equipment for integrated service delivery,
b. Mobility of health providers and patients,
c. Comprehensive information.
d. Improvement in facilities for referral transportation,
e. Encouragement and strengthening local initiatives for ambulance services at village and block levels,
f. Increasing innovative social marketing schemes for affordable products and services and
g. Improving advocacy in locally relevant and acceptable dialects.

Operational strategy for meeting un-met needs-

a. Strengthen, energize and make publicly accountable the cutting edge of health infrastructure at the village, sub center and primary health center levels.
b. Address on priority the different unmet needs
c. Formulate and implement innovative social marketing schemes
d. Improve facilities for referral transportation at Panchayat, zilla parishad and primary health center levels
e. Encourage local entrepreneurs at village and block levels to start ambulance services through special loan schemes
f. Provide special Strengthen, energize and make publicly accountable the cutting edge of health infrastructure at the village, sub center and primary health center levels.
g. Address on priority the different unmet needs
h. Formulate and implement innovative social marketing schemes
i. Improve facilities for referral transportation at Panchayat, zilla parishad and primary health center levels
j. Encourage local entrepreneurs at village and block levels to start ambulance services through special loan schemes and make site allotments for chemist shops for basic medicines and provision for medical first aid.

6) Under-Served Population Groups

a. Urban Slums

Operational strategies-

i. Finalize a **comprehensive urban health care strategy** and facilitate service delivery
ii. **Reproductive and child health services by NGOs** and private sector organizations, including corporate houses.
iii. Promote **networks of retired government doctors** and Para-medical and non-medical personnel who may function as health care providers on remunerative terms.
iv. **Strengthen social marketing** programs for non-clinical family planning products and services in urban slums.
v. **Initiate specially targeted** information, education and communication (**IEC**) campaigns for urban slums on family planning, immunization, ante-natal, natal and post-natal check-ups and other reproductive health care services.
vi. **Integrate health education with health & medical care programs**, with emphasis on environmental health, personal hygiene and healthy habits, nutrition education and population education.
vii. **Promote inter-sectoral coordination** between departments/municipal bodies dealing with water and sanitation, industry and pollution, housing, transport, education and nutrition and women and child development, to deal with unplanned and uncoordinated settlements.
viii. **Streamline the referral systems** and linkages between the primary, secondary and tertiary levels of health care in the urban areas.
ix. **Link the provision** of continued facilities **to** urban slum dwellers with their **observance of the small family norm.**

b. Tribal Communities, Hill Area Populations and Displaced and Migrant Populations

Operational strategies-

i. **Provide information and counseling** in respect of infertility, including fertility regulation
ii. **Provide Mobile clinics** for regular coverage and outreach for the nomadic nature and frequent
iii. **Promote indigenous systems of medicine** which is more trusted by these communities
iv. **Adopt a "burden of disease" approach** to meet the special needs of tribal and hill area communities.

c. Adolescents

Operational strategies-

i. Ensure **adolescent's access to information, counseling and services**, including affordable and accessible reproductive health services for which primary health centers and sub centers need to be strengthened, to provide counseling, both to adolescents and also to newly weds (who may also be adolescents).
ii. Emphasize **proper spacing** of children.
iii. Provide for **adolescents the package of nutritional services available under the ICDS** program.
iv. **Enforce the Child Marriage Restraint Act, 1976,** to reduce the incidence of teenage pregnancies.
v. Preventing the **marriage of girls below the legally permissible age of 18** should become a national concern.

vi. Provide **integrated intervention in pockets with unmet needs** in the urban slums, remote rural areas, border districts and among tribal populations.

d. Increased Participation of Men in Planned Parenthood

Operational strategies-

i. Focus **IEC efforts on men** to sensitize them towards their family responsibility
ii. **Re-popularize vasectomies**, in particular the no-scalpel vasectomy
iii. In the continuing education and **training at all levels for no-scalpel vasectomy**, and all such emerging techniques and skills are included in the syllabi, together with abundant practical training.

7) Diverse Health Care Providers

Ways of doing this include-

a. **Accrediting private medical practitioners a**nd assigning them to defined beneficiary groups to provide these services;
b. **Revival of the system of licensed medical practitioner** who, after appropriate certification from the Indian Medical Association (IMA), could provide specified clinical services.

Operational strategies-

a. At district and sub-district levels, maintain block-wise data base of private medical practitioners who after verification from IMA are accredited and assigned a population (not > 5000) for compensation based service for one year with renewal subject to client satisfaction
b. Revive the earlier system of the licensed medical practitioners who, after appropriate certification from the IMA, may participate in the provision of clinical services.
c. Involve the non-medical fraternity (retired defense personnel, school teachers) in counseling and advocacy so as to demystify the national family welfare effort,
d. Modify the under/post-graduate medical, nursing, and paramedical professional course syllabi and curricula, in consultation with the Medical Council of India, the Councils of ISMH, and the Indian Nursing Council, in order to reflect the concepts and implementation strategies of the reproductive and child health program and the national population policy.
e. Ensure the efficient functioning of the First Referral Units i.e. 30 bed hospitals at block levels
f. Augment the availability of specialists in three disciplines (gynecology & obstetrics, anesthesiology and pediatrics), by-
   i. Increasing seats in medical institutions,
   ii. Facilitate the acquisition of in-service post-graduate qualifications through the National Board of Medical Examination and open universities like IGNOU in larger numbers.
   iii. As an incentive, seats will be reserved for those in-service medical graduates who are willing to abide by a bond to serve for 5 years at First Referral Units after completion of the course.
   iv. States would need to sanction posts of Specialists at the FRUs.
   v. These specialists should be provided with clear promotion channels.

8) Collaboration With and Commitments from Non-Government Organizations and the Private Sector

Operational strategies-

a. Collaboration with and Commitments from the Non-Government Sector

i. A forum of representatives from government, the non-government organizations and the

private sector may identify hurdles that inhibit genuine long-term collaboration between the government and non-government sectors and prepare guidelines that will facilitate and promote collaborative arrangements.

ii. Collaboration with and commitments from NGOs to augment advocacy, counseling and clinical services, while accessing village levels. This will require increased clinic outlets as well as mobile clinics.

iii. Collaboration between the voluntary sector and the NGOs will facilitate dissemination of efficient service delivery to village levels. The guidelines could articulate the role and responsibility of each sector.

iv. Encourage the voluntary sector to motivate village-level self-help groups to participate in community activities.

v. Specific collaboration with the non-government sector in the social marketing of contraceptives to reach village levels will be encouraged.

b. **Collaboration with and Commitments from Industry**

i. The corporate sector and industry could, for instance, take on the challenge of strengthening the management information systems in the seven most deficient states, at primary health center and sub center levels.

ii. Introduce electronic data entry machines to lighten the tedious workload while enabling wider coverage and outreach.

iii. Collaborate with non-government sectors in running professionally sound advertisement and marketing campaigns for products and services, strengthen advocacy and IEC, including social marketing of contraceptives.

iv. Provide markets to sustain the income-generating activities from village levels upwards. In

v. Help promote transportation to remote and inaccessible areas up to village levels.

vi. The social responsibility of the corporate sector in industry must, at the very minimum, extend to providing preventive reproductive and child health care for its own employees (if >100 workers are engaged).

vii. Create a national network consisting of voluntary, public, private and non-government health centers, identified by a common logo, for delivering reproductive and child health services, free to any client. The provider will be compensated for the service provided

viii. Form a consortium of the voluntary sector, the non-government sector and the private corporate sector to aid government in the provision and outreach of basic reproductive and child health care and basic education

ix. set up privately run/managed primary schools for children up to age 14-15. Alternately, if the schools are set up/managed by the Panchayat, the private corporate sector could provide the mid-day meals, the text -books and/or the uniforms.

9) Mainstreaming Indian Systems of Medicine and Homeopathy

Operational strategies-

a. Provide appropriate training and orientation in respect of the RCH program for the institutionally qualified ISMH medical practitioners (already educated in midwifery, obstetrics and gynecology over 5-1/2 years), and utilize their services to fill in gaps in manpower at appropriate levels in the health infrastructure

b. Utilize the ISMH institutions, dispensaries and hospitals for health and population related programs.

c. Disseminate the tried and tested concepts and practices of the indigenous systems of medicine, together with ISMH medication at village maternity huts and at household levels for antenatal and post-natal care, besides nurture of the newborn.
d. Utilize the services of ISMH 'barefoot doctors' after training and orientation for
   i. Advocacy and counseling
   ii. Disseminating supplies and equipment, and as
   iii. Depot holders at village levels

10) Contraceptive Technology and Research on Reproductive and Child Health

The National Health and Family Welfare Survey provide data on key health and family welfare indicators every five years. Data from the first National Family Health Survey **(NFHS-1) 1992-93** has been updated by **NFHS-2, 1998-99 and now by NFHS-III (2005-06)**.
Annual data is generated by the **Sample Registration Survey**, which, inter alia, maps at state levels the birth, death and infant mortality rates. Absence of regular feedback has been a weakness in the family welfare program.
For this reason, the Department of Family Welfare is strengthening its management information systems (MIS) and has commenced during 1998, a system of ascertaining impacts and outcomes through district surveys and facility surveys. The district surveys cover 50% districts every year, so that every 2 years there is an update on every district in the country.

Operational strategies-

a. Government will encourage, support and advance the pursuit of medical and social science research on reproductive and child health, in consultation with ICMR and the network of academic and research institutions.
b. The International Institute of Population Sciences and the Population Research Centers will continue to review program and monitoring indicators to ensure their continued relevance to strategic goals.
c. Government will restructure the Population Research Centers, if necessary.
d. Standards for clinical and non-clinical interventions will be issued and regularly reviewed.
e. A constant review and evaluation of the community needs assessment approach will be pursued to align program delivery with good management practices and with newly emerging technologies.
f. A committee of international and Indian experts, voluntary and non-government organizations and government may be set up to regularly review and recommend specific incorporation of the advances in contraceptive technology and, in particular, the newly emerging techniques, into program development.

11) Providing for the Older Population

Operational strategies-

a. Sensitize, train and equip rural and urban health centers and hospitals towards providing geriatric health care.
b. Encourage NGOs and voluntary organizations to formulate and strengthen a series of formal and informal avenues that make the elderly economically self-reliant.
c. Tax benefits could be explored as an encouragement for children to look after their aged parents.

12) Information, Education, and Communication

Operational strategies-

a. **Converge IEC efforts across the social sectors making optimal use of media- Involve all related departments**
b. **Health and population education** must be inculcated from the school levels.
c. Fund the nagar palikas, Panchayat, NGOs and community organizations for interactive and participatory IEC activities.
d. Demonstration of **support by elected leaders, opinion makers, Public leaders, film stars and religious leaders** with close involvement in the reproductive and child health program greatly influences the behavior and response patterns of individuals and communities.
e. Utilize **radio and television** as the most powerful media for disseminating relevant socio-demographic messages. Government could explore the feasibility of appropriate regulations, and even legislation, if necessary, to **mandate the broadcast of social messages during prime time**.
f. Utilize dairy cooperatives, the public distribution systems, other established networks like the LIC at district and sub-district levels for IEC and for distribution of contraceptives and basic medicines to target infant/childhood diarrheas, anemia and malnutrition among adolescent girls and pregnant mothers.
g. **Sensitize the field level functionaries** across diverse sectors (education, rural development, forest and environment, women and child development, drinking water mission, and cooperatives) **to the strategies, goals and objectives of the population stabilization programs.**
h. **Involve civil society** for disseminating information, counseling about the small family norm, higher female literacy and late marriages for women. Civil society could also monitor availability of contraceptives, vaccines and drugs.

Legislation for NPP-2000:

It is recommended that the **42nd Constitutional Amendment that freezes, till 2001, the number of seats to the Lok Sabha and the Rajya Sabha based on the 1971 Census be extended up to 2026**

New structure:

The **NPP 2000 is to be largely implemented and managed through PRIs** in coordination with the concerned state/Union Territory administrations.

This will require comprehensive and **multi-sectoral coordination** of planning and implementation between health and family welfare on the one hand, along with schemes for education, nutrition, women and child development, safe drinking water, sanitation, rural roads, communications, transportation, housing, forestry development, environmental protection, and urban development. Accordingly, the following structures are recommended:

1. **National Commission on Population**
2. **State / UT Commissions on Population**
3. **Coordination Cell in the Planning Commission**
4. **Technology Mission in the Department of Family Welfare**

Funding

The programs, projects and schemes premised on the goals and objectives of the NPP 2000, and indeed all efforts at population stabilization, will be adequately funded in view of their critical importance to national development.

Even though the annual budget for population stabilization activities assigned to the Department of Family Welfare has increased over the years, at least 50 percent of the budgetary outlay is deployed towards non-plan activities (recurring expenditures for maintenance of health care infrastructure in the states and UTs, and towards salaries). To illustrate, of the annual budget of Rs. 2920 Crores for 1999-2000, nearly Rs 1500 Crores is allocated towards non-plan activities. Only the remaining 50 percent becomes available for genuine plan activities, including procurement of supplies and equipment. For these reasons, since 1980 the Department of Family Welfare has been unable to revise norms of operational costs of health infrastructure, which in turn has impacted directly the quality of care and outreach of services provided.

