National Health Mission (NHM)

Manual for District- Level Functionaries

2017

PREFACE

The purpose of this Development Manual for National Health Mission (NHM) is to create an enabling mechanism for improved implementation of the Centrally Sponsored Scheme (CSS) at the cutting edge, leading to enhanced outcomes in nature and extent. Accordingly, it would act as a guide for implementation by the District Collector and key District-level functionaries, enable quick learning about the Scheme, implementation modalities, roles and responsibilities of the various functionaries as well as stakeholders.

This Manual is prepared with inputs from a combination of sources, such as review of scheme guidelines and circulars issued by the Ministry of Health & Family Welfare, the nodal Ministry for administration of the scheme, interaction with nodal officers from Ministry of Health & Family Welfare; Government of India (GoI), National Health Systems Resource Centre (NHSRC), District and Sub district level authorities and discussions with the key personnel involved in the implementation of the Scheme.

For greater direction, the guidelines cited must be referred to along with the scheme website (www.nhm.gov.in) for guidance and clarifications on implementation from time to time.

CONTENTS

1. National Health Mission (NHM)

1.1 National Health Mission (NHM): About the Scheme[1]

National Rural Health Mission (NRHM) was launched in April 12, 2005 to address the health needs of the underserved rural population especially women, children and vulnerable sections of the society and to provide affordable, accessible and quality healthcare.

The National Urban Health Mission, (NUHM) was launched in May 2013 and was subsumed with NRHM as a sub-Mission of the overarching National Health Mission. (NHM). Many unique practices were encouraged like innovations in healthcare delivery practices, flexible financing to the states with strengthened monitoring and evaluation component for better health outcomes and health indicators of the states.

The vision[2] of the NHM is the "Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health".

NHM focuses on decentralized health planning, service delivery, creating knowledge hubs within district hospitals, strengthening secondary level care at district hospitals, expanding outreach services, improving community processes and behavior change communication, human resources development, public health management, and health management information systems. NHM particularly focuses on equity: prioritizing the health of tribal populations, those in LWE and urban poor. A key outcome of NHM is to reduce Out of Pocket expenditures. Health outcomes, output and process indicators are monitored through large scale surveys conducted periodically with evaluations, use of HMIS data, and periodic reviews done.

The main aim is to create a fully functional, decentralized and community owned system with greater inter- sectoral coordination so that wider social determinant factors affecting health of people like water, sanitation, nutrition, gender and education are also equally addressed.

2. National Rural Health Mission (NRHM)

2.1 Objectives[3], Goals[4] and Key Strategies [5] of the NRHM

Major Strategies were incorporated for improving outreach of health services to public for greater synergy; decentralized planning and innovation in service delivery. The summary* of objectives, goals and strategies are in Table 1:

Table 1: Objectives, Goals & Strategies of NRHM

Objectives	Goals	Strategic Changes

1. Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR 2. Population stabilization, gender and demographic balance	1. Reduce IMR to 25/ 1000 live births 2. . Prevention and reduction of anaemia in women aged 15- 49 years 3. Reduce Total Fertility Rate (TFR) to 2.1 4. Reduce MMR to 1/ 1000 live births	1. Strengthening infrastructure at all levels 2. Quality Monitoring of facilities as per Indian Public Health Standards (IPHS) Standard 3. Decentralised planning with autonomy for local action 4. Institutional Mechanisms at all levels with autonomy 5. Induction of management specialist into Programme management Units 6. Centralized technical support unit- National Health Resource Centre and State Health Resource Centre(NHSRC and SHSRC)
3. Achieve Universal access to public health services like women's health, child health, water, sanitation & hygiene, immunization, and nutrition. 4. Promotion of healthy life styles	1. Reduce household out –of-pocket expenditure on total health care expenditure	1. Decentralised planning with autonomy for local action 2. Inter sector District Health Plan includes drinking water, sanitation, hygiene, nutrition Capacity- Building of Panchayati Raj institutions 3. Developing capacities for preventive health care at all levels
5. Prevention and control of communicable and non-communicable diseases, including locally endemic diseases	1. Prevent and reduce mortality and morbidity from communicable, non-communicable, injuries and emergency diseases 2. Reduce annual incidence and mortality from Tuberculosis by half 3. Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts 4. Annual Malaria incidence to be <1/1000 Less than 1 per cent microfilaria prevalence in all districts 5. Kala- Azar Elimination by 2015, <1case per 10000 population in all blocks	1. Integrating vertical Health and Family Welfare programmes 2. Developing capacities for preventive health care at all levels 3. Reorienting Medical Education to Rural Health Issues
6. Access to integrated comprehensive primary healthcare 7. Revitalization of local health traditions and mainstream AYUSH	1. Reduce household out –of-pocket expenditure on total health care expenditure	1. Promote ASHA healthcare service delivery 2. Health Plan for each village through VHNSC 3. Untied funds with flexi pools of funds 4. Effective and visible risk pooling and social health insurance 5. Promoting non-profit sector and PPP for achieving goals in underserved areas 6. Mainstreaming AYUSH and local health traditions

*Many Strategic Changes and programme components are overlapping to achieve Goals and Objectives. For convenience they are put in one category

2.2 Components

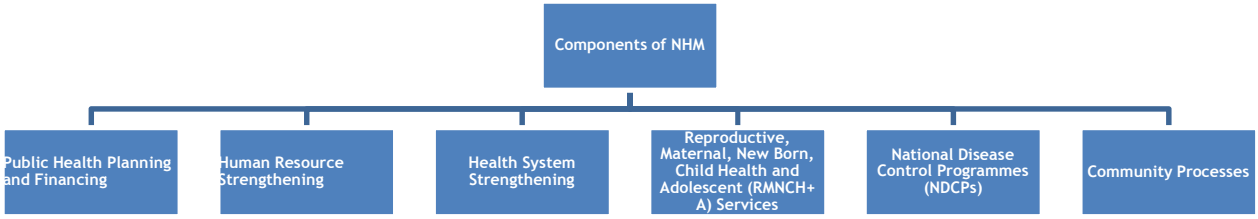


Figure 1: Components of National Health Mission

2.2.1 Public Health Planning and Financing:

- Mapping of facilities and differential planning for districts/cities/blocks as per their health indicators
- Planning for full spectrum of health services
- Emphasis on quality assurance in delivery points
- Strengthening of Management with full time Mission Director, Director Finance and Programme Management support at all levels.
- Developing a separate and trained Public health cadre of professionals including doctors and nurses

2.2.2 Human Resource Strengthening in Health; Deployment and Development

- HR gaps met based on case load. Engagement of medical specialists, Medical professionals and nurses on contract based on need.
- HR accountability: Performance- based incentives and for working in difficult areas.
- Additional incentives to health professionals to serve in rural and remote areas
- Speedy recruitment to fill up vacancy, preferable decentralized.
- Amendments in medical college norms to increase availability of doctors
- Capacity building and training of staff at all levels.

2.2.3 Health Systems Strengthening

Funds are provided for up gradation of existing and construction of new infrastructure. High focus States spend up to 33 per cent and other States up to 25 per cent of their funds on infrastructure. Relevant Guidelines in Table 2:

Table 2: Guidelines for health facilities based on population norms[6]

Health facility level	Population Covered in Plain areas	Difficult/ tribal & hilly areas	Staff Requirement
Sub centre	1 per 5,000 population	1 per 3,000 population	3
Primary Health Centre (PHC)	1 per 30,000 population	1 per 20,000 population	15
Community Health Centre (CHC)	1 per 1,20,000 population	1 per 80,000 population	25
District Hospital	100 beds per 1,00,000 population		60-70

Facility type and time taken to reach by walk[7]

Facility Type	Time taken for walking to facility from any habitation
Sub centre(in hilly and desert states)	Within 30 min

PHC	Within 30 min
CHC	With 2 hrs
However, to ensure easy access, facilities can be created/ upgraded based on the *'time to care'* approach.	

The various sub- components of Health Systems Strengthening are as follows:

1. Construction of new buildings and renovation of existing ones.

Budget provisions available for construction, maintenance, carpentry, electrical, plumbing, sanitation, water provision etc. to fulfill the infrastructural gaps based of IPHS (Indian Public Health Standards) and existing structure.

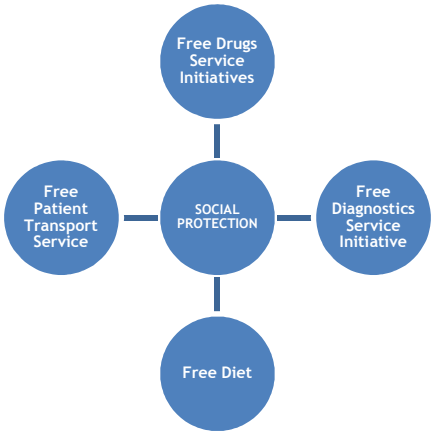
2. Improving Sanitation & Hygiene in Public facilities: Kayakalp [8]

Kayakalp initiative is a new initiative launched in 2015 under NHM, to inculcate the practice of hygiene, sanitation, effective waste management and infection control in public health facilities. It also includes recognition with Certificate of Commendation and Cash Awards of such public healthcare facilities that show extraordinary performance and compliance to protocols.

Table 3: Incentives under Kayakalp initiative

Facility Type	Ranked Awards	Certificate of Commendation
DH	1st 50 lakh, 2nd 20 lakh	Rs 3 lakh
CHC & SDH	1st 15 lakh, 2nd 10 lakh	Rs 1 lakh
PHC	2 lakh	Rs 50,000

3. Social Protection: Reducing Out of pocket expense:



A. Drugs: Free Drugs Service Initiatives[9]

- Provisions for supply of essential drugs as per the defined Essential Drugs List (EDL), free of cost, to lower the out- of- pocket expenses of the patients.
- Centrally procurement of drugs for various programmes as per the EDL and Standard Treatment Guidelines (STG).
- Provision of local purchase of drugs and supplies at lower levels, if need arises.

Drugs & Logistic Support: Procurement and Supply Chain Management Systems[10]

Drug Procurement System for public health facilities and E-procurement systems are very crucial for supply of essential drugs for JSSK and other programmes.

B. Diagnostics: Free Diagnostics Service Initiative[11]

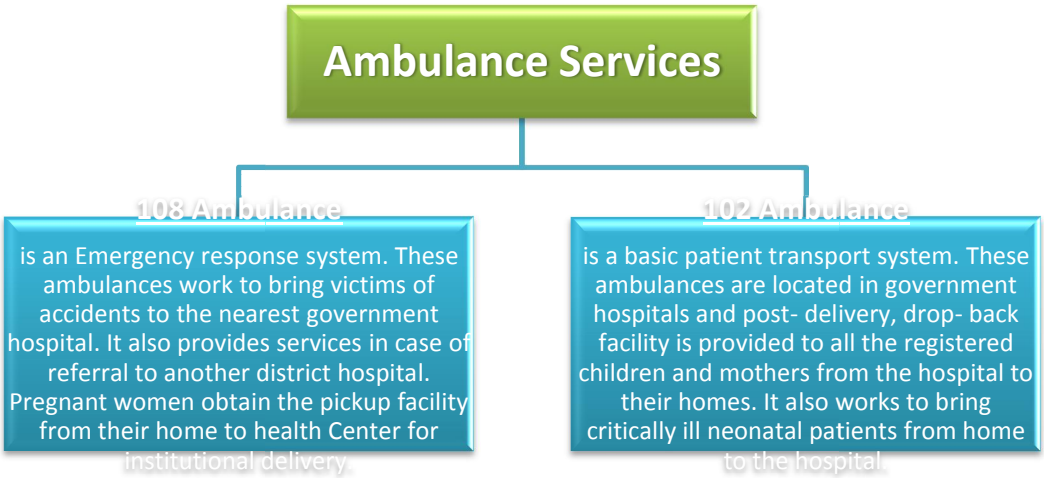
Under this programme, free diagnostics services (radiological & laboratory) are provided to patients free of charge, as per the level of the facility. (Refer Guidelines on Free Diagnostics Service Initiative.

C. Diet: Free good quality Diet

It is available to all inpatients including pregnant women.