Promotional and motivational measures for Adoption of the small family norm:

1. Panchayats and Zila Parishads will be rewarded for exemplary performance in universalizing the small family norm, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary schooling.
2. The Balika Samridhi Yojana run by the Department of Women and Child Development, to promote survival and care of the girl child, will continue. A cash incentive of Rs. 500 is awarded at the birth of the girl child of birth order 1 or 2.
3. Maternity Benefit Scheme run by the Department of Rural Development will continue. (**This Has been replaced by JSY since 2005)**
4. A Family Welfare-linked Health Insurance Plan will be established.
5. Couples below the poverty line, who marry after the legal age of marriage, register the marriage, have their first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child, will be rewarded.
6. A revolving fund will be set up for income-generating activities by village-level self help groups, who provide community-level health care services.
7. Crèches and child care centers will be opened in rural areas and urban slums.A wider, affordable choice of contraceptives will be made accessible at diverse delivery points,
8. Facilities for safe abortion will be strengthened and expanded.
9. Products and services will be made affordable through innovative social marketing schemes.
10. Local entrepreneurs at village levels will be provided soft loans and encouraged to run
11. ambulance services.
12. Increased vocational training schemes for girls, leading to self-employment will be encouraged.
13. Strict enforcement of **Child Marriage Restraint Act, 1976.**
14. Strict enforcement of the **Pre-Natal Diagnostic Techniques Act, 1994.**
15. Soft loans to ensure mobility of the ANMs will be increased.
16. The 42nd Constitutional Amendment has frozen the number of representatives in the Lok Sabha (on the basis of population) at 1971 Census levels. The freeze is currently valid until 2001, and has served as an incentive for State Governments to fearlessly pursue the agenda for population stabilization

Health Legislations in India:

1. **Legislations related to Health in general**
   a. The Epidemic Diseases Act, 1897
   b. Indian Air Craft (Public Health) Rules, 1954
   c. The Registration of Births and Deaths Act, 1969
   d. The Persons with Disabilities (Equal Opportunity, Protection Of Rights And Full Participation) Act, 1995
   e. The Biomedical Waste (Management And Handling Rules 1998) Act

2. **Legislation related to Mother/ women's Health**
   a. Hindu Marriage Act, 1955
   b. The Special Marriage Act, 1954
   c. Hindu Succession Act, 1956
   d. The Maternity Benefits Act, 1961
   e. The Dowry Prohibition Act, 1961
   f. Hindu Adoption and Maintenance Act, 1956
   g. The Immoral Traffic (Prevention) Act, 1956; amended in 1986
   h. The Medical Termination Of Pregnancy Act 1971(The MTP Rules, 1975)
   i. The Pre-natal Diagnostic Techniques (Regulation & Prevention of misuse) Act, 1994 Rules, November 26, 1996

3. **Legislations related to Child Health**
   a. The Child Marriage Restraint Act, 1929
   b. Children Act, 1960
   c. The Juvenile Justice Act, 1986
   d. The Child Labor (Prohibition and Regulation) Act, 1986
   e. Infant Milk substitute Act, 1992

4. **Legislations related to Environment**
   a. Factory Act, 1947
   b. The Atomic energy Act, 1962
   c. The Insecticides Act, 1968
   d. The Wild Life (Protection) Act 1972
   e. The Indian Forest Act, 1972
   f. The Water (Prevention and Control of Pollution) Act, 1974
   g. The Forest (Conservation) Act, 1980
   h. The Air (Prevention and Control of Pollution) Act, 1981
   i. The Environmental (Protection) Act, 1986
   j. The Motor Vehicle Act, 1988
   k. The Natural Environment Tribunal Act, 1995

5. **Legislations related to Occupation**
   a. The Workmen's Compensation Act, 1923 (Amended In 1984)
   b. The Trade Union Act 1926
   c. The Factories Act, 1948,
   d. The Employees States Insurance Act, 1948
   e. The Plantation Labor Act, 1951
   f. Mines Act, 1952

g. Plantation Labor Act, 1951
h. The Employee State Insurance Act, 1948
i. The Factories (Amendment) Act, 1976
j. The Dangerous Machine (Regulation) Act, 1983
k. Legislations related o Human rights
l. The Equal Remuneration Act, 1976
m. The Contract Labor (Regulation and Abortion) Act ,1976
n. Indecent Representation of Women (Prohibition) Act, 1986
o. The Commission on Sati (Prevention) Act, 1987
p. The Minimum Wages Act, 1948
q. The Consumer Protection Act (CPA) 1986

6. Legislations related to Medical Profession

a. The Indian Nursing Council Act 1947
b. The Dentists Act 1948
c. The Pharmacy Act 1948
d. The Indian Medical Council Act, 1956 (Amended in 1964, 1993)

Financial Management under NRHM in Rajasthan

Financial Management of NRHM in Rajasthan involves coordination with multiple levels of Central and State government, liquidity management for ensuring adequate moneys are available at field institutions, establishment of new procedures of accounting at nearly 2000 public health institutions, and ensuring that all these institutions function in accordance with FMG guidelines

It is going to take more time for the systems of financial governance to settle down as the current system is vastly different from the conventional treasury system and is not entirely works accounting system either.

Outcomes

1. Understanding of Financial & Accounting aspects in NRHM
2. Uniformity of Accounting at different level under NRHM
3. Accuracy & Timely reporting system
4. Synchronization of Tally Software
5. Improving in fund flow from various level
6. Aging of Advances & Cut down long period advances

Accounting procedures:

Accounting is process of recording the financial transaction of a business in a systematic manner and preparing summarized financial statement.

Accounting process-

1. Identification of Transaction
2. Recording the Transaction
3. Classifying the transaction
4. Summarizing
5. Analyzing and Interpretation
6. Presentation or reporting

Fundamentals of Accounting-

1. Personal Accounts
   a. Debit-Receiver
   b. Credit-Giver
2. Real Accounts
   a. Debit- What comes in
   b. Credit-What goes out
3. Nominal Account
   a. Debit-All Expenses and Losses
   b. Credit-All Income and Gains

Accounting tools-

1. **Ledger** is defined as summarized statement of all the transaction relating to Persons, Assets, Income, expenditure etc.
2. **Cash Book-**Cash book record all the transaction in cash or cheque**;** Receipt of Debit Side and Payment on Credit side

   Types of Cash Book
   a. Simple Cash book
   b. Cash book with discount

c. Cash book with Discount and Bank
d. Bank Cash Book
e. Petty Cash Book

3. **Purchase Book** /Purchase return Book
4. **Sales Book**/Sales return books
5. **Bills receivable**
6. **Bills Payable**
7. **Trial Balance-** is statement of total of all ledger accounts. Prepared at given time. Method checking arithmetical accuracy

Importance of financial management-

Two Way Process: Top-down, Bottom-up

1. Flow of funds at each level (Top-down)
   Clear purpose, adequacy, timely and sufficient guidance to spend
   Centre>States>Districts>Blocks (BMOs)>Other CHCs/PHCs>SHCs>VHSCs
2. Reporting of Expenditure through reports & returns
   Timely (discipline is important), accuracy
   VHSCs>SHCs>PHCs/CHCs>Blocks (BMOs)>Districts>State>Centre

Fund flow under NRHM:

Fund Flow to States under 2 routes:

1. Treasury Route: primarily salary component.
   a. Salaries of the posts of Auxiliary Nurse Midwife (ANMs) & LHVs
   b. Training of ANMs.
   c. Support to Family Welfare Bureau at state and district levels.
2. Society Route:
   a. for programme implementation
   b. salaries for the contractual employees hired for strengthening of programme implementation under the Mission

Financial Guidelines under NRHM:

1. Funds available for various interventions under NRHM
   a. RCH Phase-II Program
   b. Additionalities under NRHM
      i. Village Level
         1) Funds for Village Health & Sanitation Committees @Rs.10000 per VHSC p.a.(Every village upto 1500 pop.-H/h surveys, health camps, sanitation drives, & sanitation committees)
         2) Community monitoring
      ii. Sub Health Centre Level
         1) Untied funds @ Rs.10000 per sub- center per year
         2) Annual Maintenance Grant @Rs.10000 p.a.
         3) Construction of Sub-centres
         4) Additional ANM
      iii. PHC Level
         1) Funds for Selection & Training of ASHAs
         2) Untied funds @ Rs.25000 per PHC per year

3) Annual Maintenance Grant @Rs.50000 p.a
4) Rogi Kalyan Samiti @ Rs.1 lakh
5) Funds for JSY
6) Staff Nurses, Up-gradations to IPHS

iv. CHC Level
1) Untied funds @ Rs.50000 per CHC per year
2) Annual Maintenance Grant @Rs.50000 p.a
3) Funds for up-gradation of CHCs to IPH
4) Rogi Kalyan Samiti @ Rs.1 lakh-Corpus Grants
5) Funds for Selection & Training of ASHAs
6) Mobile Medical Units

v. District Level
1) Funds for construction of buildings of existing sub-centers, PHCs, CHCs etc.
2) District Health Action Plans (upto Rs.20 lakhs)
3) Rogi Kalyan Samiti (Rs.5 lakhs)
4) Funds for up-grading Dist. Hospitals/Other hospitals
5) Health Melas

c. Routine Immunization
i. Funds for routine immunization activities – BCG, DPT, Measles, Polio, Hepatitis B, etc.
ii. Introduction of newer vaccine like JE etc.
iii. Funds are for improving service delivery to achieve accelerated coverage - Alternate Vaccine Delivery, incentive to ASHAs for Mobilization, underserved areas and campaign approach.
iv. Injection safety through introduction of AD syringes.
v. Cold chain equipments –Deep freezers, ILR, , vaccine carriers, WIF & WIC (replacement of CFC with non-CFC equipment)

d. National Disease Control Programs
i. National Vector Borne Disease Control Program – Malaria, Filaria, JE, etc.
ii. Revised National Tuberculosis Control Program (RNTCP)
iii. National Leprosy Elimination Program
iv. National Iodine Deficiency Disorder Control Program
v. National Program for Control of Blindness
vi. Integrated Disease Surveillance Project
vii. National Drug De-addiction Program

e. Inter-sectoral convergence with drinking water, sanitation, AYUSH, WCD, PRI

2. Issues related to untied funds at Sub-centres, PHCs, Block CHCs, FRUs & District Levels
3. Problems relating to Funds release, disbursement, SoEs, UCs at Facility Level
4. Mechanism for optimal utilization of funds under NRHM
5. Importance of monitoring of Financial Mgt.
6. Format for monitoring the fund flow

Financial Accounting & Reporting at NRHM:

NRHM – State Level

1. Cash Balance Certificate
2. Treatment of Interest Earned in the Bank Account

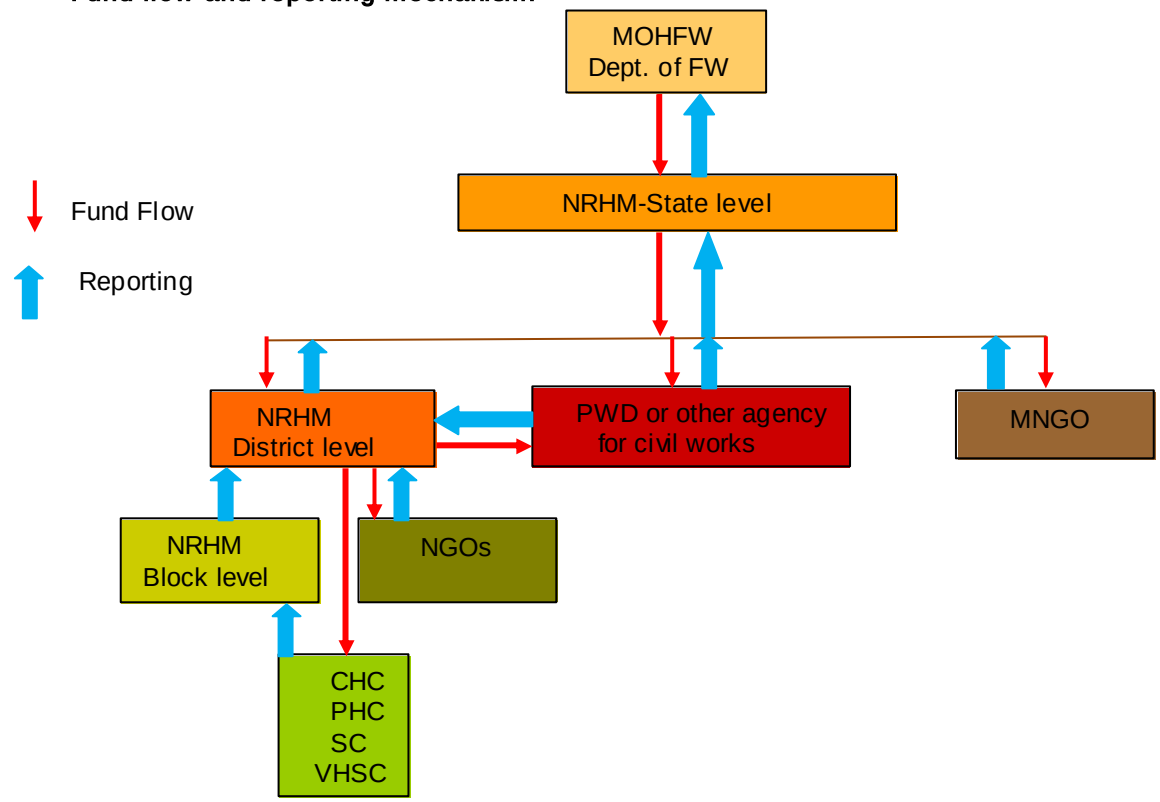
3. Preparation of Cheques
4. Cash Book with Cash & Bank Columns
5. Petty Cash Book
6. Serial Numbering of Vouchers
7. Ledger
8. District Program Management Support Unit-wise ledgers
9. Journal
10. Register of investments
11. Registers for temporary advances as below:
    a. Advance to staff
    b. Advances to Contractors / NGOs
    c. TA/DA Advance
12. Stock Register for:
    a. Machinery & Equipment
    b. Furniture & Other Non-consumable articles
    c. Register for drugs & medicines
    d. Register for consumable articles
13. Dead Stock Register (Machinery & Equipments, Other non-consumable articles)
14. Receipts & Payments Statement
15. **Reporting:**

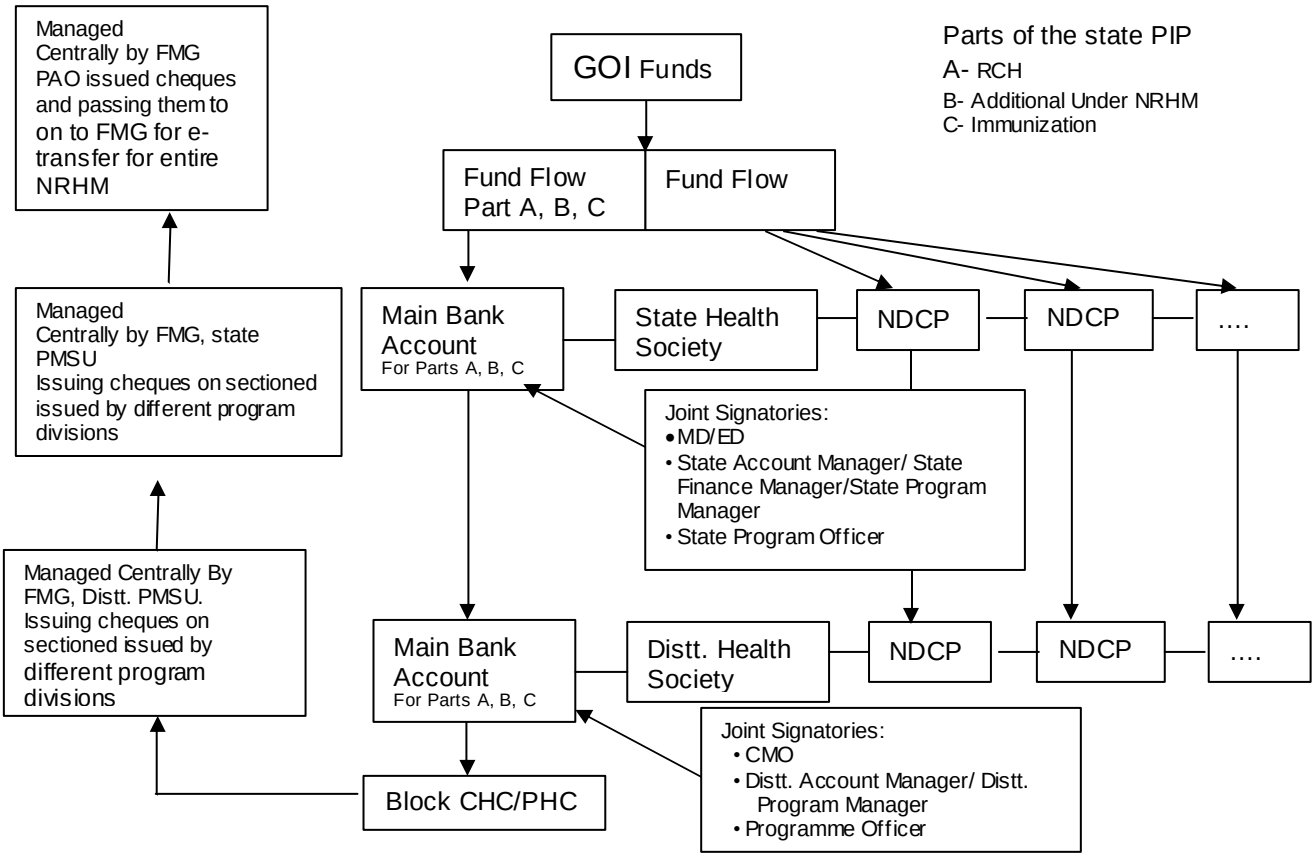
    a. Certificate by State that funds have been transferred to Districts within 15 days
    b. Monthly FMR from District Society to State Health Society
    c. Quarterly FMR from State Society to GOI
    d. Statement of fund positions
    e. Monthly statement of bank balances
    f. Annual UCs in form GFR-19A along with audited statements
    g. Annual audited accounts to GOI

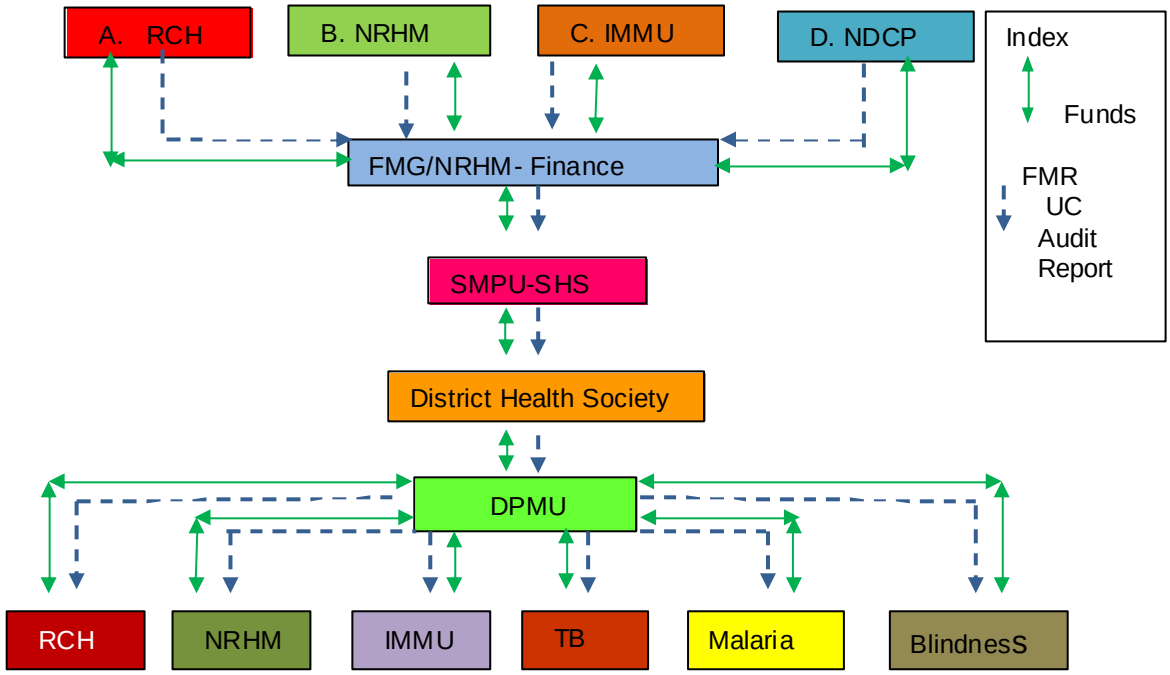
Monitoring:

a. At District Societies – based on SoEs/Bills/ Vouchers from Block PHCs on monthly basis
b. At State - Based on monthly FMR from Districts
c. At Centre – Based on Quarterly FMR from States
d. With specialized FMG in place with state-specific consultants, constant monitoring will be a success
e. Finance & Accounts Manual clearly indicates dates of all monthly, Quarterly & Annual reports with responsibility matrix
f. E-Banking:
    i. Which can be used to evaluate the program implementation status independently without waiting for Quarterly FMR
    ii. Will show red-alert districts
    iii. Will allow mid-term corrections
    iv. In conjunction with the physical delivery evaluation will become a potent monitoring tool

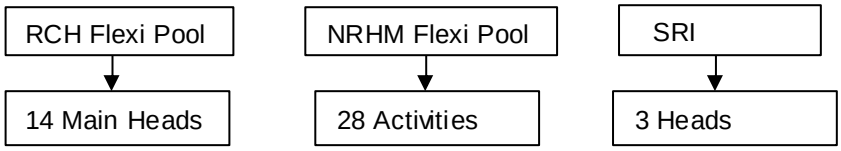
Fund flow and reporting mechanism:







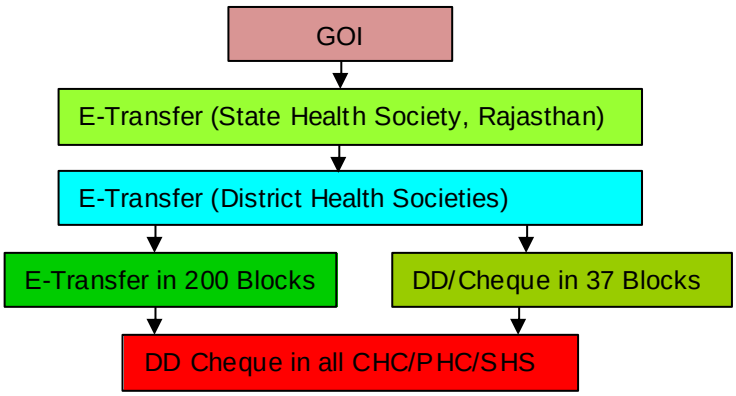
Financial Management Report



Total Accounts under NRHM-Rajasthan

12889 Bank Accounts
2 Bank A/c SHS, Rajasthan
34 Bank A/c DHS
237 Bank A/c Block
365 Bank A/c CHC
1509 Bank A/c PHC
10742 Bank A/c SC

All Bank Accounts operational. E-transfer is functional at all districts and out of 237 Block A/c 200 are covered through E-transfer. Negotiations are under process with Bankers to facilitate E-transfer/ RTGS at Block & CHC level.



Key Features of NRHM Finance & Accounts Manual:

Tranche Release Arrangements			
	Extent of Releases possible	Dead line	Conditions Precedent
1st Tranche	Up to 75% of approved PIP after taking in to account the Unspent balance available with the State/U Ts at the beginning of the financial year (i.e. 1st April 200…)	by 30th May	1. Approval of PIP by NPCC. 2. Submission of Utilization Certificates on provisional basis for the grants released in preceding year. 3. Submission of Financial Monitoring Reports for the last quarter of the preceding financial year (quarter ending 31st March 200…) 4. Submission of Statement of Fund Position (SFP) showing the bank balance and advance position of SHS (including DHS) for the last quarter of the preceding financial year (quarter ending 31st March200…) 5. Submission of Statement showing Interest earned at the State level and District level during the preceding financial year. 6. Achievement of at least half the institutional process targets specified in Annex III all of the MoU (for RCH releases).
2nd Tranche	Up to 75% of approved PIP after taking in to account the Unspent balance available with the State/U Ts at the beginning of the financial year (i.e. 1st April 200…)	By 30th October	1. Provided Annual Audited Accounts along with UCs (duly tallied with the Audited Statements) are submitted for the preceding financial year.

Bank Accounts:

1. Number of Bank Accounts: 1 (Main Bank Account) for Part A, B, C & separate accounts for each of 6 NDCPs.
   Flow of funds from GOI→SHS-RNTCP A/c→DHS RNTCP A/C.
2. Nomenclature of Bank Accounts – SHS- ……..
3. Any fund under any other intervention (Cardio-vascular, telemedicine etc) would be credited in Main Bank Account.
4. Only Saving Banks. No FDs, No Investments

Accounting Policies & Reporting requirements:

1. Accounting Centers

a. SHS
b. DHS
c. Block CHC/PHC (provided the Block Accountant has been posted). Else, DHS should be the Accounting Centre.
d. RKS of PHC/CHC/Rural Hospitals/Sub-district Hospitals

2. Movement of Records

a. SHS Level
b. DHS Level & Block CHC/PHC level:
   i. Records for all the transactions taking place at DHS & Block CHC/PHC would be kept at these institutions itself.

ii. Records will not be moved from these institutions to any other place so that they can be made available to the audit whenever necessary.
iii. Will only furnish Statement of Expenditures (SoE)/Financial Monitoring Reports (FMRs) to next higher institution (i.e. Block CHC/PHC to DHS and DHS to SHS). SHS may prescribe other reporting formats for their satisfaction.

3. Treatment of G-I-A

a. Funds transferred from GoI but not received shall be entered on the income side of the income and expenditure account under the heading "Grants- in-Aids" and taken in the balance sheet on the assets side under the heading **"Funds in Transit"** below Current Assets (Cash and Bank Balance).
b. G-i-A is reflected in the Income & Expenditure accounts as income to the extent of fund utilization against it.
c. The Grant-in-Aid to the extent of remaining unutilized at the end of the financial year is shown as liability in the Balance Sheet.

4. Recognition of Expenditure

a. Releases to Public Health Institutions: shall not be treated as expenditure unless they are reported back as expenditure (either by voucher or SoE, whichever is applicable)
b. Advance to NGOs: NO
c. Advances for Civil Works: treated as advance at the time of release. On receipt of certificate of stage of completion and part bill from PWD or Contractor, it is booked as expense to the extent it is certified by the PWD as per the terms of the agreement.
d. **Releases to VHSCs**: Untied Fund to VHSCs @ of Rs 10,000/ per annum shall be deemed to be treated as expenditure provided the Untied Funds have been credited in the Bank Account of VHSC.
e. **Commodity Grants**: not reflected in the financial statements of the Society. However, they
f. Should be appearing in the Notes on Accounts and Disclosure of the Audit Report.

5. Expenditure Reporting Basis

a. Expenditure reporting from various institutions would be considered as expenditure based on following reports or documents:
   i. From DHS: Based on FMR/SoE. However, FMR or SoE must carry a certification by the expenditure has been made for the approved items and vouchers have been retained at the District level.
   ii. From Block CHC/PHC: Based on FMR/SoE. However, FMR or SoE must carry a certification by the expenditure has been made for the approved items and vouchers have been retained at the Block CHC/PHC level.
   iii. From PHC, SHC: Based on actual receipt of vouchers and supporting documents.
   iv. From Rajasthan Medical Relief Societies at various levels: Based on Monthly and Quarterly Statement of Expenditure (SoEs).

6. Reporting from RMRS

a. Reporting from RMRS:
   i. For Monthly/Quarterly FMRs: would furnish a monthly Statement of Expenditure (SoE) to the controlling Block CHC/PHC or DHS.
   ii. For Annual Audit of DHS/SHS:
      - SHS and DHS should endeavour to make sure that Audit of all the RKS is complete within 2 months of the closure of financial year as prescribed in this Manual.

- However, if for certain reasons, the Audit of some of the RKS can not be completed then, Audit Report of the DHS should be finalized (without delay) based on monthly SoEs for the last month (i.e. March) showing monthly and cumulative expenditure for the whole financial year.
- Differences can be adjusted during next year audit correspondingly.

7. Treatment of Fixed Assets

a. Assets that are to be capitalized: to B/S while sending Utilization Certificates (UCs), the expenditure shown in UCs should include the expenditure as per Income & Expenditure Account plus the amount of such Capitalized Assets.
b. Assets not to be capitalized: in Income & Exp Statement.

Guidelines for use of Sub-centre (SC) funds under NRHM

1. As part of the National Rural Health Mission, it is proposed to provide each sub center with Rs.10, 000 as an untied fund to facilitate meeting urgent yet discrete activities that need relatively small sums of money.
2. The fund shall be kept in a joint bank account of the ANM and the Sarpanch
3. Decisions on activities for which the funds are to be spent will be approved by the Village Health Committee (VHC) and be administered by the ANM. In areas where the sub center is not co-terminus with the Gram Panchayat (GP) and the sub center covers more than one GP, the VHC of the Gram Panchayat where the SC is located will approve the Action Plan. The funds can be used for any of the villages, which are covered by the sub center.
4. Untied Funds will be used only for the common good and not for individual needs, except the case of referral and transport in emergency situations.
5. Suggested areas where **Untied Funds may be used** include:
   a. Minor modifications to sub center- curtains to ensure privacy, repair of taps, installation bulbs, other minor repairs, which can be done at the local level
   b. Ad hoc payments for cleaning up sub center, especially after childbirth.
   c. Transport of emergencies to appropriate referral centers
   d. Transport of samples during epidemics.
   e. Purchase of consumables such as bandages in sub center
   f. Purchase of bleaching powder and disinfectants for use in common areas of the village.
   g. Labour and supplies for environmental sanitation, such as clearing or larvicidal measures for stagnant water.
   h. Payment/reward to ASHA for certain identified activities
6. Untied funds shall not be used for any salaries, vehicle purchase, and recurring expenditures to meet the expenses of the Gram Panchayat.

Management of funds at the Sub-Health Centre level

Expected Funds Inflow: Sub-Centres shall receive NRHM funds under the following heads:

1. Permanent Advance for performance related incentive to ASHA
2. Annual Maintenance Grant of Rs 10,000/-
3. Untied grant of Rs 10,000/- every year.
4. Janani Suraksha Yojana.

Banking System: A bank account has already been prescribed,, to be opened and operated under joint signatures of the ANM and Sarpanch at the sub-centre level. The same may be utilized for all

funds received by the Sub-Centre. The Account can be opened in any scheduled commercial bank/ Grameen Bank/Post Office.

Joint Signatories: Sarpanch and ANM

Records: ANM may maintain a separate register for each of the activities for which funds have been received, such as JSY, Untied Grant, Maintenance Grant, etc., showing the total funds received and expenditure made date-wise. These registers should be verified by Sarpanch at the close of every month.

Submission of Statement of Expenditure (SoE): The SoE may be submitted by the ANM on a **quarterly** basis within 5 days of the end of the quarter to the controlling MO in charge. It would be desirable if, at the time of submission of SoE, ANM reconciles the expenditure with the bank statement. SoE can be submitted on the simple format for Untied Grant, Annual Maintenance Grant, JSY, etc. separately on plain paper stating as below:

Certified that following amounts were utilized during the quarter ending……., 200..

Activity	Amount utilized
Payment to beneficiaries of Janani Suraksha Yojana	----------
Payments to ASHAs	----------
Maintenance of Sub-centre	----------
Activities funded from the untied grants	----------
Others	----------
Total	

Signature …… (ANM)

Guidelines for Utilization of Untied Fund and Annual Maintenance Grant for Primary Health Centres (PHCS)

1. PHC will get Rs. 25,000/- p.a. as untied grant and Annual Maintenance Grant of Rs.50,000/-.
2. A separate register be maintained in the PHC giving sources of funds clearly for various activities.
3. PHC untied fund shall be kept in the bank account of the concerned Rogi
4. Kalyan Samitti (RKS)/ Hospital Management Committee (HMC).
5. PHC level Panchayat Committee/Rogi Kalyan Samiti will have the mandate to undertake and supervise the work to be undertaken from Annual Maintenance Grant. Both the funds will be spent and monitored by RKS.