D. Transport: Emergency Response System (ERS)/ Patient Transport Service/ National Ambulance Services (NAS)[12]

These services are offered on cashless basis and are the pillars for providing free assured transport services to the patients as entitled by Janani Suraksha Yojana (JSY) and Janani Sishu Suraksha Karyakram (JSSK)[13].



Many of these models have dedicated call centers attached to them. In Dial 108 model, approximately one ambulance is positioned for one lakh population, and each ambulance has a staff of three drivers and three paramedical emergency technicians, with two supervisors for every 15 vehicles.

Equipments: Biomedical Equipment Management and Maintenance Programme[14]
The comprehensive program includes detailed guidelines on the comprehensive

medical equipment management and maintenance in a Public Private Partnership mode, its components, structure for partnerships and inventory mapping.

Blood Services: NHM supports activities to meet annual requirements of blood through district government by supplementing Human Resources, equipment and other requirements like e- blood banking, voluntary blood donation and functional linkages of blood storage centres with blood banks.

4. Outreach Services: Mobile Medical Units[15].

Vehicles are used to improve outreach services and bring healthcare to the doorstep of especially in difficult terrain and remote areas. It may carry medical and paramedical personnel, drugs, supplies and laboratory and diagnostics equipment. The number of vehicles varies from State to State.

2.2.4 Reproductive, Maternal, New Born, Child Health and Adolescent (RMNCH+ A) Services

This programme was launched in 2013 to address increasing maternal and child health mortality, associated causes and to bring in improvement in access and utilisation of health care services by the vulnerable population. The sub-components of this Scheme are as follows:

A. Reducing Maternal Mortality Rate: Maternal Health

1. Incentivization: Janani Suraksha Yojana (JSY)[16]

This scheme is for strengthening Maternal and Child Health Services wherein incentives are paid to all the pregnant women of both urban and rural areas for deliveries in public institutions. Incentives are given to all patients irrespective of their BPL status, so as to facilitate public institutional deliveries.

Table 4 a: Incentives for Institutional Deliveries under Janani Suraksha Yojana (JSY)

State	Incentives for Institutional Deliveries under JSY			
	Rural Areas		Urban Areas	
	Pregnant Women *(Rs.)*	ASHA *(Rs.)*	Pregnant Women *(Rs.)*	ASHA *(Rs.)*

High performing States	700	600	600	400
Low performing States	1,400	Same as above	1,000	Same as above
Incentives for Home Deliveries	500	-	500	-

2. Free Patient Entitlements: Janani Sishu Suraksha Karyakram (JSSK)[17]

   JSSK scheme ensures cashless delivery and C- section for pregnant women and management of sick neonates up to one year to prevent incurring high out- of-pocket expenses and exploitation by unwarranted people.

Table 4 b: Patient Entitlements under JSSK

Pregnant women	Sick newborns till 30 days after birth.
• Free and cashless delivery • Free C- Section • Free drugs and consumables • Free diagnostics • Free diet during stay in the health institutions • Free provision of blood • Exemption from user charges • Free transport from home to health institutions • Free transport between facilities in case of referral • Free drop back from Institutions to home after 48 hours stay	• Free treatment • Free drugs and consumables • Free diagnostics • Free provision of blood • Exemption from user charges • Free Transport from Home to Health Institutions • Free Transport between facilities in case of referral • Free drop Back from Institutions to home
Unit Price per case allocations to the hospital are Drugs & Consumable for Normal Deliveries- Rs.350/-, Drugs & Consumable for C-sections- Rs.1, 600/-, Diagnostic- Rs.200/-, Blood Transfusion- Rs.300/-, Transport (Referral transport inter facility) - Rs.250/. A separate account for this budget is maintained by the institutions. (Refer Guidelines on JSSK)	

3. Strengthening infrastructure: Maternal and Child Health (MCH)[18] Services

   Under NHM, 100/50/30 bedded MCH wings are established to improve quality of care if the bed occupancy is more than 70 per cent. Such wings can be established in District Hospitals/ District Women's Hospitals/ Sub- District Hospitals/CHC- First Referral Units (FRUs) to overcome the constraints of increasing caseloads and institutional deliveries at these facilities. (Refer: Maternal and Newborn Health Tool Kit, Nov 2013; MoHFW, GoI)

4. Reorienting Medical Education: Skill Labs[19]

   Skills Labs are established for competency based training and skill enhancement of healthcare providers for RMNCH+A services, both in- service and pre- service training. Thus reorient existing personnel and train students of ANM, GNM and midwifery courses.

5. Capacity Building: Dakshata Programme[20]

It is the capacity building programme for service providers in labor room best practices during labor, delivery and post- partum.

6. Promotive Health : Mothers Absolute Affection (MAA)[21]

   It is a new initiative Programme for Promotion of Breast Feeding.

7. Improves access and Coverage: Safe Abortion Services

   Medical Termination of Pregnancy (MTP) services are provided in FRUs, functional 24x7.

8. Improving access by PPP mode: Pradhan Mantri Surakshit Matritva Abhiyan(PMSMA)[22]

   Under the PMSMA, on the 9th of every month, pregnant ladies are given free health check- up including blood pressure, sugar level, Hemoglobin test, Blood test etc. and the required treatment in all government medical facilities. Private sector gynecologists are encouraged to voluntarily participate and provide antenatal checkup (ANC) services in these public health facilities.

9. NGOs Involvement: Gender Based Violence

   ASHAs and clinical service providers are sensitized and trained to identify, counsel and refer such cases to higher centres, with the support of Non- Governmental Organisations (NGOs) and women support groups.

10. Monitoring and accountability of services: Maternal Death Review

    The purpose of both Facility- Based Maternal Death Review (FBMDR) and Community- Based Maternal Death Review (CBMDR) is to identify the causes of maternal deaths and the gaps in service delivery in order to take corrective action.

B. Reducing Infant Mortality and Child Mortality Rate: New Born and Child Health

1. New born Care Services Programme

Table 5: Programmes under New- born Care Services Programme[23]

Newborn care services	Location	Services
New Born Care Corner	All Delivery points	Essential newborn care including resuscitation, Zero day immunization
New Born Stabilization Units (NBSU)	CHCs/FRUs	Stabilization and referral of sick newborns.

2. Universal Immunization Programme (UIP)[24] & Mission Indra dhanush

Under the routine immunization, children are given vaccines for the prevention of seven life- threatening diseases (Tetanus, Tuberculosis, Diphtheria, Pertussis, Measles, Polio and Hepatitis-B). Vitamin A dosages are also given with Measles. Tetanus Toxoid is provided to the pregnant women. These vaccinations are being organized by immunization sessions in all the hospitals, health centers, sub centers and anganwadi centers, during special vaccination weeks. Cold chain logistics are provided at all facilities. Surveillance of vaccine preventable diseases is integrated with Integrated Disease Surveillance Programme (IDSP). Name- based monitoring of both mother and children for vaccination are done through Mother and Child Tracking System (MCTS)

Mission Indradhanush: To strengthen and invigorate the Universal Immunization Programme (UIP) and achieve full immunization coverage for all children at a rapid pace, the Government of India (GoI) launched Mission Indradhanush in December 2014.[25]

Mission Indradhanush ensures that all children under the age of two years and pregnant women are fully immunized with all available vaccines. (Ref: Operational Guidelines for UIP and Operational Guidelines for Mission Indradhanush)

3. Rashtriya Bal Swasthya Karyakram (RBSK)[26]

The Purpose of RBSK is to improve the overall quality of life of children, 0- 18 years, through early detection & intervention of 4Ds i.e. Defect at birth, Diseases, Deficiencies, Developmental delays and disabilities. These will cover 38 identified health conditions through dedicated mobile health teams in every block in schools and Anganwadi centers. District Early Intervention Center (DEIC) is the setup for further screening, management support and referral to higher center.

4. Integrated Management of Common Childhood Illnesses(IMNCI)

Facilities for prevention, early detection and management of diarrhea, Pneumonia and Malaria

5. Nutritional Rehabilitation Centers (NRCs)

NRCs are set up in the health facilities, especially at DHs and FRUs for inpatient management of severely malnourished children, with counseling of mothers for proper feeding and regular follow up on discharge.

6. Monitoring: Child Death Review

Reporting and reviewing of child death under 5 years is a priority area.

C. Adolescent Health Programme

1. Rashtriya Kishor Swasthya Karyakram (RKSK) [27]

Adolescent Friendly Health Services (AFHS) are present in district health facilities to provide counseling on sexual and reproductive health including menstrual hygiene, substance abuse, violence including domestic violence, mental health, injuries, non- communicable diseases and provide iron and folic acid tablets, condoms, pregnancy kits and Oral Contraceptive Pills (OCPs) through dedicated trained counselors.

D. Reducing Fertility Rate: Family Planning Services [28]

For the purpose of encouraging family planning in the district, all PHCs, CHCs and DH services provide temporary and permanent family planning methods including male and female sterilization surgeries, Intrauterine Contraceptive Device (IUCD), Post- Partum Intrauterine Contraceptive Device (PPIUCD), Oral Contraceptive Pills (OCPs), Emergency Contraceptive Pills (ECPs), condoms and counseling services. In addition, outreach sterilization services are conducted in remote areas. A month long (in two phases June 27- July 10 and July 11- July 24) national campaign on World Population Day per year, is done in all the states/ Districts. AYUSH Doctors are also trained in IUCD insertions. NSV Day (Non Scalpel Vasectomy Day) is conducted on the 21st of each month.

National family planning indemnity scheme (NFPIS) insures and indemnifies institutions against litigations in case of deaths, complications and sterilization failures.

E. Declining Sex Ratio

Under this program, Government has been implementing the Pre- Conception and Pre- Natal Diagnostic Techniques (PCPNDT) Act 1994, to control the falling child sex ratio and to prevent female foeticide. Registered ultrasound centres have to ensure that sex determination of foetus is not done under any circumstances. There is a provision of punitive action during the execution or after receiving the complaint of foetal testing.

2.2.5 Preventing Communicable and Non Communicable Diseases: National Disease Control Programmes[29]

A summary of the programmes are given below in the table.

Table 1: Summary of Non- Communicable and Communicable Disease Programmes

S. No.	Programme Name	Key Functions
Non- Communicable Disease Programmes		

S. No.	Programme Name	Key Functions
1.	National Program for Prevention and Control of Diabetes, CVD and Stroke (NPCDCS)	Specialized management of Diabetes, CVD, Stroke and Cancer.
2.	National program for Prevention and Control of Blindness (NPCB)	Providing screening for detection and management of diabetic retinopathy, refractory defects and glaucoma.
3.	National Program for Prevention and Control of Deafness (NPPCD)	Prevention of avoidable hearing loss and early detection & treatment of ear problems.
4.	National Mental Health Program (NMHP)	Providing services for early detection & treatment of mental illness in the community
5.	National Oral Health Program (NOHP)	Promotive and preventive oral health care at Primary and secondary level.
6.	National Program for Health Care of the Elderly (NPHCE)	Specialized accessible healthcare for elderly.
7.	National Iodine Deficiency Disease Control Program (NIDDCP)	To check iodine deficiency related health Problems.
8.	National Tobacco Control Program (NTCP)	To spread awareness and better implementation of tobacco control.
Communicable Disease Programmes		
1.	National Vector Borne Disease Control Programme (NVBDCP)	Prevention and control of vector borne diseases like malaria, Japanese encephalitis, dengue, chicken guinea, Kala-azar, Lymphatic filariasis.
2.	Revised National Tuberculosis Control Program (RNTCP)	Prevention, Control & Treatment of Tuberculosis.
3.	National Leprosy Eradication Program (NLEP)	Diagnosis and treatment (Multi-Drug Treatment-MDT) of leprosy patients.
4.	Integrated Disease Surveillance Program (IDSP)	Prevention and Control of outbreaks

NCD screening at Population Level

This is a new initiative. In March 2017, GOI has initiated a programme in Population level screening of risk factors of NCDs (Diabetes, Hypertension, Common Cancers-Oral, Breast, and Cervical) by the ASHAs and Auxiliary Nurse Midwife (ANMs).[30]

2.2.6 Community Processes[31]: Institutionalizing Community- Led Action for Health[32]

A summary of Community- Led Activities under NRHM is given below:

S. No.	Community Led Activities	Functions
1.	Village Health Sanitation & Nutrition Committee (VHSNC)	• Formed at each village level within the framework of Gram Sabha. • Subcommittee or a standing committee of the Gram Panchayat. • Representation of disadvantaged sections including women. • Acts as a platform for convergence of all departments at village level. It is also functions as a Planning and monitoring committee at the village level.
2.	ASHA	• Interface between the community and the public health system. • They are female health activists at household level. • Involved in educating and mobilizing communities particularly marginalized communities. • Functions include home visits, attending the Village Health and Nutrition Day (VHND), visits to the health facility, holding village level meetings and maintaining records. • In rural areas, one ASHA worker per village and in urban areas, one ASHA per 1000-2500 population.
3.	Anganwadi Workers	• Under the ICDS programme Involved with ASHAs and ANM(Triple A team) in convening the Village Health & Nutrition Days and VHSNCs.
4.	Jan Sunwai or Jan Samvad	• Public Dialogues/Public Hearings - taking direct feedback taken from the Community members • Grievance Redressal mechanism

Table 2: Summary of Community- Led Activities under NRHM

IEC Activities: Comprehensive communication strategy adopted with a strong behavior change communication (BCC) component in the IEC strategy; dissemination in villages and lowest levels. There is participation of non government agencies and professional and specialized agencies, visible mass media efforts in massive health communication efforts. There is a substantial portion of the interpersonal BCC effort is through local ground level workers including ASHA and ANMs, and community level structures equipped with communication kits, interacting on a one to one basis with families.