Fund allocation:

Type of Grant	Entity to which due	Amount
Annual untied grant	i. VHSC ii. SC iii. PHC iv. CHC	10000 10000 25000 50000
Annual Maintenance Grant	i. SC ii. PHC iii. CHC	10000 50000 100000
Annual group grants to RMRS	i. PHC ii. CHC iii. Rural Hospitals	100000 100000 500000

Suggested areas where Untied Fund may be used include:

1. Minor modifications to the Center- curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level
2. Patient examination table, delivery table, DP apparatus, hemoglobin meter, copper-T insertion kit, instruments tray, baby tray, weighing scales for mothers and for newborn babies, plastic/rubber sheets, dressing scissors, stethoscopes, buckets, attendance stool, mackintosh sheet
3. Provision of running water supply
4. Provision of electricity
5. Ad hoc payments for cleaning up the Center, especially after childbirth.
6. Transport of emergencies to appropriate referral centers
7. Transport of samples during epidemics.
8. Purchase of consumables such as bandages in the Center
9. Purchase of bleaching powder and disinfectants for use in common areas Under the jurisdiction of the Centre.
10. Labor and supplies for environmental sanitation, such as clearing or Larvicidal measures for stagnant water.
11. Payment/reward to ASHA for certain identified activities
12. Repair/operationalising soak pits

Management of funds by Block Medical Officers and Medical Officers in charge of CHC/PHC in relation to regular program funds under NRHM

Besides the untied / maintenance grants which shall go to the Rogi Kalyan Samitis, the Block Medical Officer (BMO) and Medical Officers in-charge of CHC / PHC will receive funds either for carrying out regular activities under various programs or for further disbursement / distribution to lower institutions. These include funds, among others, for the following activities:

1. Janani Suraksha Yojana.
2. Untied Grants/annual maintenance grants to Sub-Centres and Village Health and Sanitation Committees
3. Workshops for Block Level Mission team
4. Constitution & Orientation of all community leaders on PHC and CHC committees
5. Training of community health workers (ASHAs, AWW etc)
6. ASHA support/mentoring mechanism
7. Training of ANM, PHN, Staff Nurses etc
8. Support for School Health Programs.
9. Improving physical infrastructure
10. Ambulances for PHC/CHC
11. National Disease control Programs,
12. Health melas, RCH Camp,
13. Program Management, etc.

Banking arrangement: The BMO and MO-in-Charge of CHC/PHC should have a separate bank account for all funds received for regular activities under various programs. This Bank Account may be in the name of the institution itself or in the name of the BMO or the Medical Officer in-charge of CHC/PHC. This bank account may be operated by two joint signatories (e.g. BMO / Medical Officer in-charge and Accountant of the block PHC / CHC/ PHC). If this is not possible, operation by a single signature of the BMO / MO-in- Charge can also be permitted. State Governments may issue a specific Government Order (GO) to put this system in place.

Records: A separate cash book should be maintained for the Bank Account in the name of the institution or the BMO /Officer in-charge of CHC/PHC, as the case may be. The Accountant posted at the BMO Office / CHC / PHC should maintain a separate ledger for each of the activities for which funds are being received.

Submission of Statement of Expenditure (SoE)

SoE should be submitted on a **monthly** basis within 5 days of the end of the month to the Block Medical Officer by the Medical Officer in-charge of the CHCs/PHCs within the jurisdiction of the BMO

Procurement & Logistics management:

The proper management of equipment and supplies is essential to the efficiency and effectiveness of RCH clinical and support services. Quality care depends upon the availability of appropriate equipment, materials and services. To ensure efficiency, and to reap benefits of scale, a supplies strategy is needed to:

1. Address supply management arrangements to decide appropriate levels of purchasing activities at state, district and local level.
2. Establish a modern, integrated, cost-effective logistics and supply chain for states.
3. Set key performance measures and indicators.

In designing an RCH Phase II supply strategy the following areas need to be addressed:

1. The scope of the strategy
2. What is handled in-house or outsourced?
3. Non-pay expenditure on items such as pathology, IT, drugs
4. Non-pay expenditure on services such as outsourced contract management
5. Information needs and reporting levels
6. Physical distribution and storage
7. Payment systems
8. The need for the supply strategy to integrate with other activities such as environmental, human resources and health and safety arrangements
9. The ways in which the strategy will support other objectives such as estates management and cost improvement programs
10. Decision-making delegations with respect to outsourcing, acquisition, procurement, tendering, contracting and expenditure limits
11. The level and balance of collaboration nationwide, state-wide and locally.
12. Expectations of staff and suppliers' behavior in terms of public accountability and adherence to statutory and mandatory regulations (e.g. standing orders, financial instructions and procurement regulations).
13. Policy or intentions for e-commerce
14. Strengthening Systems and Partnerships

Procurement in RCH Phase II

In the initial two years of RCH Phase II the MoH&FW will be responsible for procurement of drugs, vaccines, equipment, kits and contraceptives as done in RCH Phase I. Procurement plans for year 1 and year 2 have been shared with the development partners. The states will be gradually encouraged to undertake procurement at their level for which the MoH&FW has framed the following guideline document:

"Guidelines for Procurement" issued by GoI briefly provide the essential information and step-by-step procurement procedures to achieve objectives. However, the states may be required to customize the procedure described herein to meet the requirements of existing system preferably by way of development of a state specific operation manual.
For additional guidance on this subject, DGS&D manual can be referred to. DGS&D booklets governing the contract and standard tender forms e.g Bank Guarantee for EMD, bank guarantee for performance security, performance statement etc. are available on www.dgsnd.gov.in or www.dgsnd.nic.in. The choice of procurement procedures may be decided by the executive committee of the state for the entire procurement or for each procurement on a case-to-case basis.

This document is intended for the procurement officer to use a uniform system of procurement in all the states. It is also intended to guide the Procurement Service Agents (PSAs), wherever hired, to understand the procurement procedure. The rights and obligations of the purchaser and the contractor of goods and works are governed by the tender documents and by the contracts signed by the purchaser with the contractor and not by these guidelines.
The aim of the procurement process should be to ensure that necessary supplies of the right quality are obtained at reasonable cost through a fair and transparent system.

1. **Procurement plan and procedures**
When making procurements, specific budget provision should be available for meeting the expenditures in the financial year in which it is to be incurred.

a. Procurement plan

- Preparation of a procurement plan is essential. A procurement plan covering civil works, equipment,goods, consultancy services and resource support shall be prepared on a firm basis for the first year of the program and on a tentative basis for the subsequent years.
- Procurement plans shall be prepared every year for proper monitoring and execution.
- Procurement plans shall be prepared contract-wise.
- Method of purchase shall be based on the value of the contract, urgency of the demand, type ofgoods/services, and availability of different sources of supply etc.
- Limit of value per contract applicable to the particular procurement procedure shall be strictlyadhered to.
- It shall be ensured that the procurement is based strictly on actual need.
- The Principles and Evidence Base for State RCH Phase II Program Implementation Plans (PIPs)

b. Procurement procedure

- The procurement procedure broadly consists of the following steps:
- Assessment of requirement
- Deciding procurement strategy including technical specifications
- Mode of procurement
- Preparation of tender document
- Advertisement of the tender
- Issue of tender documents
- Opening of the tender
- Evaluation of the tender
- Clearance of World Bank/DFID, whenever required
- Award of contract
- Notification of delivery to consignee
- Inspection and testing notification of delivery to consignee
- Receipt of consignment
- Acceptance and storage of the consignment
- Resolution of disputes, if any

2. Forecasting/assessment of the requirement
Bulk requirement of the stores for state level/district level should be assessed prior to the beginning of the financial year to get competitive prices. Action for procurement should be initiated in accordance

with the purchase procedures. While forecasting the requirement the following factors should be considered:

- Average time period required in complete procurement cycle. In some cases; it can take 8 to 12 months to complete the procurement cycle.

- The trends in usage at the time of requirement.
- Current stock, where the stock is located, when the product is due to reach the expiry date and what the projected time scale is for distribution.
- Storage capacity for receiving the bulk consignment. In case the storage capacity is limited, the procurement/supply of commodities should be phased over time rather than arriving as one consignment.
- List of consignees and their storage capacity.
- The problems, if any, encountered with procurement and distribution over the last few years.
- Consolidating several program procurement requirements can result in savings through price discounts as well as reduce the administrative costs associated with having to process multiple orders.

3. Deciding on procurement strategy

It is important to agree on the procurement strategy before initiating the tendering. For example, purchase of drugs having limited shelf life shall require a different procurement strategy than purchase Strengthening Systems and Partnerships of hospital beds, for example. Issues like pre-qualification of suppliers to reduce the procurement cycle time in the case of life-saving drugs and having multiple supply lines for essential items should also be considered. Similarly for civil works, options like work contract on lump-sum basis or based on bill of quantities can be explored. The procurement strategy should cover:

- Key objectives of the procurement for the project
- Chosen procurement option
- Chosen procurement route (Open, Negotiated, Restricted)
- Key milestones (check that enough time will be allowed for negotiations, if relevant.)
- Key documents (e.g. requirements specification)

Key factors influencing the procurement strategy relate to the degree of complexity, innovating and uncertainty about the requirement, together with the time needed to achieve a successful outcome.

4. Mode of procurement

The methods of procurement normally followed are:

- Global tender/international competitive bidding (ICB)
- Open advertised tender/national competitive bidding (NCB)
- Limited tender (National /International)
- Shopping (National/International)
- Single tender/direct contracting
- Procurement of civil works through PRIs

A. Global tender/International Competitive Bidding (ICB)

This method is generally adopted where the supplies need to be imported and foreign firms are expected to participate, irrespective of the value. In the case of RCH procurement, this method is adopted when the estimated cost of the procurement is more than the equivalent of US $ 1,000,000 for goods and US $ 10,000,000 for works.

Requirement

- Apart from wide publicity nationally, invitation to bid shall also be forwarded to embassy and trade representatives of the countries of likely suppliers/contractor of the goods and works and also to those who have expressed interest in response to the general procurement notice.
- Invitation to bid will also be published in UNDB and DgMarket in cases where estimated value of the contract is more than the equivalent of US $ 200,000. This publication will be arranged by the World Bank/DFID.
- Use of standard tender document.
- Sale of bidding documents should start only after publication of invitation to bid.
- Bidding period 45 to 90 days from the date of start of sale of bidding document.
- Other procedures for global tender will broadly be same as that of open advertised tender.
- The Principles and Evidence Base for State RCH Phase II Program Implementation Plans (PIPs)

B. Open advertised tender/National Competitive Bidding (NCB)

- Open tender is the competitive bidding procedure normally used for public procurement in the country and by their nature or scope may be the most efficient and economical way of procuring goods or works. The procedures shall provide for adequate competition in order to ensure reasonable prices.
- The method to be used in the evaluation of tenders and the award of contracts shall be made known to all bidders and not be applied arbitrarily.
- In the case of RCH procurement open tender is normally adopted where the contract value is less than US $ 1,000,000
- Civil works, and also goods, could be procured under contracts awarded in accordance with the procedures prescribed under open tenders.
- Various steps involved in procurement under open tender procedure have been enumerated in clause I (b).
- Notification/Advertising: Timely notification of bidding opportunities is essential in competitive bidding:
- Invitation to bid shall be published in daily newspapers with wide circulation all over India, in at least one national English and one regional language daily. If the advertisement is for more than one item, it should also be indicated whether the evaluation would be item-wise or as a package.
- The advertisement should also be placed on the website of the department.
- If a condition in the invitation for tender is that earnest money is to be deposited by the supplier/
- contractor, the bid of a supplier / contractor not complying with this requirement, shall be rejected.
- In the case of deposit of earnest money, the state's existing procedure may be followed. However, it is desirable that a level playing field be created in this regard.
- In a package, the earnest money is indicated taking into account all the items. This cannot be changed later on. Once it is decided that the contract is for a package the earnest money for that package is to be indicated and the same cannot be changed according to each item.
- The last date for receipt of tender shall be the day following the date for close of sale of tender documents.
- Tendering period shall not be less than 30 days from the date of start of sale of tender documents.

- Tenders can be sold from different places but the tenders may be received at one place to avoid problems arising out of late/delayed tenders. Tenders should normally be opened half an hour after the deadline for receipt.

Tender documents:
The state government's standard tender documents should be used. Sale of tender documents should begin only after the publication of notification for tender in the newspapers. The tender documents shall furnish all information necessary for a prospective bidder to prepare a tender for the goods and works to be provided. Tender documents should be made available to all who seek them after paying the requisite fees, if any, regardless of registration status and they should be allowed to bid.

Clarity of tender documents: Tender documents shall furnish clearly and precisely the work to be carried out, the location of the work, the goods to be supplied, the place of delivery or installation, the schedule for delivery or completion, specification/technical specification, minimum performance
Strengthening Systems and Partnerships requirements, warranty and maintenance requirements, if any, and the method of evaluation. The basis for tender evaluation and selection of the lowest technically suitable and evaluated tender shall be clearly outlined in the instructions to tenders and / or the specifications.
Tender documents should state clearly whether the bid prices will be fixed or whether price adjustments will be made to reflect any change in major cost components of the contract.

Standards and technical specifications:
The implementing agency shall specify the generally accepted standards of technical specifications. Unbiased technical specification shall be prepared with no mention of brand names and catalogue numbers. In case the item to be procured is not covered under BIS or I.P. and specifications are to be framed, these may be prepared by a committee of experts associated with the trade, if required. The functional performance, design, quality, packaging and additional requirements should be clearly spelt out in the specifications. The specifications should be generic and should not appear to favor a particular brand or supplier.

Technical specifications, bill of quantities and civil drawings should be prepared before tendering. Clear specifications for the articles to be procured should be drawn up in every case. No deviation from the specifications should be allowed after opening of tender.

Validity of tender:
Bidders shall be required to submit tenders valid for the period specified in the tender documents. Normally, the bid validity period shall not exceed 90 days.

Earnest money:
Earnest money of normally 2% of the estimated cost of the item or works shall be the appropriate amount, which should be indicated, as a specific amount. The earnest money shall be in the form of a demand draft / bankers' cheque/bank guarantee from a scheduled bank, which should be valid up to 45 days beyond the validity period of the tender. The earnest money of unsuccessful bidders shall be refunded soon after the final acceptance of tenders. The earnest money shall be forfeited in the event of withdrawal of the tender within the original validity once submitted or in case a successful bidder fails to execute necessary agreement within the period specified.

Pre-bid conference:
A pre-bid conference (date/venue to be indicated in the bid document) may be arranged wherein potential bidders may meet the representatives of the implementing authority to seek clarifications on

the tender documents. Copy of minutes of the pre-bid conference should be furnished to the bidders who have already purchased the bid documents and also sold along with the bid document to the parties purchasing the document subsequent to the pre-bid conference.

Terms and methods of payment:
Payment terms shall be in accordance with the practices applicable to the specific goods and works. Tender documents should specify the payment method and terms offered.

Conditions of contract: The contract documents shall clearly define the scope of work to be performed, the goods to be supplied, the rights and obligations of the implementing agency and of the supplier or contractor, and the functions and authority of the engineer, architect, or construction manager, (if one is employed by the implementing agency) in the supervision and administration of the contract. Special conditions related to specific items should also be clearly specified in the tender document.