2.3 Convergence

2.3.1 Convergence with Private Institutions and NGOs

A. **PPP Mode:** National Dialysis Programme[33]

This Programme enables for providing free dialysis services in District Hospitals on Public Private Partnership (PPP) Mode. The service provider provides medical and technical staff, dialysis machine and Reverse Osmosis (RO) Plant infrastructure while government provides Drugs, Water and Electricity and pays for the dialysis costs.

B. Role of Civil Society and Grant in aid to NGOs: Mechanisms for consultation with civil society are developed. The civil society members are made part of community processes. Involvement of NGOs in training, evaluations and filling service delivery gaps to achieve the goals. Up to 5%[34] of the NHM budget (of resource envelope of state) is used to support NGOs for a range of activities i.e. to provide implementation support, undertake service delivery in remote areas, community monitoring, capacity building, for innovations in community processes, implementation research, impact assessments and research.

2.3.2 Inter and intra sectoral Coordination: Convergence with Other Departments[35][36]

A. Revitalization of local traditions: Mainstreaming of AYUSH
This includes co- location of AYUSH services at public health facilities including placing an AYUSH doctor at PHCs to strengthen Out- Patient (OP) services and setting up of separate AYUSH units/clinics at CHCs and District Hospitals. AYUSH doctors are trained and involved in Skilled Birth Attendant (SBA), IUCD insertion etc. and in preventive, screening and referral services under National Disease Control Programmes such as NPCDCS.

B. Integration with other programmes of Ministry of Health & Family Welfare [MoHFW]
MoHFW has large number of National Disease Control Programmes (Communicable and Non communicable) like RNTCP, IDSP, NVBDCP etc. All are brought under together in District/City/Village Plan so that preventive, promotive and curative aspects are well integrated at all levels and there is efficient and effective utilization of manpower and financial allocations under common District Health Society and availability of services at one point(UPHC).

C. With National Aids Control Organization (NACO):
NHM provides support to NACO programme implementation at district and sub-district levels. NACO provides counselors at CHCs and PHCs and testing kits as a part of NACP-III. Additional training is provided to existing medical officers and Para healthcare workers at lower levels on HIV/AIDS, condom promotion and Information Education and Communication (IEC) activities for better outreach.

D. Swachh Swasth Sarvtra:
Joint initiative with Ministry of Drinking water and Sanitation (MDWS), is to complement initiatives of Kayakalp and Swachh Bharat to make India free of Open Defecation and have safe drinking water.[37] Convergence at the level of Panchayati Raj Institutions (PRIs), a common VHSNC, and common ASHA workers looks into the all these aspects.

E. Ministry Of Women And Child Development
A**nganwadi Centre** is a major activity centre for health services in addition to ICDS activities. AWW and MAS to work as a team for promoting health and nutrition related activities

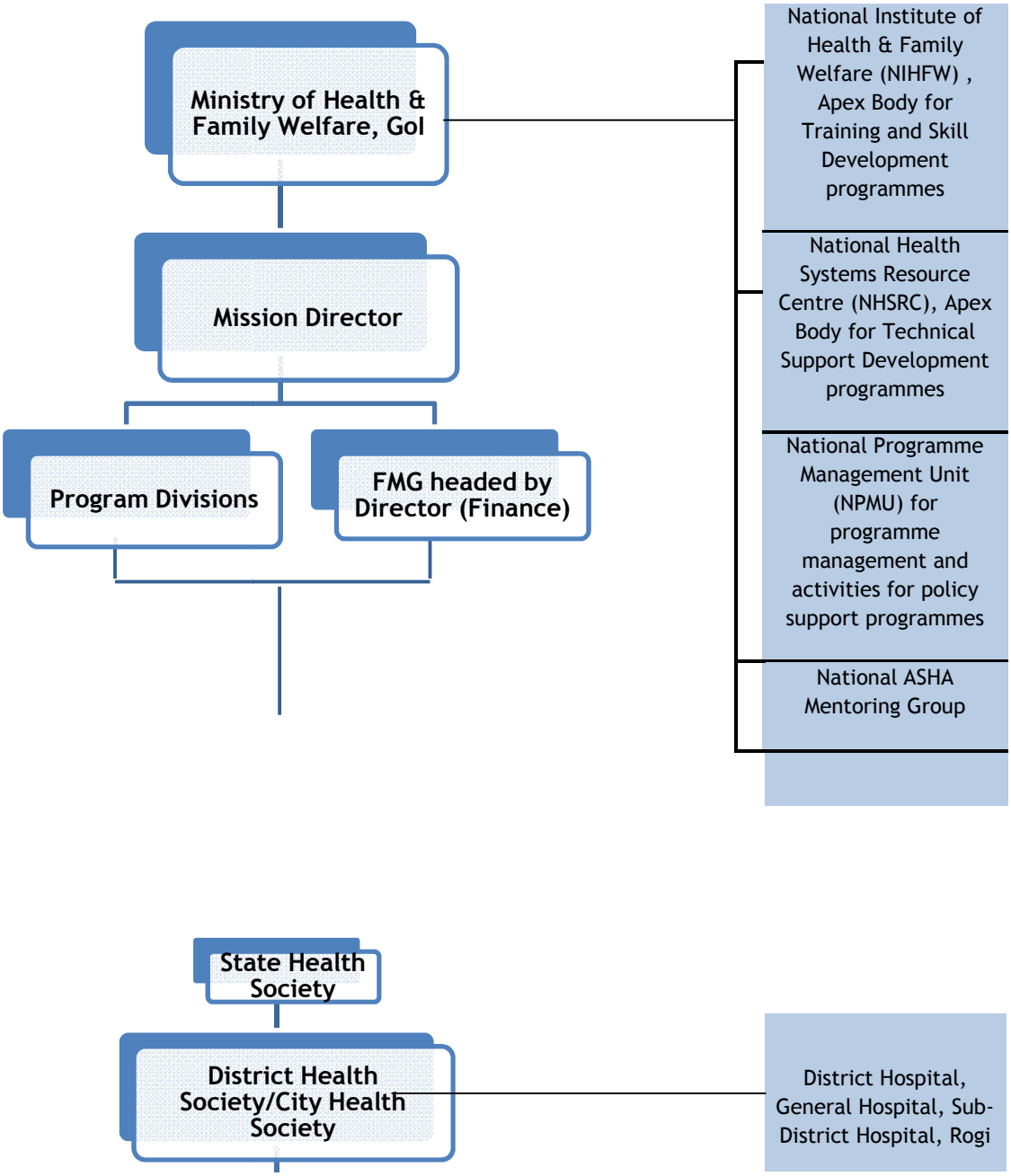
F. Convergence with the Education department and programmes such as SABLA for preventing early age at marriage for girls.

At Ministry level, interdepartmental Committee with Mission Director as Chairman, reporting to Empowered Programme Committee (EPC), is developed. Convergence at the level of Mission Steering Group (MSG) with representation of all concerned Ministries is also done for Review and Monitoring.

2.4 Institutional Framework

A. National Level Implementation

At National Level, there is a Mission Steering Group (MSG) under the chairmanship of Union Minister of Health & Family Welfare and Convener as Secretary, Department of Health & Family Welfare. MSG provides policy direction to NHM. There is an Empowered Programme Committee (EPC) headed by Secretary, Department of Health & Family Welfare, which scrutinizes all financial proposals before approval by MSG.[38] A diagrammatic representation of the Governance structure of NHM is given below:



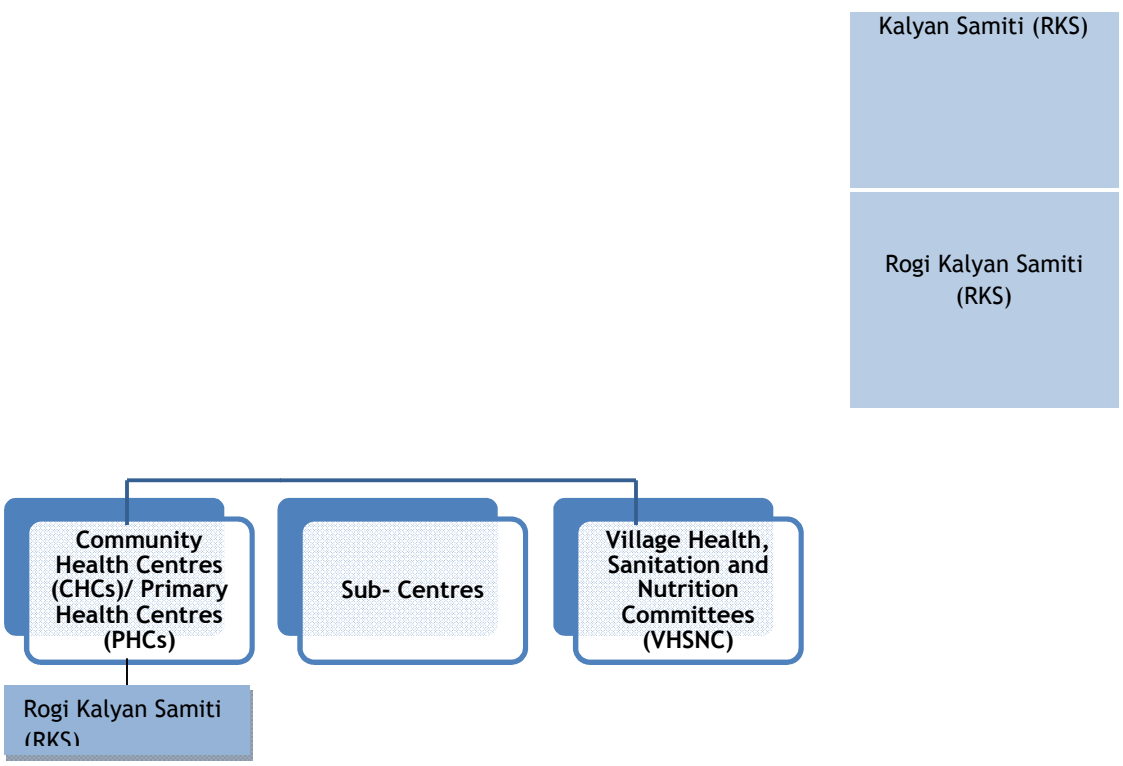


Figure 2: Governance Structure of National Health Mission (NHM)

B. State Level Implementation

There is a State Health Mission with the State level Health Society (SHS), headed by the Mission Director. It is further supported by State Programme Management Unit, State Health Resource Centre and State Institute of Health & Family Welfare.

C. District Level Implementation

At District Level, the mission operates under the District Health Mission (DHM)/City Health Mission (CHM) with District Health Society (DHS) headed by District Collector. Societies for various National and State Health Programmes are merged in DHS.