Performance security deposit:
Tender documents for works and goods shall require security in an amount sufficient to protect the implementing agency in case of breach of contract by the contractor. This shall be in the form The Principles and Evidence Base for State RCH Phase II Program Implementation Plans (PIPs)
of a bank guarantee or any other instrument and the amount should be specified in the tender document. The amount of performance guarantee shall normally be 5% of contract price (valid till 28 days from the date of expiry of defect liability period or the guarantee/warranty period as the case may be).

- The performance security deposit shall be refunded within one month of the completion of supply of goods/works. It will, however, be refunded after the expiry of guarantee/warranty period (as mentioned above) where there is condition of guarantee/warrantee.
- The performance security deposit shall be forfeited in case any terms and conditions of the contract are infringed upon or the bidder fails to make complete supply satisfactorily or complete the work within the delivery/completion period agreed in the contract.

Retention money:
In contracts for works, normally 5-10% of contract price shall be recovered for retention money. 50% of such money shall be retained till completion of the whole work and 50% shall be retained till the end of defects liability period.

Liquidated damages:
Provisions for liquidated damages shall be included in the conditions of contract when delays in the delivery of goods, completion of works, failure of the goods or works to meet performance requirements would result in extra cost, or loss of revenue or loss of other benefits to the implementing agency.

Tender opening:

- The time for the tender opening should be at least half an hour after the deadline for receipt as discussed above.
- Tenders shall be opened in public. The bidders or their representatives shall be allowed to be present at the time of opening of bids.
- All tenders received should be opened. No bid should be rejected at bid opening except for late tenders. Late tenders shall be returned to the bidders unopened.

- The name of the bidder and total amount of each bid along with important conditions like excise duty, sales tax, delivery terms, delivery period, special conditions, if any, shall be read out at the time of bid opening.
- Spot comparative statement (minutes of bid opening) must be prepared by the bid opening official and should be signed.

Confidentiality:

After the public opening of tenders, information relating to the examination, clarification, and evaluation of tenders and recommendations concerning awards shall not be disclosed to bidders or other persons not officially concerned with this process until the successful bidder is notified of the award of the contract.

Examination of tenders.

a. The implementing agency shall ascertain whether the tenders
   - Meet the eligibility requirements specified
   - Have been properly signed
   - Are accompanied by the required earnest money and valid for the period specified in the tender document Strengthening Systems and Partnerships
   - Are substantially responsive to the tender document
   - Have the technical and financial capability to successfully execute the contract. For ensuring financial capacity a minimum turnover requirement should be indicated in the bid document are otherwise generally in order.

b. is not substantially responsive, that is, it contains material deviations from or reservationsto the terms, conditions, and specifications in the tender documents, it shall not be consideredfurther. The bidder shall not be permitted to correct or withdraw material deviations or reservationsonce tenders have been opened.

Tender evaluation and comparison

The purpose of tender evaluation is to determine the cost to the implementing agency of each tender in a manner that permits a comparison based on its evaluated cost. The tender with the lowest evaluated cost and substantially responsive, but not necessarily the lowest submitted price, should be selected for award.

- The bid price read out at the bid opening shall be adjusted to correct any arithmetical errors for the purpose of evaluation.
- Evaluation of tenders should be made strictly in terms of the provision in the tender documents to ensure compliance with the commercial and technical aspects.
- The conditional discounts offered by the bidder shall not be taken into account for evaluation.
- The past performance of the suppliers/ contractor should also be taken into account while evaluating the tenders. (this should also be indicated in the bid document)
- The implementing agency shall prepare a detailed report on the evaluation and comparison of tenders setting forth the specific reasons on which the recommendation is based for the award of the contract.

Negotiation

Negotiation after tenders are opened should ordinarily be discouraged. However, in exceptional cases it may be undertaken only with the lowest evaluated responsive bidder (L-1) as per the state's procurement procedure. In case the rates even after negotiation are very high, fresh tenders should be

invited. While fixing the date for negotiation, it should be ensured that sufficient time is allowed to the bidders to attend the same.

Extension of validity of tenders

As far as possible, the contract should be finalized within the original validity of the offers mentioned in the tender. An extension of bid validity, if justified by exceptional circumstances with the approval of next higher authority, shall be requested in writing from all bidders (of valid tenders only) before the expiry date. Bidders shall have the right to refuse to grant such an extension without forfeiting their earnest money, but those who are willing to extend the validity of their bid shall also be required to provide a suitable extension of earnest money.
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Post-qualification of bidders

If bidders have not been pre-qualified, the implementing agency shall determine whether the bidder whose bid has been determined to offer the lowest evaluated cost has the technical capability and financial resources to effectively carry out the contract as offered in the bid. The criteria to be met shall be set out in the tender documents, and if the bidder does not meet them, the bid shall be rejected. In such an event, the implementing agency shall make a similar determination for the next lowest evaluated bidder and so on.

Repeat orders

Purchases under open tender method may be increased as per the prevailing state procedure up to 15% of the quantity originally ordered through repeat orders after recording reasons provided that such orders shall be given before the date of the expiry of last supply made and also subject to the condition that prices have since not reduced and purchases were required urgently.

Rejection of all tenders

Tender documents usually provide that the implementing agency may reject all tenders. Rejection of all tenders is justified when none of the tenders are substantially responsive or when negotiations with the L1 bidder has failed. However, lack of competition shall not be determined solely on the basis of the number of bidders. If all tenders are rejected, the implementing agency shall review the causes justifying the rejection and consider making revisions to the conditions of contract, design and specifications, scope of the contract, or a combination of these, before inviting new tenders.

- If the rejection of all tenders is due to lack of competition, wider advertising shall be considered. If the rejection is due to most or all of the tenders being non-responsive, new tenders may be invited.
- Rejection of all tenders and re-inviting new tenders, irrespective of value shall be referred to the competent authority for approval after examining whether technical specifications need any change.

C. Limited tender (National/International)

Limited tendering is nothing but NCB done by direct invitation to selected potential suppliers of proven capacity-cum-capability (from at least two different countries in case of international limited tender) without open advertisement but enough to ensure receipt of competitive bids.
This procedure could be adopted where:

- There are only a limited number of suppliers of the particular goods or services
- Demand is urgent in nature

- Exceptional reasons exist justifying departure from full Advertised Open Tender. Other procedures under limited tender will be same as that of open advertised tender. Rate contracts of Directorate General of Suppliers and Disposals (DGS&D) and rate contracts of state governments shall also be an appropriate method under limited tender system. The purchaser shall, however, check that the rate contracts are representative of market price and are not obsolete. In all such cases, approval of the competent authority to dispense with open advertised tender should be taken. Strengthening Systems and Partnerships

D. Shopping

- Shopping is a procurement method based on comparing price quotations obtained from several suppliers/contractors, usually at least three, to ensure competitive prices.
- Goods including drugs and equipment, and civil works estimated to cost below the financial ceiling prevailing in states or less per contract may be procured under the shopping.
- It is an appropriate method for procuring readily available off-the-shelf goods or standard specifications commodities of small value or simple civil works of small value.
- Approval of competent authority may be obtained for items of goods to be purchased or civil works to be constructed/renovated/repaired along with specifications, estimated costs and agencies from whom quotations should be invited.
- The requests for quotations shall indicate the description, specification and quantity of the goods and terms of delivery or specification of works, as well as desired delivery or completion time and place. If the quotations are called for more than one item/works, it should also be indicated whether the evaluation would be for each item or for each civil work or as a package.
- Quotations could also be obtained by telex or facsimile. The terms of accepted offer shall be incorporated in a purchase order or brief contract.
- Rate contracts entered into by DGS&D and by state governments will be acceptable for any procurement under shopping.

E. Single tender/Direct contracting

- The single tender system may be adopted in case of articles including drugs and equipment, which are specifically certified as propriety in nature, or where only a particular firm manufactures the articles demanded or in case of extreme emergency.
- The single tender system without competition shall be an appropriate method under the following circumstances:
- Extension of existing contracts for works or goods awarded with the prescribed procedures, justifiable on economic grounds
- Standardization of equipment or spare parts to be compatible with existing equipment may justify additional purchases from the original supplier
- The required item is proprietary and obtainable only from one source
- Need for early delivery to avoid costly delays
- Works are small and scattered or in remote locations where mobilization costs for contractors would be unreasonably high; and
- In exceptional cases, such as in response to natural disasters.

F. Procurement of civil works through Panchayati Raj Institutions (PRIs)

For small works of value up to Rs. 6 lakh, the states may decide to get these executed through PRIs wherever considered appropriate. In the RCH Phase II, construction/repair of sub-centers would fall within this threshold limit. Wherever works are entrusted to PRIs, it should be ensured that these institutions do manage to obtain contributions from the community. The extent of such contribution may

be decided by the states. It should also be ensured that adequate arrangements for supply of The Principles and Evidence Base for State RCH Phase II Program Implementation Plans (PIPs) standardized designs and preparation of estimates, supervision of construction, maintenance of quality control, and rendering appropriate accounts are in place.

G. Award of contract

The implementing agency shall award the contract, within the period of the validity of tenders, to the bidder who meets the tender conditions in all aspects, has the necessary technical capability and financial resources and whose bid is substantially responsive to the tender documents and has the lowest evaluated cost. The purchaser can, if so desired, depute a team of 3-4 officers to the premises of the manufacturer to whom the contract is proposed to be awarded to satisfy itself that the manufacturer has capability to produce the required quantity and also the necessary quality testing and assurance facilities to meet the required standards. Based on the report of this committee, the purchaser may decide to award the contract to the successful bidder offering the lowest or reasonable price after approval of the appropriate authority.
Single tenders should also be considered for award, if it is determined that publicity was adequate, bid specification/conditions were not restrictive or unclear, and bid prices are considered reasonable.

H. Inspection, sampling and testing procedure

The inspection authority and procedure for sampling and testing should be clearly specified in the tender document. A purchaser must select a set of accredited testing laboratories for testing the samples accordance with ISO requirements. The purchaser should request a written confirmation from the supplier that the results of the testing laboratory chosen for qualification and compliance testing will be accepted by the supplier. The name of the testing lab should be incorporated in the tender document.
The authority that will collect random samples should also be specified.

The purchaser will decide whether 100% pre-dispatch inspection is required at the manufacturer's premises, depending on the items to be purchased. Sometimes it is important to verify that each manufactured batch complies with the specifications before it is finally dispatched to the consignee. When a consignment is ready for dispatch, the supplier will inform the purchaser that the consignment is ready for the testing. The purchaser then instructs the inspection agency to carry out the inspection viz. visit the supplier's factory and draw samples from the batches offered for inspection, in accordance with sampling guidelines. The inspection agency will send the samples directly to the designated testing laboratory chosen by the purchaser for quality testing. Based on the results of the test, the batch may be cleared for dispatch. To avoid later dispute on the testing results, a representative of the supplier may be invited to witness the testing of the sample at the laboratory, if feasible.

In case of procurement of kits, where the kits are assembled by another party before supplying the final kits to the purchaser, the inspection and quality control procedures should be clearly mentioned in the tender document.

The above procedure applies mainly for procurement of drugs. In case of procurement of other goods, they may be inspected on arrival at purchaser's premises for any possible damage/defect either in manufacturing or in transit. In case of complex capital goods, the inspection at manufacturers' premises may also be required.

If the stores do not meet the performance requirement, they should not be accepted. If there are any disputes or doubts about the quality of the products, a procedure of resolution of dispute may be followed as per the terms of the contract.

Strengthening Systems and Partnerships

I. Notification of delivery to consignee

Notification of delivery or dispatch in regard to each and every installment shall be made by the supplier to the consignee through a packing account quoting the number of the supply order and the date of dispatch of the stores. All packages, containers, bundles and loose materials part of each and every installment shall be fully described in the packing account and full details of the contents of the packages and quantity of materials shall be given to enable the consignee to check the stores on arrival at destination. The railway receipt, consignment note or the bill of the lading, if any, should be drawn in the name of the consignee and should be sent to him by registered post acknowledgement due immediately on dispatch of stores, quoting the No. (s) and date (s) of the corresponding Inspection Note(s) in relation to the stores covered by the said Railway Receipt, the consignment note or the Bill of Lading, as the case may be. The contractor shall bear and reimburse to the purchaser, demurrage charge, if any paid by the reasons of delay on the part of the supplier in forwarding the railway receipt, consignment note or bill of lading.

J. Receipt of consignment

In case of imported stores, the purchaser should be aware of the custom clearance requirement prior to issuing the contract. A clear procedure (i.e. who will clear the goods and pay the duties, loading and unloading of the consignment, transport of the consignment to the premises of the consignee etc.) for custom clearance should be specified in the contract.

At the time of the delivery of the stores, the consignee should accept the stores on “said to contain” basis and should issue the provisional receipt certificate in the standard format (sample attached). After opening the package and making a detailed examination of the stores the consignee will issue the final acceptance certificate if he is satisfied with the quality of the goods. Notwithstanding the pre-qualification or the inspection of the goods/services by the inspection agency, the consignee has the right to further inspect and test the goods but within a reasonable time (say up to 60 days) and if the goods fail to meet the specifications given in the contract, he should reject the goods and ask the supplier to replace the goods or rectify the defects.

K. Storage

Experience has demonstrated that properly packed, good quality goods (except some drugs and vaccines or specific items) do not deteriorate when stored at average temperature found in tropical climates.

Air-conditioning is generally not necessary if the goods are properly packaged and stored in a clean, dry and well-ventilated environment.

If quality assurance measures have been strictly followed during the manufacturing process; the conditions of warehousing and storage play a major role in ensuring that quality goods received reach final users in good condition. They should be left in their original packaging while in storage. The batch number and marking on the cartons should be recorded to ensure that all batches are traceable and distributed on a first in first expiry basis. The drugs, which require special storage such as maintaining proper temperature, should be stored in appropriate condition.

L. Resolution of disputes

The dispute resolution methodology should be very clearly indicated in the contract document. As far as possible, disputes may be resolved with mutual agreement between purchaser and buyer through alternate dispute resolution methods to avoid going through arbitration and litigation stage.

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There a number of possible causes of disputes during the execution of contract. These may involve:

- Interpretation of the terms and conditions of the contract

- Delay in delivery/completion of the works
- Delay in release of payment
- Independent laboratory test results
- Condition of the items on arrival at consignee and after delivery
- Rate of the items, variation in quantity in civil works contract etc.
- Design/specification issue

Disputes over laboratory results

Disputes over product acceptance usually arise when independent testing determines that the product is not in compliance with the required specification or standard. It is also possible for a manufacturer to dispute a decision made by the inspection agency regarding product packaging or appearance.
In most cases, manufacturers accept the results of independent laboratories and replace batches that have been rejected. When manufacturers do not accept the test results, they usually present test results or other evidence to suggest that the independent laboratory test are incorrect and do not accurately represent the quality of the product tested. Procedures for dealing with such disputes should be covered in the contract.