District Health Society (DHS): Like State Health Mission, there is a District Health Mission in every District and under it functions a District Health Society to support its activities. It has a Governing Body with District Collector/District Magistrate as the Chairperson and Chief Medical Officer (CMO) as the Chief Executive Officer (CEO). It also has an Executive Committee with Deputy District Collector (DDC)/CMO (if no DDC) as the Chairperson and District Programme Manager (DPM) as the CEO and Convener. DHS is responsible for planning and managing all NHM programmes in the district.[39]

District Programme Management Unit (DPMU), District Public Health Resource Centre and District Education and Training Centre perform similar functions as their state and national counterparts.

Each District Hospital's role is strengthened to create District Hospital and Knowledge Centre (DHKC)[40]. This includes secondary care provision, considerable tertiary care provision, referral support, centre for skill based in service training, clinical site training for nursing, paramedical and public health professionals, data management and analysis for district planning, knowledge support for clinical centres below it via telemedicine etc.

A diagrammatic representation of the structure at District level is given below:

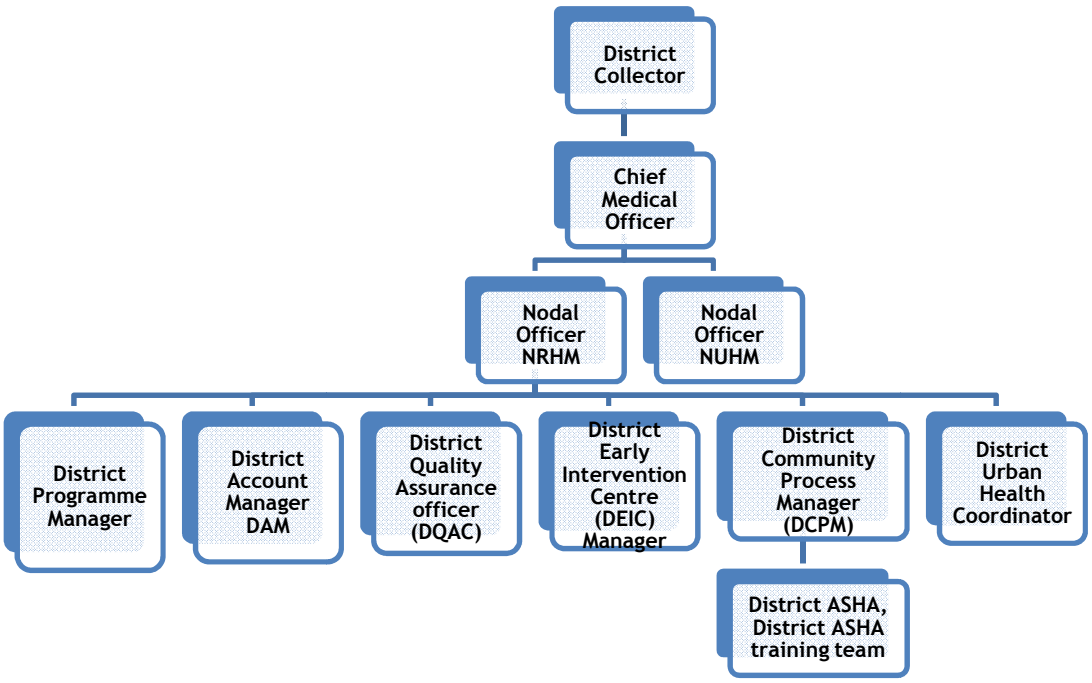


Figure 3: Organisational Structure of National Health Mission (NHM) at District Level

D. Block and Below Level Implementation

Implementation of programme and utilization of funds starts at Block level. Block Accounts Officer disburses the funds to Block Level PHCs, CHCs, Sub- centres, and VHCs under his jurisdiction and monitors its utilization.

A diagrammatic representation of the structure at Block level is given below:

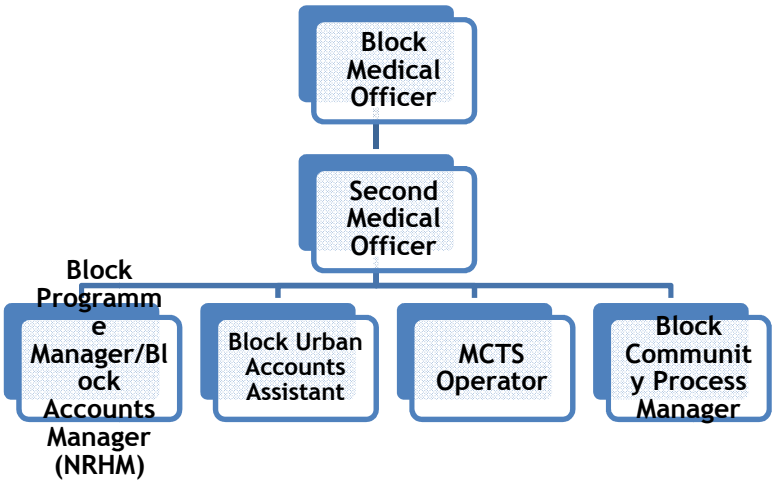


Figure 4: Organisational Structure of National Health Mission (NHM) at Block Level

At Village level, there is PHC Medical Officer in Charge and ASHA Facilitators (1 per 20 ASHAs) supported by ANM; AWW and Village Health Sanitation and Nutrition Committee (VHSNC). VHSNC acts as a platform for convergence of all departments at village level.

Hospital Development Society (HDS)/ Rogi Kalyan Samiti (RKS)

A HDS is constituted at facility level i.e. PHC, CHC, AH, DH quarter Hospitals. They are separate legal entities and are registered under the respective Societies Registration Act of the State.

Each RKS has three functional committees- Governing Body, Executive Committee and Monitoring Committee. It has representation of PRIs, eminent citizens, leading donors, NGOs, Local Member of Parliament (MP)/Member of Legislative Assembly (MLA) etc.[41]

The heads of the Committees for a district and sub- district hospitals are mentioned below:

Table 8: Committees at district and sub- district levels

Level of Facility	Governing Body	Executive Committee
District Level	Chairperson: D M Member Secretary : Chief Medical Superintendent (C.M.S) of the hospital	Chairman: C.M.S of the hospital Member Secretary: Senior Medical Officer of the hospital
Sub District Hospital	Chairperson: Sub Divisional Magistrate/Block Development Officer(BDO) Member Secretary: Senior Medical Officer of the hospital	Chairperson: Officer In charge of hospitals Member Secretary: Medical Officer of hospital
For remaining facility levels and composition details ((Refer Guidelines for RKS in Public Health Facilities, 2015).		

The Governing Body has full control and authority over the affairs of the facility. The Executive Committee reviews Out- Patient Department (OPD), In- Patient Department (IPD) and Outreach performance of the hospitals every month and

targets for next month and takes up remedial measures for observations of Monitoring Committee. Monitoring Committee collects patient feedback from hospital wards and sends a monthly report to District Collector and Chairperson, Zilla Parishad.
HDS meets at least once a quarter or more frequently, if required. A quorum of at least one third of members should be maintained. The members are re- nominated after every three years.

2.5 Untied Funds

NHM brought redesigning of health systems with an aim to provide the field units more functional, administrative and financial resources with suitable autonomy. This was undertaken to fill gaps due to unavailability of funds and inflexibility of fund usage in traditional systems for local innovative and facility specific need based activity at block and down levels. Following are the funds which are given by NHM to each facility per annum, depending upon the type of facility.

Table 9: Funds given under NHM to each facility per annum[42]

Type of facility	RKS Grants/each facility/annum *(Rs.)*	Annual Maintenance Grants (for physical infrastructure) /each facility/ annum *(Rs.)*	Untied Funds/each facility/annum *(Rs.)*
District Hospital	5 lakh		
SDH	1 lakh		
CHC/UGPHC/Area Hospital (AH)	1 lakh	1 lakh	50,000
PHC	1 lakh	50,000	25,000
Sub- centre	-	10,000 (Selected Sub centre)	10,000/ 20,000 (varies from Sub- centre to sub- centre)

Funds are received from NHM in the Bank account of the concerned HDS and are utilized with prior approval of council members of HDS except for emergencies where they are vetted by the council members after spending. HDS is also empowered to utilize hospital funds from registration charges, collections and donations etc. This fund is used for maintenance and improvement of physical infrastructure mainly, incentives to ASHAs but not for paying salaries, purchase of any vehicle, drugs, consumables etc. Please refer to Guidelines[43] for utilization of untied funds, Annual Maintenance Grant and RKS (HDS) for further details.
In case of emergency/ exigency, the designated person can sanction the specified amount and later get it ratified in the next RKS meeting. The amount which can be spent in emergency varies from State to State.
All bank- related operations including signing of cheque are done by joint signatories i.e. following authorized members of respective RKS of the facility:

Table 30: Authorised signatories at various levels

S. No.	Level	Approved Signatories
•	DH	CDMO/CHMO/CMO & Senior most Medical Officer
•	SDH	SDMO & Senior most Medical Officer
•	Block PHC/CHC/AH	Medical Officer (In charge) & Senior most Medical Officer/AYUSH Doctor/BPO/Pharmacist in that order decided by the Governing Body
•	PHC	Block Medical Officer (In charge) & MO (In charge)/AYUSH doctor/Pharmacist who is Member Secretary cum treasurer of respective RKS, in that order

•	VHNSC	Gram Pradhan & ANM

2.6 Fund Flow Management

States are strengthened to carry out health reforms with additional resources and appropriate flexibility as per local needs. Planning and implementation are decentralized to the States (State Health Mission developing State Health Action Plan) to Districts (Districts Health Mission developing District Health Action Plan) to Block Health Action Plan which are community- owned and as per local needs, keeping in view the implementation guidelines of various programmes.

Funds in NHM are pooled under "Mission Flexi Pool". It is divided into five components under which funds are utilized for respective programmes, as follows:

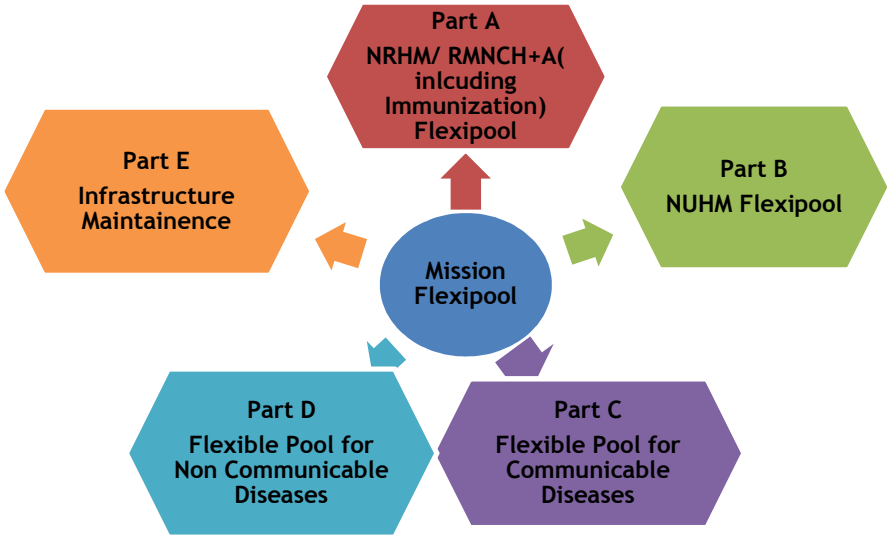


Figure 5: Mission Flexi Pool Components

There is a separate financial envelope tied to Part A to D with flexibility provided to all States to allocate finds across various strategies as per local needs and broad national priorities. The number of components under Flexi pool varies from State to State.

At least 70 % of funds of State under Part A- NRHM –RMNCH flexible pool is allocated to the districts, with high priority districts allocation are at least 30 % more per capita than non priority districts.[44]

The NHM funding between the Centre and States is in the ratio of 60:40 (for all states except NE and 3 Himalayan States), 60 from Central government and 40 from State.[45]

States have to work towards increase of at least 10 % in expenditure every year.[46] Maximum funds have to be spent at lower levels i.e. at least 70% at Block and below, 20 % District level and 10 % at State Level.[47] For implementation and supervision of the scheme, Decentralized planning and funds dispersion from Top to Bottom is done. There is periodic reporting at each level through their supervisory units to GOI. The fund flow mechanism is as follows:

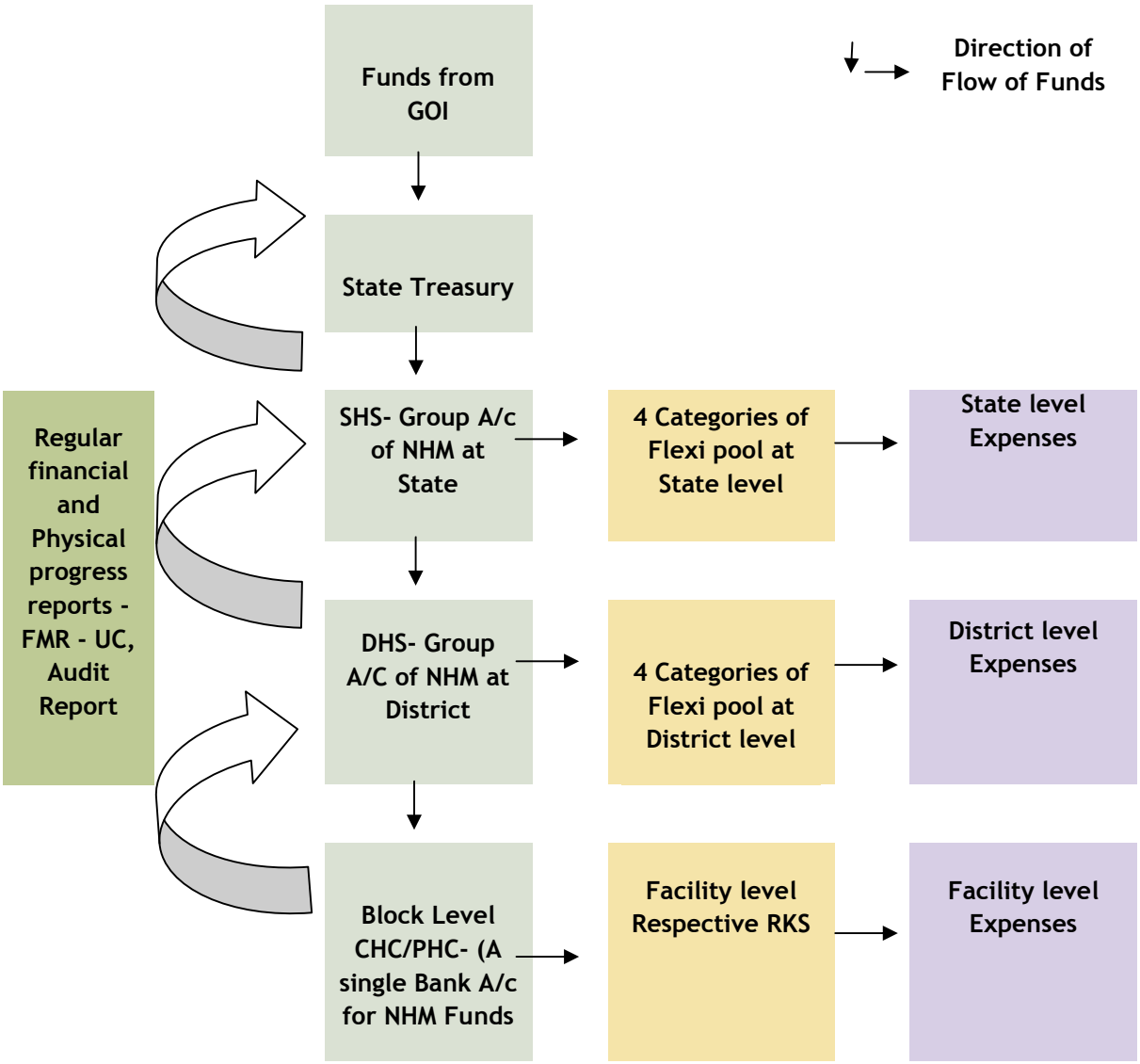


Figure 6: Direction of Flow of Funds in NHM

2.7 District Health Action Plans (DHAP)[48]/City Health Action Plan[49]

INTEGRATION: DHAP is prepared by District Programme Management Unit (DPMU) based on Block Health Action Plans (BHAP). BHAP are prepared by Block Programme Management Units based on the facility level plans and village level plans. It is prepared after reviewing the targets, both physical and financial achievement in last PIP and after a consultation workshop/review meeting with the relevant stakeholders of lower levels. It depicts the resources requirements and budget required for various activities at various district and sub districts levels.

Figure 7a1: District Health Action Plan (DHAP) Preparation

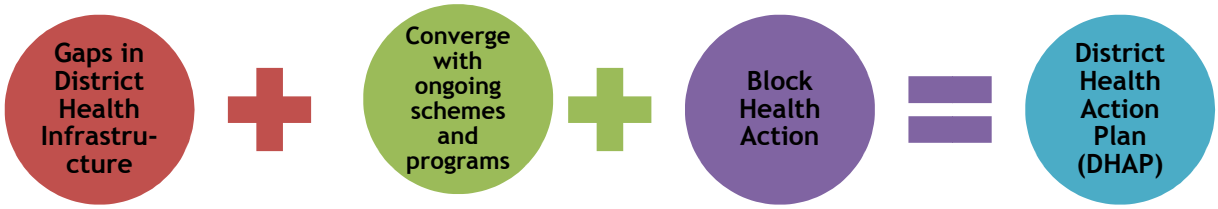
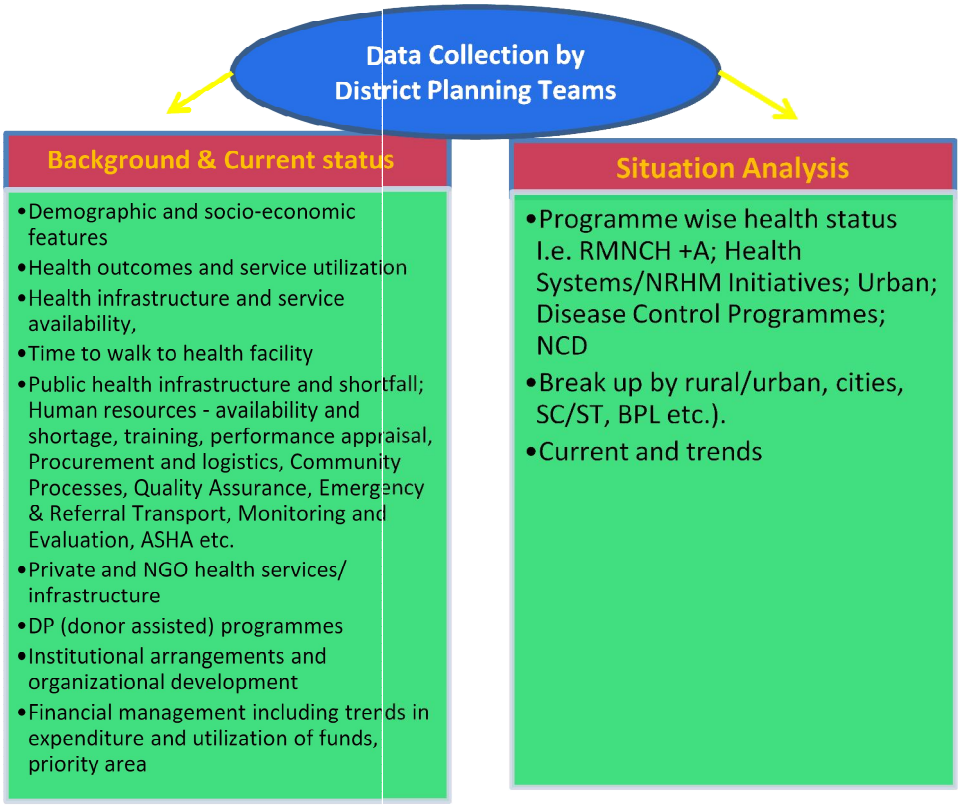


Figure 7b2: Pre Preparation Data Collection by District Planning Team



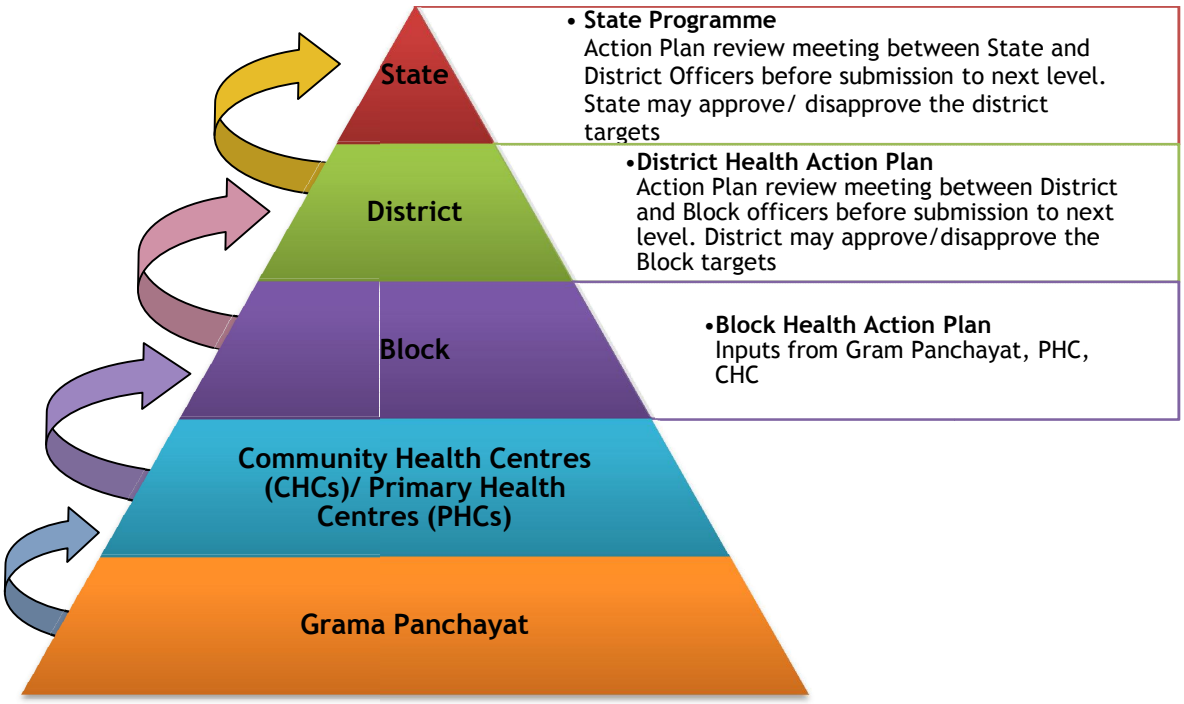


Figure 7 c: Decentralized and Bottoms Up Approach[50] *: Preparation of State, District and Block Level Health Action Plan

(*) = The number of Units in each level will vary from State To State.

PROCESS OF DHAP Preparation:

Figure 8 shows the process and Figure 9 shows the tentative timelines of DHAP preparation.

- Up to 10 % of district allocation is earmarked for schemes to be developed by the districts as per their local needs.
- The district/city health action plan will clearly prioritize intra district areas which are more difficult to reach, or have lower baseline indicators and devise plans to improve access to services.
- Districts should prepare also prepare facility plans for high volume facilities, taking in account funds available from untied grant. [5152].
- DHAP also integrate the common goals of related departments like Women and Child Development, School Education, Water and Sanitation, Housing and Urban Poverty Alleviation, Rural Development, Urban Development, and Environment.

Figure 8: Process of District Health Plan (DHAP) preparation


Mission Director sets up formal planning teams at State, and district/City levels
Allocation of Funds by the State to the Districts
Guidelines for District/City disseminated
One day workshop held for the district planning team to explain the key guidelines, criteria and process for approval of district plan and timeframe
States provides detailed formats to district for preparing their respective plans, for easy consolidation in State PIP
Data Collection by District Planning Teams
Setting up of realistic Targets and goals for indicators of service delivery, outputs for district, lower levels including facilities
Organization of District level workshop with stakeholders
DHAP approved by the Governing Body of the District Health Society (DHS) for submission to State
Budgeting done for appropriate provisions, incentives, entitlements and staff compensation
Data Analysis and identification of core issues,in the District and lower levels.
Outcome definition and identification of priority key areas for next three years
Draft Preparation of DHAP
State Programme Implmentation Plan approved , final approval i.e. Records of Proceedings(RoP) are sent to Districts.
Based on the approved plan, funds are released by the State Health Society (SHS).