Decision on re-testing

Re-testing should only be undertaken when there is reasonable evidence that the laboratory has made a mistake. Before considering a re-test all the available data should be reviewed. If a manufacturer disputes a test result, the following issues should be considered in deciding whether to allow a re-test:

- What is the margin by which the product has failed to comply?
- Is the manufacturer's history of production for the client a good one?
- What is the nature of the difference between the manufacturer's and the laboratory's test results?
- Where appropriate, the laboratory should keep the failed samples of goods so that the manufacturer can examine them.
- Samples of the failed batch could be sent to the designated appellate testing laboratory as specified in the contract.

The amount of information available for review depends on the type of test.
In all cases, the manufacturer should bear the cost of a retest, unless it can be demonstrated that it is likely that the laboratory results; it is always desirable to invite the representative of the supplier to witness the testing of samples.

M. Laws governing the contract

- The contract shall be governed by the laws of India in force.
- The courts of the place from where the acceptance of tender has been issued shall alone have jurisdiction to decide any dispute arising out of or in respect of the contract irrespective of the place of delivery, the place of performance or place of payment under the contract Strengthening Systems and Partnerships or the place of issue of advance intimation of acceptance of tender, the contract shall be deemed to have been made at the place from where the acceptance of the tenders have been issued

N. Arbitration (NCB/Shopping)

In the event of any question, dispute or difference arising under the contract conditions or any special conditions of contract, or in connection with the contract (except as to any matters the decision of which is specially provided for by these or the special conditions) the same shall be referred to the sole arbitration of an officer, from the department other than the department who has decided the contract

having sufficient knowledge of Law, appointed to be the arbitrator by the purchaser. The award of the arbitrator shall be final and binding on the parties to this contract.

- In the event of the arbitrator dying, neglecting or refusing to act or resigning or being unable to act for any reason, or his award being set aside by the court for any reason, it shall be lawful for the purchaser to appoint another arbitrator in place of the outgoing arbitrator in the manner aforementioned.
- It is further a term of the contract that no person other than the person appointed by the purchaser as aforementioned should act as arbitrator and that, if for any reason that is not possible, the matter is not to be referred to arbitration at all.
- The arbitrator may from time to time with the consent of all parties to the contract, enlarge the time for making the award.
- Upon every and any such reference, the assessment of the costs incidental to the reference and award respectively shall be in the discretion of the arbitrator.
- Subject as aforesaid, the Arbitration Act, amended up to date and the rules there under and any statutory modification thereof for the time being in force shall be deemed to apply to the Arbitration proceedings under this clause.
- If the value of the claim in a reference exceeds Rs.1 lakh the arbitrator shall give reasoned award.
- The venue of arbitration shall be the place from which formal Acceptance of Tender is issued or such other place as the purchaser at his discretion may determine. Suitable cause may be incorporated in the tender enquiry to obtain the consent of the bidder to accept the arbitration clause.

O. Extension of contract

Normally, the contract once awarded should not be extended. Under exceptional circumstances, extension of existing contracts up to 50% of the original contract value may be considered, if it is justifiable on economic grounds.

P. Complaint redressal mechanism (also applicable to service procurement)

In order to deal with the complaints received from the contractors/suppliers effectively, a compliant handling mechanism should be available at the national level as well as at state level, and immediate action should be initiated on receipt of complaints to redress the grievances. All complaints should be handled at a level higher than that of the level at which the procurement process is being undertaken and the allegations made in the complaints should be thoroughly enquired into. If found correct, appropriate remedial measures should be taken by the appropriate authorities. The Principles and Evidence Base for State RCH Phase II Program Implementation Plans (PIPs)

In case any individual staff is found responsible, suitable disciplinary proceedings should be initiated against such staff under the applicable government conduct rules. The existing provisions under the Indian law including the instructions of central vigilance commission should be followed in this regard.

Q. Procurement audit (also applicable to service procurement)

All the procurements made by the central and state governments are subject to post-audit either by Comptroller and Auditor General (CAG)/State Audit Departments and by the Development Partners (DPs).

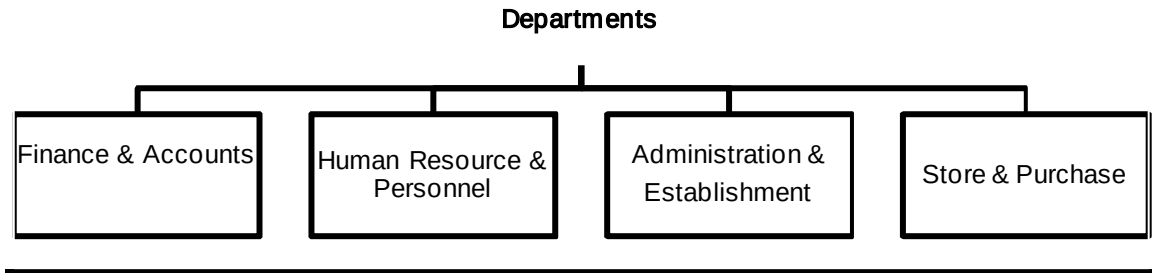
Hence, all the documents related to the procurement should be filed and kept systematically and safely.

Office procedures:

Introduction:

Office is a room or set of rooms in which business, professional duties, clerical work, etc., are carried out. It is a back bone of an organization, it controls all activities of administration.

The efficiency of an organization, to a large extent, depends on evolution of adequate processes and procedures of its office (administration) and the ability of its employees to follow them. Accordingly, the efficiency of persons handling secretarial work in an organization can be judged by their ability to dispose of receipts with speed, following the procedures prescribed for the purpose. The ultimate object of all Government business is to meet the citizens' needs and to further their welfare without undue delay. At the same time, those who are accountable for the conduct of that business have to ensure that public funds are managed with utmost care and prudence. It is, therefore, necessary, in each case, to keep appropriate record not only of what has been done but also of why it was so done.



A department is responsible for formulation of policies of the government in relation to business allocated to it and also for the execution and review of those policies.

Receipts

Perusal and marking of receipts

The diarist will submit all receipts to the concerned officer who will:

(1) Go through the receipts;
(2) Forward misdirected receipts to the sections concerned;
(3) Separate those which, either under the departmental instructions or in his discretion, should be seen by higher officers before they are processed and mark them to such officers;
(4) Keep a note in his diary of important receipts requiring prompt action or disposal by a specified date.

Entry of receipts in diary

(1) Each section will maintain a section diary
(2) The diarist will diaries in the section diary all receipts except the following before they are submitted to the officers concerned or distributed among the dealing hands:
    a. Receipts which, as a class, are adequately taken care of by a register specially devised for the purpose (e.g. telephone bills which are entered in telephone bill register);

b. Receipts which have already been diarized in computer;
c. Unsigned communications (except e-mail) on which no instructions have been recorded by officers and on which no action is to be taken;
d. Identical copies of representations, save the one received first;
e. Post copies of telegrams unless the endorsement contains a message in addition to that contained in the telegrams;
f. Petty contingent vouchers such as those relating to night duty or overtime claims of the staff, claims for coolie hire or conveyance hire, chits asking for articles of furniture, stationery etc.
g. Routine acknowledgements;
h. Casual leave applications;
i. Copies of miscellaneous circulars, office memoranda, extracts, etc; circulated by any section for general information, e.g., orders of general application, telephone lists, notices of holidays, tour program, etc; and
j. Any other types of receipts which under departmental instructions are not required to be diarized.

(3) Inter-departmental notes, telegrams, or any other category of receipts sought to be distinguished from the rest, may be entered in the section diary in red ink.
(4) Receipts redirected to other sections will also be diarized.
(5) Papers referred to another department will be diarized each time they are received back. For those referred under diary numbers, however, previous and later entries in the diary will be linked by giving the earlier and the later diary numbers against each entry.
(6) If a receipt is diarized after a lapse of more than 15 days from the date it bears, the entry regarding date in column 3 of the section diary will be circled in red ink.
(7) The concerned officers will scrutinize the section diaries once a week to see that these are being properly maintained and append his dated initials in token of scrutiny.

Action by higher officers

Officers to whom receipts are submitted will:
(1) Go through the receipts and initial them;
(2) Remove receipts which they may like to dispose of without assistance from section or to submit to higher officers;
(3) Enter the diary numbers of the receipts removed on the movement slip
(4) Where necessary, give directions regarding line of action to be taken on other receipts; and
(5) Return the receipts together with movement slip, if any, to the Officer for action

Allocation of disputed receipts

If a section feels that it is not concerned with a misdirected receipt forwarded to it the same should be brought to the notice of the officer designated by the department for deciding allocation of disputed receipts.

Dispatch

Despatch of postal communications

(1) The despatcher will hand over communications to be sent by post to the peon/daftry, who will:
    (a) Separate those to be sent by foreign post from the rest;
    (b) Paste the telegrams, if typed on plain paper, over the printed form of telegram supplied by the Department of Posts and affix service postage stamps of the appropriate value thereon;

(c) If a credit deposit account is maintained for issuing telegrams, affix rubber-stamp indicating the credit deposit account number assigned to the department in the space provided for affixing postage stamps;
(d) Affix postage stamps of the appropriate value on covers, packets, etc. where necessary after weighing them, using ordinary postage stamps for foreign post and service postage stamps for inland post;
(e) Stamp the covers with a rubber-stamp bearing the name of the department; and
(f) Return the communications to the dispatcher.

(2) The despatcher will enter the particulars of the communications and the value of stamps affixed thereon in the dispatch register. This can be generated automatically in a computer environment.

Despatch of non-postal communications

(1) Non-postal communications will be sorted out according to the location of the addressees, entered in messenger books and handed over to messenger for delivery to the addressees.
(2) Messenger books will be numbered serially and an adequate number of such books allotted to each department/office or several departments/offices grouped conveniently according to their location.
(3) Urgent communications will be despatched promptly. The time of despatch will invariably be noted in the messenger book. The receipts will similarly be required to indicate the time of their receipt. Ordinary communications will be despatched at least twice a day at suitable intervals.
(4) Only urgent communications will be despatched outside office hours.
Return of papers - After issue of fair communications the despatcher will make over office copies, together with drafts and relevant files, if any, to the clerk maintaining the issue diary. The latter will return the papers to the diarists of the sections concerned after making entries in column 3 of the issue diary.

Reference lists

(1) To facilitate quick despatch of papers the central issue section will maintain the following lists and directories:

(a) Residential addresses and telephone numbers of officers and staff of the department;

(b) Departments which have arrangements within the central registry for receipt of dak outside office hours (with name and telephone number of the official incharge);

(c) Residential addresses and telephone numbers of officers of other departments designated to receive urgent dak outside office hours;

(d) Residential addresses and telephone numbers of officers of other departments designated to receive parliamentary papers;

(e) Postal addresses of all offices under the department, attached offices, subordinate offices, autonomous bodies, etc; which deal directly with it;

(f) Telegraphic and e-mail addresses, and telephone and fax numbers of State Governments and other outstation offices frequently addressed;

(g) Schedule of postal rates.
(h) Postal PIN code directory

(2) These lists will be kept up to date and displayed prominently for easy consultation by the despatcher, the resident clerk and other officials on duty.

Note Sheet

The aim of a note is to present the facts in the most intelligible, condensed and convenient form so that the decision taking authority may take a quick and correct decision.

Guidelines for noting

(1) All notes will be concise and to the point. Lengthy notes are to be avoided.
(2) When passing orders or making suggestions, an officer will confine his note to the actual points he proposes to make without reiterating the ground already covered in the previous notes. If he agrees to the line of action suggested in the preceding note, he will merely append his signature.
(3) The dealing hand will append his full signature with date on the left below his note. An officer will append his full signature on the right hand side of the note with name, designation and date.
(4) A note will be divided into serially numbered paragraphs of easy size, say ten lines each. Paragraphs may preferably have brief titles. The first paragraph will give an indication of the evidence and the conclusions reached. The final paragraph should weigh the arguments and make recommendations for action.
(5) A small margin of about one inch will be left on all sides (left, right, top and bottom) of each page of the note sheet to ensure better preservation of notes recorded on the files as at times the paper gets torn from the edges making reading of the document difficult. However, notes should be typed/written on both sides of the note sheet.

Noting on files received from other departments

(1) If the reference seeks the opinion, ruling or concurrence of the receiving department and requires detailed examination, such examination will normally be done separately through routine notes and only the final result will be recorded on the file by the officer responsible for commenting upon the reference.
(2) Where the reference requires information of a factual nature or other action based on a clear precedent or practice, the dealing hand in the receiving department may note on the file straightway.
(3) Where a note on a file is recorded by an officer after obtaining the orders of a higher officer, the fact that the views expressed therein have the approval of the latter should be specifically mentioned.

Oral discussions

All points emerging from discussions (including telephonic discussions) between two or more officers of the same department or from discussions between officers of different departments, and the conclusions reached will be recorded on the relevant file by the officer authorizing action.

Oral instructions by higher officers

(1) Where an officer is giving direction (including telephonic direction) for taking action in any case in respect of matters on which he or his subordinate has powers to decide, he shall ordinarily do so in writing. If, however, the circumstances of the case are such that there is no time for giving the instructions in writing, he should follow it up by a written confirmation at his earliest.

File Management

Filing of papers

(1) Papers required to be filed will be punched on the left hand top corner and tagged onto the appropriate part of the file viz. notes, correspondence, appendix to notes and appendix to correspondence, in chronological order, from left to right.

(2) Earlier communications referred to in the receipt or issue, will be indicated by pencil by giving their position on the file.

(3) Routine receipts and issues (e.g., reminders, acknowledgments) and routine notes will not be allowed to clutter up the file. They will be placed below the file in a separate cover and destroyed when they have served their purpose.

(4) On top of the first page of the note portion in each volume of the file, file number, name of the Department, name of branch/section and subject of the file will be mentioned.

File numbering system - A proper file numbering system is essential for convenient identification, sorting, storage and retrieval of papers.

Every file will be assigned a file number which will consist of: Serial No.Year under a standard head and Subject of the file and An abbreviated symbol identifying the Dept./Section

Note: In a computer environment file numbering will be done electronically in either of the systems. A unique file number will be automatically generated whenever a fresh file is opened.

Records Management

Records Section: Records Section is a very important section as far as an office is concerned,. The old records, containing important orders and decisions and valuable registers have to be arranged and kept in a section for future reference. A systematic arrangement is necessary to keep the old records, to make them available for immediate reference and also for weeding out of the old records.

Activities involved in records management –

(1) Records management covers the activities concerning recording, retention, retrieval and weeding out.
(2) **Stage of recording** - Files should be recorded after action on the issues considered thereon has been completed. However, files of a purely ephemeral nature (such as casual leave records or circulars of temporary nature) containing papers of little reference or research value may be destroyed after one year without being formally recorded.
(3) **Custody of records -** Recorded files will be kept serially arranged in the sections/desks concerned for not more than one year, after which they will be transferred to the departmental record room.
(4) **Records maintained by officers and their personal staff** - Each department may issue departmental instructions to regulate the review and weeding out of records maintained by officers and their personal staff.

Forms and Procedure of Communication

Forms of written communications and methods of delivery -

The different forms of written communication and their methods of delivery generally used by a department are described below. Each form has a use and, in some cases, a phraseology of its

own. Only black or blue ink will be used in communications. A small margin of about one and half inch will be left side and one inch on right side of each page of communications to ensure better preservations of records as at times the paper gets torn from the edges, making reading of the documents difficult.