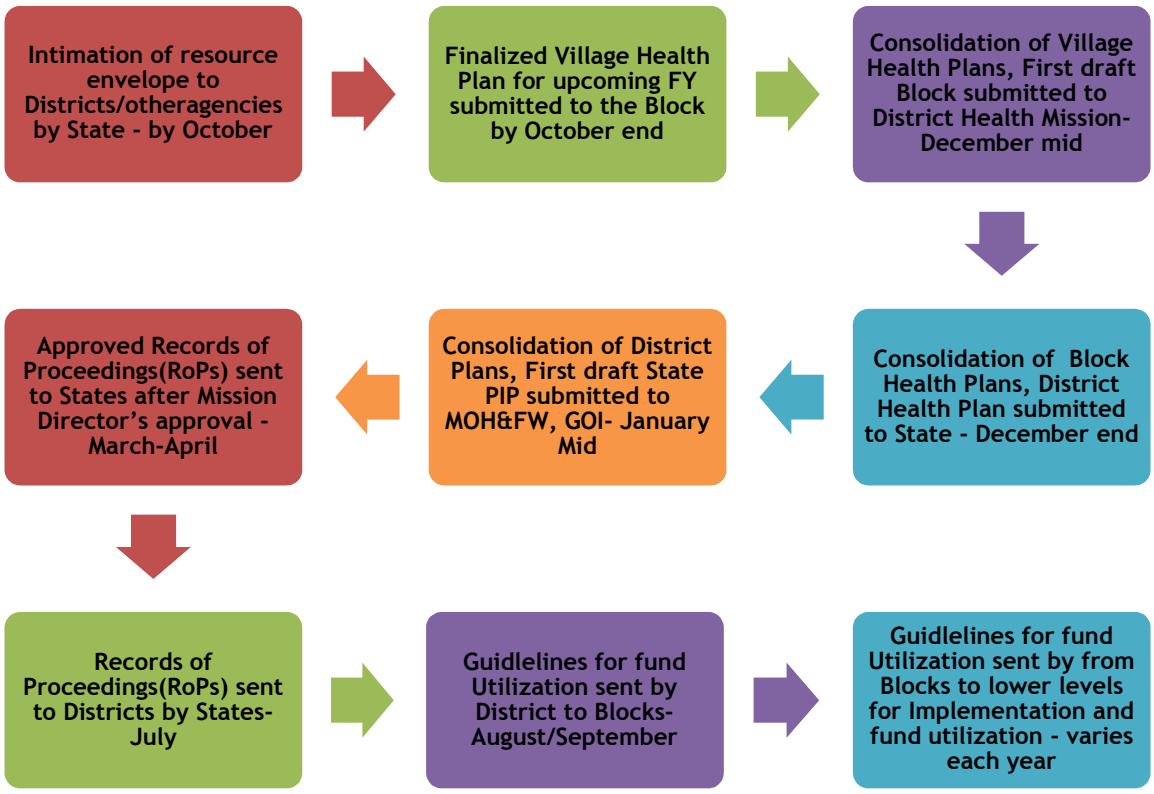


Figure 93: Tentative timelines and Process for preparation and finalization of PIP at the district/ state/ national level

2.8 Best Practices/ State Innovations[53]

NHM encourages innovations by the States and the Districts to meet the local needs. Some of the innovations are given in Table 15 below:

Table 15: Best Practices/State Innovations

S No.	Name of the Best Practice	Name of the State	Details
1	Infection Control by Swachhata Mission Audit	Gujarat	Swachhata Mission monitoring and reporting online data entry Portal
2	Kangaroo Care	UP	Innovative and comfortable Health systems for New born care developed to reduce IMR
3	Overcoming vaccine hesitancy in Measles Rubella campaign	Karnataka	Innovative communication channels used- Awareness campaigns in schools, using Radio Channels as partners for spreading awareness
4	DAMAN –Improving access to malaria control services at	Odisha	Improved Access for the Inaccessible people, vector control interventions, diagnosis and treatment with the help of ASHA workers and others

	community level		
5	Core Dash Board Integrated Hospital Sanitation Monitoring System	Andhra Pradesh	New Scientific Sanitation Policy-2015 for better implementation of sanitation in government hospitals with Hospital Sanitation Monitoring Application (HSMS) for scientific daily Monitoring mechanism and decentralized services

Please refer for more details of the Best Practices/Innovations by the State from National Health Care Innovation Portal.[54]

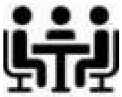
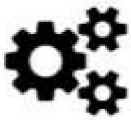
***

3. Roles and Responsibilities of Key District Level Functionaries

3.1 Chair of District Health Society (DHS) *(District Collector/ Magistrate)*

District Collector/ District Magistrate, the Chair of District Health Society is envisaged to play a crucial role at the district level to bring in convergence, both amongst the scheme components and other external resources.

Table 11: Roles and Responsibilities of District Collector/ Magistrate

Role	Responsibilities
PLANNING 	**District Health Action Plan(DHAP)**
	• Facilitate conduct of data collection by planning teams followed by data analysis as inputs for district health action plan
	• Ensure that the district health action plan is based on identified health needs, block/village plans, and available resources
	Manpower/Resources
	• Ensures recruitment of individual/institutional experts to strengthen the technical / management capacity of the District Health Administration.
IMPLEMENTATION 	**Approvals**
	Finalize and approve DHAP and submit to State Nodal Department/SHS for integration into PIP
	Approve district health packages- specific entitlement & incentives for national health programmes based on district specific requirements e.g. JSY, JSSK & family planning etc.
	Approve and oversee receivable, management and accounting for the funds received from the Govt. (including State health Society) for implementation of NHM in the district as the Chairman of DHS.
	Mobilize financial and non-financial resources for implementing/ supplementing the health and family welfare activities in the district.
	Integration & Convergence
	• Steer inter departmental coordination for multi-sectoral intervention required for implementation of DHAP such as nutrition, water and sanitation, education, etc.
	• Act as the nodal officer for district health society & all stake holders- line departments, PRI and NGOs- to participate in various health and family welfare programs and projects in the district.
	Target achievement
	• Guides the district health officials in strengthening of all the district health facilities for preventive, promotive, curative and rehabilitative health services as well as for the district Health knowledge centre, to achieve the defined goals and targets programme wise.
	• Recommends corrective measures to ensure that the programme objectives are achieved and services delivered in an effective as well as efficient manner.
	Capacity Building
	• Ensures capacity building at all levels in the district, are done as planned.
	Grievance Redressal

Role	Responsibilities
	• Institute a formal grievance redressal mechanism for both patients and staff in the district in a time bound manner.
	Fund Management
	• Ensure that the DHS & RKS at District level maintains an exclusive account for receipt and expenditure at the district level
	• Allocate Funds to DHS & RKS as per approved DHAP.
	• Ensure mechanisms for proper utilization of funds and transparent
	• Ensure expenditure statements and Utilization Certificates (UCs) to State Nodal Department timely.
MONITORING& REPORTING 	• District Collector is the overall monitoring authority for the district
	Reports Review /HMIS review/evaluation
	• Monthly review the progress vis a vis the targets in NRHM Dashboards[55]/ HMIS/indicators at the district level.
	• Ensure that physical and financial progress of all the components are reported in the respective HMIS
	• Support external evaluation agencies in their monitoringactivities and review reports of the external evaluation agencies.
	Committees/Meetings
	• Assists District /City Level Vigilance and Monitoring Committee for strict adherence to prudent fiscal norms, inter-sectoral convergence, community participation and monitoring.
	• Regular monitoring and transparent functioning of hospital management societies/RKS in the district as a Chairperson of Governing body.
	• Conducts review meetings quarterly for ensuring the progress of implementation of the District Health Action Plan and National Health Programmes under NHM and provide guidance.
	• Convene the meetings of District Health Mission and District Health Societies on monthly basis or as per State bylaws.
	• Ensures, monitors and supports the implementation of National Quality Assurance standards with District Quality Assurance Officer and coordinate with the State
	Field Visits
	• Undertake regular visits to the health facilities in rural/urban/city areas and ensure the availability of human resource at various levels.

Functions of the Chief Medical Officer (CMO)/Chief District Medical Officer (CDMO)/CMHO/Civil Surgeon assists DM in his above functions i.e. planning, implementing and monitoring activities of the NRHM programme.

3.2 Village/ Block/City / District/Ward Level Officers- Programme Management Unit (PMU)

Table 42: Roles and Responsibilities of Village/ Block/City / District/Ward level Officers- Programme Management Unit (PMU)

Deliverable/ Officer Responsible*		
Village Level **ASHA**	**Block/City Level** **Block Programme Manager (BPM)**	**District/Ward Level** **District Programme Manager (DPM)**
PLANNING		
Health Action Plan/PIP Preparation		
• Village Health Committee (Gram Sabha Pradhan along with the Multipurpose Workers (MPW) and ASHA etc.), provide information on intervention requirements and village level gaps for village level health plans as per local needs. This is done by doing house to house survey, from village health registers and from village health camps. [56]	• Block Health Monitoring and Planning Committee and PHC Health Monitoring and Planning Committees contribute to development of the Block Health Plan, based on an assessment of the situation and priorities for the Block. This is done by PHC and CHC records, Discussions with and interviews of the CHC RKS members, Report of Public dialogue (Jan Samvad), quarterly feedback from village and PHC Health Committees, Periodic assessment of the existing structural and functional deficiencies. There is a PHC Health Monitoring and Planning Committee at PHC level.[57] • BPM coordinate with stakeholders and consolidate Village level health Plans for preparation of Block Level Health Action Plan (BHAP).	• District Health Monitoring and Planning Committee contribute to development of the District Health Plan, based on an assessment of the situation and priorities for the district. This is done from Report from the PHC Health committees Report of the District Mission committee Public Dialogue (Jan Samvad)[58] • DPM Coordinate with stakeholders and lower levels for preparation of District Health Action Plan (DHAP) and approval by District Health Society (DHS). • Brief, consult and assist Chief Medical Officer (CMO) in human and financial resources planning and management related activities. • Coordinate with respective monitoring division and conduct field- level studies to identify gaps for ascertaining intervention requirements and district action plan scope. • Support Block Programme Managers in preparation of the block action plans in line with the district plans.
IMPLEMENTATION		
COORDINATION/LAISIONING		
• ASHA is First portal of call for any health related demands especially for marginalized and in difficult access areas. [59] • **COUNSELLING** ○ Counseling women on birth preparedness, importance of breast feeding and	• Coordinate implementation of activities according to BHAP. • Provide periodic feedback to Medical Officer in- Charge and District Programme Manager on quality of services and status of implementation of programme activities. • Communicate to lower levels	• Coordinate implementation of activities in district according to DHAP and provides logistics support to staff in the field for implementation. • Support Block Programme Managers in development of BHAPs for all NRHM interventions.