(1) Letter - This form is used for corresponding with Foreign Governments, State Governments, the Union Public Service Commission and other constitutional bodies, heads of attached and subordinate offices, public enterprises, statutory authorities, public bodies and members of the public generally. A letter begins with the salutation Sir/Madam as may be appropriate.

C..omponents of a letter:

- Number of communication along with no. of file
- Letter head -showing details of office
- Place & Date of Communication
- Name & Address of sender
- Name & Address of Addressee
- Subject
- Salutation
- Subscription
- Signature, Name & Designation of Sender
- Copy to, as endorsement, if needed ;and signed again at the bottom

(2) Demi-official letter -

(a) This form is generally used in correspondence between Government officers for an inter-change or communication of opinion or information without the formality of the prescribed procedures. It may also be used when it is desired that the matter should receive personal attention of the individual addressed. Since demi-official letter is written in the first person in a personal and friendly tone, it should be addressed by an officer in a Department who is ordinarily not more than one or two levels below the officer to whom such communication is addressed.

(b) Communications to non-officials can also take the form of a demi-official letter.

- When to write a DO:
    - Correspondence between officers without formality of prescribed procedures
    - In matters seeking personal attention
    - In cases of delayed action and reminders going un-noticed, for inviting personal attention
- Features of DO:
    - Addressed personally to officer
    - Written in First person
    - Starts with Salutation-"My Dear or Dear...."
    - Ends with subscription-"yours sincerely"
    - Signed without mentioning designation

(3) Office Memorandum - This form is generally used for corresponding with other departments or in calling for information from or conveying information to its employees. It may also be used in corresponding with attached and subordinate offices. It is written in the third person and bears no salutation or supersession except the name and designation of the officer signing it.

(4) Inter-departmental note -

(a) This form is generally employed for obtaining the advice, views, concurrence or comments of other departments on a proposal or in seeking clarification of the existing rules, instructions etc. It may also be used by a department when consulting its attached and subordinate offices and *vice versa*.

(b) The inter-departmental note may either be recorded on a file referred to another department or may take the form of an independent self-contained note. The subject need not be mentioned when recorded on the file.

(5) Telegram –

This form is used for communicating with out-station parties in matters demanding prompt attention. The text of the telegram should be as brief as possible.

(6) Fax facility – In urgent and important matters (including legal and financial messages), departments may use fax facilities to send messages, wherever available.

Offices not connected through fax but having telex facilities, may send urgent and important messages through telex instead of a telegram in communicating with out-station offices.

(7) Registered Post/ Registered AD – This method of delivery is used in communicating with offices to ensure receipt of the communication and in the case of Registered AD an acknowledgement of the delivery is also received by the issuing office.

(8) Speed Post – This method of delivery is used to ensure quick receipt of messages warranting urgent attention at the receiving end and an acknowledgement of the delivery is also r eceived by the issuing office.

(9) Office order - This form is normally used for issuing instructions meant for internal administration, e.g., grant of regular leave, distribution of work among officers and sections, appointments and transfers, etc.

(10) Order - This form is generally used for issuing certain types of financial sanctions and for communicating government orders in disciplinary cases, etc., to the officials concerned.

(11) Notification - This form is mostly used in notifying the promulgation of statutory rules and orders, appointments and promotions of gazetted officers, etc. through publications in the Gazette of India.

(12) Resolution - This form of communication is used for making public announcement of decisions of government in important matters of policy, e.g., the policy of industrial licensing, appointment of committees or commissions of enquiry. Resolutions are also published in the Gazette of India.

(13) Press communiqué/note - This form is used when it is proposed to give wide publicity to a decision of government. A press communiqué is more formal in character than a press note and is expected to be reproduced intact by the press. A press note, on the other hand, is intended to serve as a hand-out to the press which may edit, compress or enlarge it, as deemed fit.

(12) Endorsement - This form is used when a paper has to be returned in original to the sender, or the paper in original or its copy is sent to another department or office, for information or action. It is also used when a copy of a communication is proposed to be forwarded to parties other than the one to which it is addressed. Normally this form will not be used in communicating copies to state governments. The appropriate form for such communication should be a letter.

(13) Circular – This form is used when important and urgent external communications received or important and urgent decisions taken internally have to be circulated within a department for information and compliance by a large number of employees.

(14) Advertisement – This form is used for communicating with the general public to create awareness and may take the form of audio-visual or written communication.

(15) E-mail – This is a paperless form of communication to be used by department having computer facilities supported by internet or intranet connectivity and can be widely used for subjects where legal or financial implications are not involved.

Telephonic communications

(1) Appropriate use of the medium of telephone may be made by departments for intra and inter-departmental consultation and for communication of information between parties situated locally.

(2) In matters of urgency, departments may communicate with out-station offices also over the telephone.

(3) Telephonic communications, wherever necessary, may be followed by written communications by way of confirmation.

(4) Resort to ISD/ STD and trunk calls will be regulated by departmental instructions.

Target date for replies - In all important matters in which State Governments, departments of the Central Government, or other offices, public bodies or individuals are consulted, time limit for replies may ordinarily be specified. On the expiry of the specified date, orders of the appropriate authority may be obtained on whether the offices, whose replies have not been received, may be allowed an extension of time or whether the matter may be processed, without waiting for their replies.

Drafting of Communications

General instructions for drafting

- A draft should carry the message sought to be conveyed in a language that is clear, concise and incapable of misconstruction.
- Lengthy sentences, abruptness, redundancy, circumlocution, superlatives and repetition, whether of words, observations or ideas, should be avoided.
- Communications of some length or complexity should generally conclude with a summary.
- Depending upon the form of communication the subject should be mentioned in it (including reminders).
- A draft should clearly specify the enclosures which are to accompany the fair copy.
- The name, designation, telephone number, fax number, and e-mail address of the officer, over whose signature the communication is to issue, should invariably be indicated on the draft.
- In writing or typing a draft, sufficient space should be left for the margin and between successive lines to admit additions or interpolation of words, if necessary.
- A slip bearing the words `Draft for approval' should be attached to the draft. If two or more drafts are put up on a file, the drafts as well as the slips attached thereto will be marked `DFA I', `DFA II', `DFA III' and so on.

- Drafts which are to issue as `Immediate' or `Priority' will be so marked under the orders of an officer not lower in rank than a Section Officer.

Marking of drafts for issue

After a draft has been approved, the concerned officer will:

(1) Examine the draft to see that all corrections of spelling and grammar, etc., have been properly carried out and that there are no typographical errors;

(2) Photocopy of signed communication will be preferably kept as office copy;

(3) ensure that copies of enclosures are attached to the draft where these are available in the section;

(4) Give clear indication on the draft, where a communication is to be despatched by a special messenger/fax/speed post/registered post on account of its special nature, importance or urgency;

(5) Mark the draft for `issue' (if there are more than one draft for issue from the same file, indicate the total number of drafts, e.g., `issue 3 drafts'); and

(6) Mark the file for recording it in a case where the issue of said communication constitutes final disposal of the case under consideration.

The same procedure may be followed for issue of drafts generated through computer.

Meetings and Consultation

Departmental meetings may be held where it is necessary to elicit the opinion of other departments on important cases and arrive at a decision within a limited time. No such meeting will normally be convened except under the orders of an officer not below the level of Joint Secretary. In respect of such meetings, it will be ensured that:

a. The representatives attending the meeting are officers who can take decisions on behalf of their departments;
b. An agenda/minutes setting up clearly the points for discussion is prepared and sent along with the proposal for holding the meeting, allowing adequate time for the representatives of other departments to prepare themselves for the meeting; and
c. A record of discussions is prepared immediately after the meeting and circulated to the other departments concerned, setting out the conclusions reached and indicating the department or departments responsible for taking further action on each conclusion.
d. On occasions it may be necessary to have oral discussions (including teleconferencing or video conferencing) with officers of other departments.
e. The result of such oral consultation should be recorded in a single note on the file by the officer of the department to which the case belongs. The note will state clearly the conclusions reached and the reasons thereof. A copy of the note will also be sent to the departments consulted in order that they have a record of the conclusions reached.

Conducting Meeting

What is a meeting?

Two or more people coming together, for the purpose of discussing/ debating on a (usually) predetermined topic /agenda.

Purpose of meeting in health sector-

- Sharing information,

- Receiving instructions,
- Planning,
- Crisis management

Process:

- **Pre-plan**
  - who will be invited to the meeting (Enlist),
  - convey the purpose of the assembly(communication),
  - the topics to be covered (identify & enumerate)and
  - The information to be gathered and disseminated (formats and procedure).
- **Call/Send -circular/ notices** – minimum 15 days in advance to confirm the timing and location.
  - Participants will be better prepared
  - The desired dossier can be prepared by the participants for bringing to the meeting**.**
- **Get all the requisite /reports/records in advance**, analyze them and prepare brief to facilitate interaction.
- Make a **specific goal** for themeeting. The end goal could be a brainstorming session, a decision making on new strategies / review of performance /planning for a new service.
- Write a **precise agenda**. Detail the important facts.
- **Distribute** the explicitly detailed **agenda** along with the meeting notices.
- **Set up the Meeting Place**-
  - Cleanliness ,Comfortable,
  - Sitting space,
  - Proper AV aids,
  - Food/snacks.
  - Note pad & Pen to scribble
- Keep extra copies of notices and agenda.
- Keep a attendance sheet ready and have it signed by those attending
- Keep handy the supplementary papers/ reports/ references.
- **Welcome the participants** to the meeting and make sure everyone has their agenda in front of them. State the purpose of the meeting and the preset ending time.
- **Explain the purpose, process and expected outcomes.**
- **Listen** to the participants **first before offering comments.**
- **Stay on track** and quickly **hit the highlights** and address questions.
- If the meeting is a presentation that you are doing, keep check of your own timing. At the beginning you can request that questions be kept to the end of the presentation.
- **Assign a repertoire** (to record proceedings)
  1. Who attended?
  2. What problems were discussed?
  3. Key decisions reached.
- **Meeting needs to be focused & moving.**
- **Summarize the key points** as the meeting ends.
- Break the meeting on time and **thank everyone for their contribution**

Follow up:

After 7-15 days ensure-

- Communication is sent on the desired action points
- Feed back obtained
- Responses acknowledged
- Corrective measures taken and communicated
- Actions appreciated in writing

Security of Official Information and Documents

Unless authorized by general or specific orders, no official will communicate to another official or a non-official, any information or document(s) *(including electronic document(s))* which has come into his possession in the course of his official duties.

Confidential character of notes/ files

The notes portion of a file referred by a department to another will be treated as confidential and will not be referred to any authority outside the secretariat and attached offices without the general or specific consent of the department to which the file belongs. If the information is in the electronic form it will be handled by the authorized official only.

Communication of information to the press

1. Official information to the press and other news media, i.e. radio and television, will normally be communicated through the Press Information Bureau.

2. Whenever it is proposed to release an official information to the press, or to hold a press conference or press briefing, or to give publicity to an official report, resolution or any other publication, the department concerned will consult the accredited information officer in advance. The accredited information officer will meet the authorized officials from time to time and collect information worthy of publicity.

Office Automation and their Safety

Purpose of office automation - Use of modern office equipment in of business in the disposal Government departments is intended to facilitate faster processing and delivery of information, accurate analysis of facts and figures, higher efficiency and productivity, and elimination of fatigue arising from performing repetitive jobs manually. So taking care of these is not only the responsibility of a single person but of every employee who is working on them.

Computer and peripherals such as printer, scanner, server, CD writer, ISDN server, etc–

Electronic typewriter, Photocopier, Dictaphone, Microfilming of records

a. Internal Communication Aids -Electronic Private Automatic Exchange (EPAX), Local Area Network (LAN),
b. External Communication Aids - Electronic Mail(E-Mail) and FAX, Paper Binding Equipment, Document shredder, Risograph, Overhead projector, Slide projector, LCD projector, Video projection system, Video Conferencing Equipment .

Handling of Public/Staff Grievances

1. All officers will redress public grievances pertaining to the divisions under their charge. They will view public grievances with sympathy and make special efforts to decide on such cases expeditiously.
2. The name, designation, room number, telephone number, etc., of the Officer of Grievances should be displayed prominently at the Reception and some other convenient place in the office building of Department/ Public Sector Undertaking/ Autonomous Body so that the public are made fully aware of it.
    a. Each grievance petition will be acknowledged within 15 days. Even if no action is warranted on a petition, a reply intimating the stand of the organization must be sent to the petitioner.

b. Time limits will be fixed for disposal of various types of public/Staff grievances which are handled in the department with due regard to the minimum time needed for each type, through departmental instructions.
c. While sending replies communicating final decision rejecting a grievance petition, the reason or the rule(s) under which it has been rejected will be communicated to the petitioner along with details of the appellate authority wherever applicable.

3. The feedback mechanism and the monitoring system for grievance redress will be strengthened, in view of the time limits fixed
4. The record of grievances will be retained in the computer for one year after the date of final disposal of the grievances.

Call Book

The section officer will scrutinize the call book in the last week of every month to see that the cases which become ripe for further action during the following month are brought forward and action initiated on due dates. The call book will be submitted to the branch officer/ Divisional Head once a quarter, i.e. during the months of January, April, July and October. He will satisfy himself that no case on which action could have been taken suffers by its inclusion in the call book and, in suitable cases, give directions for the action to be taken.

Miscellaneous

Monthly progress reports of recording and review of files

On the first working day of each month, the record clerk will prepare, in duplicate, progress reports on the recording and review of files for the preceding month and submit them, together with the following records, to the concerned officer:

(a) Register for watching the progress of recording; and

(b) Lists of files received for review.

Monitoring of Court/CAT cases and implementation of Court/CAT Orders

The Personal section of each Joint Secretary/Director (if the Director submit cases direct to Secretary/Additional Secretary) will maintain a separate register of Court/CAT Cases from the date of filing the petition/application in Court/CAT. The serial number at which a petition is entered in the register will be prominently marked on the petition/application together with its date of registration.

Check-list of periodical reports

1. To ensure timely receipt, preparation and despatch of periodical reports, each section will maintain two check-lists, one for incoming reports and the other for outgoing reports, in the forms.
2. The check-lists will be prepared at the commencement of each year, approved by the section officer, shown to the branch officer and displayed prominently on the wall.
3. The section officer will go through the check-lists once a week to plan action on items requiring attention during the next week or so.

Review of periodical reports/returns

All periodical reports and returns relating to each section will be reviewed every three years with the following objectives;

- To eliminate those are unnecessary;
- To redesign those do not provide information/data in usable form;
- To rationalize/simplify the essential ones by combining two or more of them when possible; and

- To revise the frequency in relation to the need with due regard to constraint of time required for collection of information/data from field levels.

Responsibilities of Administrative Officer -

A. General Duties –

(i) Distribution of work among the staff as evenly as possible;

(ii) Training, helping and advising the staff;

(iii) Management and co-ordination of the work;

(iv) Maintenance of order and discipline in the section;

(v) Maintenance of a list of residential addresses of the Staff.

B. Responsibilities relating to Dak –

(i) to go through the receipts;

(ii) to submit receipts which should be seen by the concerning Officer or higher officers at the dak stage;

(iii) to keep a watch on any hold-up in the movement of dak; and

(iv) to scrutinize the section diary once a week to know that it is being properly maintained.