Deliverable/ Officer Responsible*		
Village Level **ASHA**	**Block/City Level** **Block Programme Manager (BPM)**	**District/Ward Level** **District Programme Manager (DPM)**
complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection (RTI)/Sexually Transmitted Infection (STI) and care of young child. • **MOBILIZATION** Make house visits and Creating awareness and provide information to the community ○ on determinants of health such as nutrition, basic sanitation & hygienic practice, healthy living and working conditions, ○ Information on existing health services and need for timely utilization of health and family welfare services Mobilizing the community and facilitating in accessing health and related services available at village level. • **COMMUNITY LEVEL CURATIVE CARE** ○ Providing medical care for minor ailments at the grassroots for fever, diarrhea, first aid, sick children, DOTS for Tuberculosis etc. and act as depot holder with provisions like ORS, Iron and Folic Acid tablets, delivery kits. • **ESCORT SERVICES** ○ She will escort pregnant women/children to nearest health facility- PHC/CHC/FRU. ○ She will inform Sub-Centers/Primary health Center about the birth and deaths and any outbreaks in their village. ○ Participate in Block level ASHA Day	under jurisdiction of the Block for the implementation of BHAP. • Support district and state level visit to augment local level coordination. • Planning and monitoring Village Health and Nutrition Day (VHND). • Coordination of meetings of RKS and monitor implementation of decisions taken. • Locate and coordinate with local field level implementation organizations (NGOs, communication implementation agencies, RKS, village health and sanitation committee) and provide logistic support for implementation. • **CAPACITY BUILDING:** Developed capacity building plans for ASHAs, NGOs, RKS and VHSCs.	• Assist CMO in coordinating District Health Society meetings. • Provide periodic feedback to Chief Medical Officer and Regional Monitoring Division on quality of services and status of implementation of programme activities. • Coordinate and liaison with other consultants at State/District/Block levels for implementation of NRHM programme. • Assist CMO in managing human resource including posting, transfer, performance monitoring, training etc. • Provide support to technical consultants at State and field levels during their field visits

Deliverable/ Officer Responsible*		
Village Level **ASHA**	**Block/City Level** **Block Programme Manager (BPM)**	**District/Ward Level** **District Programme Manager (DPM)**
CONVERGENCE		
• Works with women health groups, NGOS, VHSNC, ANMs, Gram Panchayats and Anganwadi workers for implementation of activities at the village level. This is done by attending Village Health and Nutrition Day (VHND) and as a member of VHSNC convenes Village level meeting. • She promotes construction of household Toilets under Total sanitation Campaign	• Liaison with Block level stakeholders to disseminate information and mobilize support for program activities in the Block. • Coordinate implementation with other development departments in the block.	• Coordinate for smooth implementation with other development departments in the district and give inputs for planning convergence activities. • Coordinate with development partners (aid agencies, UNICEF, WHO etc. & other NGOs) in the field and ensure convergence of programme activities.
MONITORING		
FINANCIAL MANAGEMENT & AUDIT[60]		
• Maintain records and reporting of activities and statistics as defined at village level.	• Ensure appropriate receipt and disbursement of funds in accordance with BHAP. • Processing of transfer of funds to VHSCs and SCs. • Ensure appropriate utilization of funds by implementing partners in coordination with data cum account officer and district account manager • Facilitate all audits of the block level units. • Monitoring of physical and financial progress in accordance with the BHAP with Block Accountant under the guidance of BMO. • Ensure submission of utilization certificates for all funds released to BPMUs and also to CHCs in their blocks. • Ensure provision of timely and	• Ensure appropriate receipt and disbursement of funds in accordance with DHAP. • Assist CMO in financial matters control and logistics management • Monitor funds received from State from Part A, B and C of NRHM as per the implementation plan and utilization of blocks/ district level and request for next tranche of funds in time. • Ensure appropriate utilization of funds by implementing partners in coordination with District Accounts Manager. • Obtain timely statement of expenditures and utilization reports from different levels in requisite formats and submission to SPMU. • Preparation and Analysis[61] of monthly and quarterly monitoring reports of the Districts and take corrective action.

Deliverable/ Officer Responsible*		
Village Level **ASHA**	**Block/City Level** **Block Programme Manager (BPM)**	**District/Ward Level** **District Programme Manager (DPM)**
	accurate monthly reporting in the requisite formats to district level Level. • **Regular Field visits** for Physical verification.	• **Regular Field visits** for Physical verification.
PERFORMANCE INDICATORS & PROGRESS MEASUREMENT		
• Ensure timely submission of data as per defined indicators.		

3.3 Block/City / District Level Officers- Community Process Unit

Table 13: Roles and Responsibilities of Block/City / District level officers- Community Processes Unit

(Please note that Village level officials and their roles in Community Processes are same as Programme Management Unit.)

Deliverable/Officer Responsible*	
Block/City Level **Block Community Process Manager/Block Community Mobilizer**	**District Level** **District Community Process Manager/ Community Mobilizer/ District ASHA Programme Coordinator**
PLANNING	
HEALTH ACTION PLAN/PIP	
• Works with VHSNCs in completion of all the village health plans and contribute in preparing the community processes section of the block/ district health action plan and funds planning;	• Support Block Programme Managers in developing localized communication and implementation plans. • Facilitate compilation of communication plan and funds plan, of the Block health action plans and preparation of communication plan at the District level (as a part of DHAP), with Block Programme Managers.
IMPLEMENTATION	
COORDINATION & LAISIOING	
• Coordinates with district level functionaries, BPMU and Block Medical Officer/ In- Charge to ensure efficient implementation of community process. • Facilitating regular conduction of RKS meetings and helping block officials in preparation of RKS expenditure plans based on the identification of the specific facility requirements. • Replenish ASHA kits, supplies etc.	• Liaise with district level stakeholders to disseminate information and mobilize support for programme activities. • Develop TOR for selection of implementing agency and taking approval from SPMU/DHS through CMO. • Follow up with Block Programme Managers on working of RKS • Conduct and oversee community mobilization and awareness campaigns for all programmes in the District. • Ensure operationalization of all Delivery points for institutional deliveries and entitlements and incentives to ASHA for JSY, JSSK etc. • Ensure ASHA uniforms and functional ASHA Rest Rooms, Replenish ASHA kits, logistics support, drugs and consumables • Ensure Database updation and selection of ASHA and ASHA facilitators as per norm.

Deliverable/Officer Responsible*	
Block/City Level **Block Community Process Manager/Block Community Mobilizer**	**District Level** **District Community Process Manager/ Community Mobilizer/ District ASHA Programme Coordinator**
DATABASE OF FUNCTIONARIES • Reports and maintains a facilitator wise data base for the profile of every ASHA, training status and dropouts; ASHA selection, payments to ASHA, regular supply distribution and replenishment of ASHA Kits • Supports the formation and improved functioning of VHSNCs and maintains database of VHSNCs for their training, functionality, expenditure and back logs;	
CONVERGENCE • Establishes smooth working relationships with block level functionaries of other government departments such as; WCD, Water and Sanitation and Rural Development to avoid/ solve issues related to field level in coordination or conflicts if present.	• Develop communication network inter and intradepartmental with District Level functionaries & with community resources for optimal implementation of the programme and coordination. • Coordinate with State ASHA and Community Process Resource Centre & DHS to ensure training calendar, organize and supervise trainings for ASHA, ASHA facilitators and VHNCS members. • Supervision and monitoring of the ASHA support mechanisms with the support of NGOs.
CAPACITY BUILDING & HANDHOLDING • Evaluation of skills and knowledge of ASHA and ASHA facilitators after the trainings. • Support for improving HMIS/MCTS data quality through supportive supervision and onsite mentoring ANM and ASHA; • Supporting orientation of field staff/ASHAs with Community Based Monitoring tools, implementation, organization of Jan Samwaad and overall support to the programme	
MONITORING	
COMMUNITY MONITORING • Facilitating Community participation activities, NGOs involvement, VHSNC formation, its regular meeting, and utilization of untied funds in the block.	• Facilitating Community participation activities, NGOs involvement, VHSNC formation, its regular meeting, and utilization of untied funds in the district.
PERFORMANCE INDICATORS & PROGRESS MEASUREMENT	
	• Document field level innovations, achievements and challenges in

Deliverable/Officer Responsible*	
Block/City Level **Block Community Process Manager/Block Community Mobilizer**	**District Level** **District Community Process Manager/ Community Mobilizer/ District ASHA Programme Coordinator**
• Undertakes monthly block level compilation of performance indicators according to the formats submitted by ASHA Facilitators, to assess functionality of ASHA on key tasks. • Further, identifies the poor performing ASHAs, assess the causes of low performance and devise strategies for improvement; • Support in identification and selection of best ASHAs for felicitation at ASHA Sammelan and overall support in ensuring their participation in the Sammelan; • Helping the ASHA Facilitators and block officials in identifying and narrating best ASHA stories based on exceptional performance.	implementation of programme. • Furnish district news for inclusion in ASHA newsletter and distribution of ASHA Bullet to stakeholders, district and state levels. • Ensure data collection and reporting systems from grass root levels, in HMIS and monthly review. • Ensure timely reporting of Maternal Deaths, Child Deaths and Births. • Ensure completion of monitoring progress performance reports, field visit reports (Random & Planned) in the requisite format on a monthly basis. • Seek feedback of district level activities from monitoring division as compared to other district. • Undertake monitoring of interventions implementation agencies, including GOs, in line with their implementation plans.
	• Responsible for coordination and monitoring of community led activities in the District- ASHAs, VHSNC, and Village Health & Nutrition Days etc.
REVIEW MEETINGS	• Conducts Block wise review and ensures full and timely payment of all ANMs. • Monitors and reviews ASHA performance of its functions, ASHA meetings and VHND sessions as per schedule.

• Participating in district review meetings with complete and updated status of various Community Process programmes being implemented in the concerned block;
• Organizing block review meetings every month on a fixed day, in coordination with Block Medical Officer In-charge (BMOIC) and Block Programmer Manager for facilitating:
  ○ Periodic refresher trainings, capacity building, updating information and sharing new guidelines;
  ○ Review and assessment of performance of ASHAs along with trouble shooting;
  ○ Replenishment of ASHA drugs/ equipment kits;
  ○ Verifying records and release of payments;
• Provides supportive supervision and continuous monitoring through – monthly meeting of the ASHA facilitators at block headquarters and field visits to assess functionality and handholding ASHA Facilitators and ASHAs;
• Review and assess the functionality of	

Deliverable/Officer Responsible*	
Block/City Level **Block Community Process Manager/Block Community Mobilizer**	**District Level** **District Community Process Manager/ Community Mobilizer/ District ASHA Programme Coordinator**
VHSNCS in terms of regular meetings, fund utilization etc. • Supporting micro planning, quality activities, monitoring and reporting of Sub-Centre level AAA forum meetings in the selected districts.	
Regular Field visits	
• For Physical Verification and supervision.	○ Ensuring operationalization of delivery points District wise review of operation and status, HMIS review. ○ Field visits to facilities for physical verification and supervision visits and monitor quality of intervention implementations- IFA tablets, home based care etc. ○ Ensure adoption and implementation of localized communication interventions, identify gaps and take corrective action
• **Designations included in the table are indicative and generic in nature. States may have different administrative structures for implementation**	

4. Accountability, Monitoring[62], and Reporting

4.1 Accountability Framework [63]

Accountability frameworks are developed at all levels for making executives accountable for the services provided and for better review of the progress of the programme.

1. **REVIEW MEETINGS:** The Governing Body and Executive Committees of the DHS hold regular review meetings (at least annually and thrice a year respectively). The DHS (Chairperson and Member Secretary) is also answerable to Legislature and Parliament. RKS at the facility level also plays a similar role.

2. **AUDITS:** NRHM is subjected to Comptroller and Audit General (CAG) audit as well as audit by Charted Accountants, down to district and block levels. All districts have a system of periodic concurrent audit and an annual audit. All audit reports have to be presented and reviewed in the Governing Body Meeting of District Health Society under the Chairmanship of District Collector.

3. **Community monitoring** of facilities supported by NGOs:

   - Community monitoring itself brings in accountability.
   - Health Monitoring and Planning Committee at PHC, Block and District levels ensure community monitoring activities and use these inputs for developing Health Action Plans and PIP.
   - Periodic Jan Sanwad or Jan Sunwai where direct feedback is provided by the community/beneficiaries.
   - Special Rapporteurs are appointed by the mission to carry out field visits and evaluate the progress of programme. Mentoring group of ASHA and Regional Resource Centres are also involved. Sample household and facility surveys are done by external research organizations/NGOs.
   - Public health surveys by district /Block level Mission Teams/ research and resource institutions at PHC, CHC and District levels to verify whether patients are receiving their entitlements.
   - Display of Citizens Charter with rights of the citizens, User Charges and Agreed Entitlements and service guarantees, at prominent locations in the facilities.