C. Responsibilities relating to issue of draft –

(i) to see that all corrections have been made in the draft before it is marked for issue;

(ii) to indicate whether a clean copy of the draft is necessary;

(iii) to indicate the number of spare copies required;

(iv) to check whether all enclosures are attached;

(v) to indicate priority marking;

(vi) to indicate mode of despatch.

D. Responsibility of efficient and expeditious disposal of work and checks on delays –

(i) to keep a note of important receipts with a view to watching the progress of action;

(ii) to ensure timely submission of arrear and other returns;

(iii) to undertake inspection of Assistants' table to ensure that no paper of file has been overlooked;

(iv) to ensure that cases are not held up at any stage;

(v) to go through the list of periodical returns every week and take suitable action on items requiring attention during next week.

E. Independent disposal of cases –

He should take independently action of the following types –

(i) issuing reminders;

(ii) obtaining or supplying factual information of a non-classified nature;

(iii) any other action which a Officer is authorized to take independently.

F. Duties in respect of recording and indexing –

(i) to approve the recording of files and their classification;

(ii) to review the recorded file before destruction;

(iii) to order and supervise periodic weeding of unwanted spare copies;

(iv) ensuring proper maintenance of registers required to be maintained in the section;

(v) Ensuring proper maintenance of reference books, Office Orders etc. and keep them up-to-date;

(vi) Ensuring neatness and tidiness in the Section;

(vii) Dealing with important and complicated cases himself;

(viii) Ensuring strict compliance with Departmental Security InstructionS.

NFHS-III, Rajasthan

Indicators	NFHS III (2005-06)	NFHS II (1998-99)	NFHS I (1992-93)
Marriage & Fertility			
Women age 20-24 married by age 18 (%)	57.1	68.3	69.5
Men age 25-29 married by age 21 (%)	56.7	N.A.	N.A.
Total fertility rate (children per woman)	3.21	3.78	3.63
Women age 15-19 who were already mothers or pregnant at the time of the survey (%)	16.0	N.A.	N.A.
Median age at first birth for women age 25-49	19.6	19.4	19.7
Married women with two living children wanting no more children (%)	72.8	58.3	44.2
a. Two sons	83.9	74.8	57.4
b. One son, one daughter	77.7	63.1	53.0
c. Two daughters	33.1	12.5	6.7
Family Planning (currently married women, age 15-49)			
Any method (%)	47.2	40.3	31.9
Any modern method (%)	44.4	38.1	31.0
a. Female sterilization	34.2	30.8	25.4
b. Male sterilization	0.8	1.5	2.4
c. IUD	1.6	1.2	1.2
d. Pill	2.0	1.5	0.5
e. Condom	5.8	3.1	1.5
Unmet need for family planning			
Total unmet need	14.7	17.6	19.8
a. For spacing	7.3	8.7	10.8
b. For limiting	7.4	8.9	9.0
Maternal and Child Health			
Mothers who had at least 3 antenatal care visits for their last birth (%)	41.2	23.6	18.1
Mothers who consumed IFA for 90 days or more when they were pregnant with their last child (%)	12.8	N.A.	N.A.
Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	43.2	35.8	19.3
Institutional births (%)	32.2	21.5	12.0
Mothers who received PNC from a doctor/nurse/LHV/ANM/other health personnel within 2 days of delivery for their birth (%)	28.9	N.A.	N.A.
Child immunization and Vitamin A supplemantation			
Children 12-23 months fully immunized (BCG, measles, 3 doses each of polio/DPT) (%)	26.5	17.3	21.1
Children 12-23 months who have received BCG (%)	68.5	53.9	45.6
Children 12-23 months who have received 3 doses of polio vaccine (%)	65.2	44.6	33.9
Children 12-23 months who have received 3 doses of DPT vaccine (%)	38.7	26.1	29.6
Children 12-23 months who have received measles vaccine (%)	42.7	27.1	31.3

Children 12-35 months who received a vitamin A dose in the last 6 months (%)	13.2	N.A.	N.A.
Treatment of childhood diseases (children under 3 years)			
Children with diarrhea in the last 2 weeks who received ORS (%)	16.0	20.3	12.1
Children with diarrhea in the last 2 weeks taken to a health facility (%)	56.6	58.2	50.0
Children with ARI or fever in the last 2 weeks taken to a health facility (%)	68.9	N.A.	N.A.
Child Feeding Practices and Nutritional Status of Children			
Children under 3 years breastfed within one hour of birth (%)	13.3	4.8	8.1
Children age 0-5 months exclusively breastfed (%)	33.2	N.A.	N.A.
Children age 6-9 months receiving solid or semi-solid food and breastmilk (%)	38.7	N.A.	N.A.
Children under 3 years who are stunted (%)	33.7	52.0	41.8
Children under 3 years who are wasted (%)	19.7	11.7	21.2
Children under 3 years who are underweight (%)	44.0	50.6	44.3
Nutritional Status of Ever-Married Adults (age 15-49)			
Women whose Body Mass Index is below normal (%)	33.6	36.1	N.A.
Men whose Body Mass Index is below normal (%)	33.8	N.A.	N.A.
Women who are overweight or obese (%)	10.2	7.1	N.A.
Men who are overweight or obese (%)	8.4	N.A.	N.A.
Anaemia among Children and Adults			
Children age 6-35 months who are anaemic (%)	79.6	82.3	N.A.
Ever-married women age 15-49 who are anaemic (%)	53.1	48.5	N.A.
Pregnant women age 15-49 who are anaemic (%)	61.2	51.4	N.A.
Ever-married men age 15-49 who are anaemic (%)	20.5	N.A.	N.A.
Knowledge of HIV/AIDS among Ever-Married Adults (age 15-49)			
Women who have heard of AIDS (%)	33.8	20.8	N.A.
Men who have heard of AIDS (%)	74.2	N.A.	N.A.
Women who know that consistent condom use reduce the changes of getting HIV/AIDS (%)	27.3	N.A.	N.A.
Men who know that consistent condom use reduce the changes of getting HIV/AIDS (%)	63.2	N.A.	N.A.
Women's Empowerment			
Currently married women who usually participate in household decisions (%)	40.2	N.A.	N.A.
Ever-married women who have ver experienced spousal violence (%)	46.3	N.A.	N.A.

DLHS-3, Rajasthan

Indicators	DLHS-3 (2007-08)	DLHS-2 (2002-04)
Sample Size		
Households	40052	33833
Ever-married women (15-49)	41448	N.A.
Currently married women (15-44)	35366	32911
Unmarried women (15-24)	8418	N.A.
Population and household profile		
Population literate age 7+ (%)	61	57.2
Population below 15 years (%)	36.2	39.2
Mean HH size	5.4	5.7
Percentage of HH that		
Have electricity	61.7	61.9
Have access to toilet facility	25.1	29.4
Live in kachcha house	34.5	31.3
Live in pucca house	37.7	53.3
Use piped drinking water	34.6	42.2
Low standard of living	50.6	49.3
High standard of living	22.5	22.6
Awareness about Government health programs (based on response of HH)		
DOTS (%)	79.5	N.A.
Leprosy eradication (%)	53.8	N.A.
Malaria/dengue/chikunguinea	90.6	N.A.
Prevention of sex selection (%)	64.3	N.A.
Marriage		
Mean age at marriage for boys	20.7	20.3
Mean age at marriage for girls	17.7	17.2
Boys married below age of 21	48.4	53.4
Girls married below age of 18	41	50.8
Currently married wome 20-24, married before 18 years (%)	57.6	N.A.
Indicators based on currently married women (age 15-44)		
Characteristics of women		
Currently married non literate women (%)	66.3	68.4
Currently married women with 10 or more years of schooling (%)	9.2	9.6
Fertility		
Births to women during age 15-19 out of total births (%)	4.7	N.A.
Women 20-24 reporting birth order of 2 and above (%)	45.9	60.3
Women with 2 children wanting no more child	56.0	40.8
Mean children ever born to women (40-44 years)	4.4	4.8
Current use of family planning methods		
Any method (%)	57	45.9
Any modern method (%)	54.0	41.4
Female sterilization (%)	40.5	31.2
Male sterilization (%)	0.5	0.6
Pill (%)	3.2	2.6
IUD (%)	1.4	1.3
Condom (%)	8.3	5.5

Any traditional method (%)	2.8	4.5
Rhythm/Safe period (%)	1.7	3.2
Couple using spacing method for more than 6 months (%)	9.6	N.A.
Ever used Emergency Contraceptive Pills (%)	0.5	N.A.
Unmet need for family planning		
Total unmet need (%)	17.9	22.1
For spacing (Definition I) (%)	7.7	8.3
For limiting (Definition I) (%)	10.2	13.8
Total unmet need (%)	11.4	N.A.
For spacing (Definition II) (%)	4.4	N.A.
For limiting (Definition II) (%)	7.0	N.A.
Antenatal care (based on women whose last pregnancy outcome was live/still birth during reference period)		
Mothers who received any antenatal check-up (%)	56.6	67.3
Mothers who had antenatal check-up in first trimester (%)	32.7	29.3
Mothers who had 3 or more ANC (%)	27.7	28.8
Mothers who had at least one tetanus toxoid injection (%)	55.0	61.4
Mothers whose Blood Pressure (BP) taken (%)	29.5	32.3
Mothers who consumed 100 IFA Tablets (%)	15.6	7.4
Mothers who had full antenatal check-up (%)	5.7	4.5
Delivery care (based on women whose last pregnancy outcome was live/still birth during reference period)		
Institutional delivery (%)	45.5	30.3
Delivery at home (%)	53.7	69.2
Delivery at home conducted by skilled health personnel (%)	13.4	20.0
Safe delivery (%)	52.7	43.4
Mothers who received PNC within two weeks of delivery (%)	38.2	N.A.
Mothers who received financial assistance for delivery under JSY (%)	31.9	N.A.
Child immunization		
Number of children age 12-23 months	3411	4183
Children 12-23 months fully immunized (%)	48.8	23.9
Children 12-23 months not received any vaccination (%)	14.3	29.6
Children 12-23 months who have received BCG vaccine (%)	82.8	60.0
Children 12-23 months who have received 3 doses of DPT vaccine (%)	55.6	35.0
Children 12-23 months who have received 3 doses of polio vaccine (%)	63.9	35.2
Children 12-23 months who have received measles vaccine (%)	67.5	35.1
Children (age 9 months and above) received at least one dose of vitamin A supplement (%)	50.8	21.6
Child feeding practices (base on last born child) (%)		
Children under 3 years breastfed within one hour of birth	41.9	14.3
Children age 0-5 months exclusively breastfed	65.5	N.A.
Children age 6-35 months exclusively breastfed for at least 6 months	25.4	5.3
Children age 6-9 months receiving solid/semi-solid food and breast milk	43.7	N.A.

Awareness about Diarrhea and ARI		
Women aware about danger signs of ARI (%)	98.6	71.7
Treatment of childhood diseases (based on last two surviving children born during the reference period)		
Children with diarrhea in the last 2 weeks who received ORS (%)	30.6	28.9
Children with diarrhea in the last 2 weeks who were given treatment (%)	59.7	61.7
Children with ARI or fever in the last 2 weeks who were given advise or treatment (%)	69.8	70.1
Awareness of RTI/STI and HIV/AIDS		
Women who have heard of RTI/STI (%)	47.3	63.8
Women who have heard of HIV/AIDS (%)	52.3	30.0
Women who have any symptoms of RTI/STI (%)	16.2	47.9
Women who know the place to go for testing of HIV/AIDS (%)	64.9	N.A.
Women underwent test for detecting HIV/AIDS (%)	0.8	N.A.
Other reproductive health problems		
Women had primary or secondary infertility (%)	4.8	N.A.
Women had problem of obstetric fistula (%)	0.4	N.A.
Quality of family planning services		
Currently married non-users who ever received counseling by health personnel to adopt family planning (%)	21.8	9.6
Current users ever told about side effects of family planning methods (%)	21.1	32.5
Users who received follow-up services for IUD/sterilization within 48 hours (%)	62.3	N.A.
Indicators based on unmarried women (age 15-24)		
Characteristics of women		
Unmarried non-literate women (%)	16.3	N.A.
Unmarried women with 10 or more years of schooling (%)	26.6	N.A.
Family life education		
Unmarried women who opined family life education/sex education important (%)	71.1	N.A.
Unmarried women who ever received family life education/sex education (%)	38.1	N.A.
Unmarried women who are aware of legal minimum age at marriage for girls in India (%)	94.9	N.A.
Awareness of contraceptive methods		
Unmarried women who know about condom (%)	73.7	N.A.
Unmarried women who know about pills (%)	82.3	N.A.
Unmarried women who know about Emergency Contraceptive Pills (%)	32.3	N.A.
Unmarried women who ever discussed about contraception with any one (%)	25.0	N.A.
Awareness of RTI/STI and HIV/AIDS		
Unmarried women who have heard of RTI/STI (%)	41.6	N.A.
Unmarried women who have heard of HIV/AIDS (%)	72.9	N.A.
Unmarried women who know the place to go for testing of HIV/AIDS (%)	68.3	N.A.
Unmarried women underwent test for detecting HIV/AIDS (%)	0.2	N.A.

Indicators	DLHS-3 (2007-08)
Villages covered	
Number of villages	1265
Health Facilities covered	
Sub centers (SC)	1004
Primary Health Centers (PHC)	692
Community Health Center (CHC)	355
District Hospitals (DH)	32
Health programmes at village level	
Number of villages having ASHA	927
Villages having beneficiary under JSY (%)	95.7
Villages where Health and Sanitation Committee formed (%)	10.0
Villages where Pradhan/Panchayat member aware of untied fund (%)	29.3
Accessibility of Health Facility	
Villages with Sub Center within 3 kms (%)	72.4
Villages with PHC within 10 kms (%)	66.2
Infrastructure, staff and services at Sub Center (SC)	
Sub Center located in government building (%)	76.2
Sub Center with ANM (%)	86.5
Sub Center with male health worker (%)	9.5
Sub Center with additional ANM (%)	21.8
ANM living in Sub Center quarter where facility is available (%)	55.1
Infrastructure, staff and services at Primary Health Centers (PHC)	
PHCs having Lady Medical Officer (%)	6.2
PHCs having AYUSH Medical Officer (%)	19.9
PHCs with at least 4 beds (%)	89.9
PHCs having residential quarter for Medical Officer (%)	63.3
PHCs functioning on 24 hours basis (%)	56.9
PHCs having new born care services (%)	23.9
PHCs having referral services for pregnancies/delivery (%)	31.5
PHCs conducted at least 10 deliveries during last one month (%)	42.1
Infrastructure, staff and services at Community Health Centers (CHC)	
CHCs having Obstetrician/Gynaecologist (%)	31.5
CHCs having 24 hours normal delivery services (%)	98.9
CHCs having functional Operation Theatre (%)	60.3
CHCs designated as FRUs (%)	52.7
CHCs designated as FRUs offering caesarean section (%)	18.2
FRUs having new born care services on 24 hour basis (%)	88.2
FRUs having blood storage facility (%)	15.0

SRS October 2009 (Reference Year 2008)

Indicator	Rajasthan	India
Birth Rate	27.5	22.8
Death Rate	6.8	7.4
Natural Growth Rate	20.7	15.4
Infant Mortality Rate	63	53