4. **DISHA District Development Coordination and Monitoring Committee (DISHA) / District Level Vigilance & Monitoring Committee (DLVMC)**[64]

The DISHA /DLVMC is constituted to monitor the progress of implementation of National Health Mission (both NRHM & NUHM) under the overall Framework of Implementation. This committee is chaired by MP of Lok Sabha in each District. The committee is mandated to review the inter-sectoral convergence, community monitoring mechanisms, management information system etc.[65]

4.2 Monitoring[66] & Evaluation Activities

There is a multi fold approach for monitoring. This includes

i. Large scale population surveys
ii. Evaluation studies or research on implementation
iii. HMIS data
iv. Field visits by officials.

1. **Periodic Population Health Surveys and Demographic information**
Periodic Sample Registration Surveys (SRS), Death statistics, National Sample Survey Organization (NSSO) data on cost of care and morbidity, District Level Household survey (DLHS) and National Family Health Survey (NFHS) is done to give insights into the functioning of NRHM.

2. **Evaluation studies or research on implementation**[67]
Expert groups from multiple organizations are involved for conducting independent evaluation of all components of NRHM. Evaluation of the programme implementation in districts is done by Regional Evaluation Teams and reports are available in public domain.

3. **Strengthening Data Capturing: Health Management Information systems (HMIS)**[68]:
Data is regularly uploaded from all levels, facility wise and programme wise and is monitored by the District Teams.
Health Management Information System (HMIS) Reports: HMIS is a web based monitoring system to capture information from the primary levels and is consolidated at State Level on a monthly basis. This is used to monitor performance of health programmes at facility and district level and thus helps in timely corrective action

The information from HMIS and other sources like National Family Health Survey (NFHS), District Level Household Survey (DLHS), Census, SRS and performance statistics, is compiled into the **NHM Health Statistics Information Portal**.[69]

Data Analysis is done based on the data uploaded and further used for development of Scorecards/Grading of CHC/Dashboards of performance based on key performance indicators for Grading of Districts all over the country. [70] Process and Outcome (Mortality and Morbidity rates) indicators for diseases and Output indicators for programmes, are measured and monitored regularly. Suitable corrective actions are

taken for facilities with low scores and reward/recognition for high performing facilities. Achievement of goals of Universal health care i.e. out of pocket expenditure by patients, percentage of access/coverage of people for specific services, assured services access and availability on a cashless basis is also monitored. This is an important monitoring tool used by District level Programme Managers.

State and District wise analysis reports are published and are available in the public domain. [71]

4. Access of services to disadvantaged communities of various geographical areas is monitored by surveys and MCTS reporting system. **Mother and Child Tracking System (MCTS)**[72] is a web- based application to monitor Maternal and Infant Mortality, by facilitating tracking of Case specific pregnant women (both ANC and PNC), child births and immunization of children up to five years of age. It is a tool which sends regular alerts to the service providers as well as beneficiaries about the services, to ensure the continuity of services.

5. **Field Visits/Appraisal Visits:** by public health experts. Reports of Common Review Mission (CRM) annually, integrated monitoring teams of the Ministry, the Regional Directors, and the Population Resource Centers (PRC) are some of the important ones. There are regular monitoring visits from the Programme Management Units from States, Districts and Block to respective lower levels under their jurisdiction.

6. **Training Information Management System(TMIS)**[73]**:** It is an online database from district level and above, which captures details of trainings(Guidelines, manuals, course content, real time trainings, nominations, registrations, post training evaluations, deployment of staff etc). This is used for monitoring of in-service trainings of health professionals in India on a single mouse click.

7. **Quality Monitoring**

   a. **Quality Assurance in Public Health Facilities**[74]

GoI has rolled out the "National Quality Assurance Standards (NQAS) Guidelines" in 2013. These guidelines define a 'road map' for implementing and improving quality standards of Public Health Facilities. Each healthcare facility has in- house Quality Management System and Ranking of the facilities is done based on performance against predefined standards. There is a State Level and District Level Quality Assurance Cell (State Quality Assurance Committee (SQAC) & District Quality Assurance Committee (DQAC)) coordinating these activities.

   b. **Mera Aspataal**[75]

GOI recently initiated an ICT- based Patient Satisfaction System (PSS) i.e. "Mera Aspataal/ My Hospital". This to empower the patients to express their views on the health services delivered in a public facility and empanelled private hospitals.

5. National Urban Health Mission (NUHM)

5.1 About the Scheme [76]

As a response to stagnation and even worsening of key health indicators in urban areas, the NUHM was launched in 2013. Urban health issues[77] are distinct and unique, requiring new skills and capacities for analyzing complex urban scenario, assessing differential health needs and innovating novel context-specific solutions. The NUHM aims to provide comprehensive primary healthcare services to the urban poor and enable convergence with social determinants that have a direct bearing on the health of marginalized and vulnerable population in urban areas. Urban health facilities under NUHM are envisaged as having robust upward and downward linkages to address urban specific needs. The figure below gives a population based structure of urban service delivery model under NUHM:

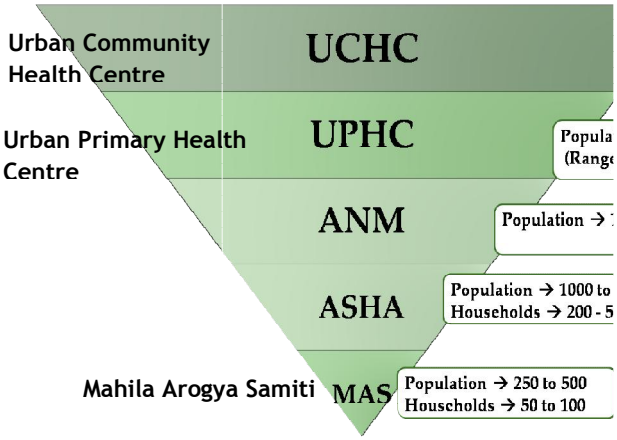


Figure 10: Population based service delivery model under NUHM[78]

NUHM strategies are designed to target populations[79] such as the homeless, rag pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants. NUHM also emphasises building partnerships with for profit & not-for-profit sectors for urban health-care delivery. NUHM focus goes beyond health to cover wider determinants of health like-air pollution, solid waste management, water quality, occupational safety, road safety, housing, vector control, reduction of violence and urban stress.

Mahila Arogya Samiti[80]: is a Community group of 5-20 women from a slum area, covering 50-100 household's i.e. 250-500 population. They are involved in behaviour change promotion and communication on Health and Hygiene and facilitating community risk pooling programmes in their coverage area. This is to improve access to healthcare at household level. ASHA may provide leadership to

MAS. Each MAS has an elected Chairperson/Secretary and another representative like Treasurer. NUHM gives an annual grant to MAS of Rs 5000 every year.[81]

5.2 Goals, Objectives and Strategies of NUHM[82]

Table 14: Goals, Objectives and Strategies of NUHM

Goals	Objectives	Strategies
1.Identify marginalized and vulnerable pockets and improve the status of health care delivery services to cover entire urban population	1. Operationalizing program management units at State, District and city level 2. Mapping of vulnerable population & health facilities 3. Setting up urban health facilities (Urban Primary Health Centres- UPHCs, Urban Community Health Centres- UCHC) as per the population norms* 4. Developing a network of community healthcare workers (ASHAs and Mahila Arogya Samities - MAS)	1. Mapping of vulnerable population in the urban area 2. GIS mapping of city to mark location of major landmarks, slum and vulnerable pockets, government and private health facilities with their catchment areas 3. Constituting Urban Primary Health Centres (UPHCs) and Urban Community Health Centres (UCHCs) as per the population norms and in proximity to slums 4. Providing adequate HR, infrastructure and resources to the facilities 5. Establishing UPHCs as centres for assured comprehensive primary health care services (clinical, diagnostic, Non Communicable Diseases and outreach) and multi-directional referral units 6. Mobilizing community to UPHCs with the help of ASHAs and MAS 7. Forming referral linkages of UPHCs with UCHCs, DH, Nutrition Rehabilitation Centres (NRCs), Mental health clinics, de-addiction centres, palliative care hospices, homeless shelters and domestic violence help centres etc. 8. Conducting regular outreach services (UHNDs & Special outreach sessions) in remote vulnerable areas
2.Link urban health with other social determinants of health like clean drinking water, sanitation, pollution, solid waste management, nutrition, education etc.	5. Convergence[83] with Urban Local Bodies (ULBs) and other Ministries at State and ward level.	9. Convergence of NUHM with all National Health Programmes 10. Ensuring regular convergence[84] meeting of officials from MoHFW with officials from other Ministries like Ministry of Urban Development, Ministry of Women and Child Development, Ministry of Housing and Urban Poverty Alleviation, Department of AYUSH etc.

5.3 Institutional Framework[85]: Resource Planning in NUHM

The National Urban Health Mission leverage on the institutional structures of the NRHM at the National, State and District level for operationalisation of the NUHM. However in order to provide dedicated focus to issues relating to Urban Health the institutional mechanism under the NRHM at various levels are strengthened for NUHM implementation.

1. **State Level:** There is a separate Urban Health Cell for NUHM at State level, reporting to State Mission Director.

2. **District Level:** At the District level the States may either decide to constitute a separate District Urban Health Missions/ District Urban Health Societies or use the existing structure of the District Health Society / Mission under NRHM with additional stakeholder members.

At the district level, the management of NUHM activities may be coordinated by a District level Urban Health Committee headed by the District Magistrate/ Additional District Magistrate/Sub Division Magistrate based on whether the district is a district headquarters or a sub-division headquarter. This would help ensure better coordination with municipal departments like sanitation, water, waste management, especially in times of response to disease outbreaks/epidemics in the district.

Further for enhancing the Program Management, a District Program Management Unit (DPMU) may be established. The staff at the District PMU level may be as proposed below:

(i) Urban Health Data Manager/Coordinators.

(ii) Urban Health Accounts Manager

(iii) Consultant (Epidemiologist)

The National Urban Health Mission would promote participation of the urban local bodies in the planning and management of the urban health programmes.

Components, Fund management, Fund flow and Monitoring and Accountability of NUHM are on the same lines as NRHM and thus refer Section 2 of this document for details.

5.4 Convergence [86]

Following areas of Convergence are present in NUHM. Some other areas of Convergence are already mentioned in Section 2.3.2 of this document.

A. **Ministry of Urban Development and Ministry of Housing and Urban Poverty Alleviation: Convergence with Jawaharlal Nehru National Urban Renewal Mission (JnNURM):** Basic Services to the Urban Poor (BSUP), which is a sub mission of JnNURM mandates the provision of health services to the urban poor via a seven point charter, namely security of land tenure, affordable shelter, water, sanitation, education, health and social security.

B. **Convergence with Rajiv Awas Yojana (RAY):** GIS based physical mapping of the slums and the spatial representation of the socio-economic profile of slums (Slum MIS) is being undertaken under RAY. This will also be useful for development of city health plans.

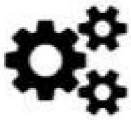
C. **Convergence with Swarn Jayanti Shahri Rozgar Yojana (SJSRY)**: The community level structures under NUHM can be strengthened by effectively aligning them with the SJSRY structures.

D. **Ministry Of Human Resource Development;** Convergence with School Health Programme for Medical Examination of children and health education activities.

5.5 Roles and Responsibilities of District Health Society in Urban Areas (NUHM)

District Urban Health Coordinator will assist the District Magistrate (DM) and Chief Medical Officer (CMO) in implementation of these roles and responsibilities:

Table 15: Roles and Responsibilities of District Health Society in Urban Areas

Role	Responsibilities
PLANNING 	• Ensure that the program management units in state, district and cities are in place and stationed with adequate & qualified HR, infrastructure and resources
	• Facilitate vulnerability assessment and GIS mapping of the districts
	• Ensure that the session sites chosen for outreach are located in remote areas away from urban health facilities, to expand benefits to extremely marginalized population
IMPLEMENTATION 	**COORDINATION & LAISIOING:**
	• Organize population based screenings for NCDs.
	• Facilitate UPHCs to develop strong referral linkages with centres of urban specific needs like Nutritional Rehabilitation centres, mental clinics, de-addiction centres, homeless shelters, palliative care centres and domestic violence shelters etc.
	• Facilitate land allotment for identified UPHCs or support the rented UPHCs in rationalizing the rent costs
	• Facilitate increased coverage through allotment of community halls for conducting special outreach sessions
	• DDeveloping un-used open spaces into clean and green belts/ gardens for public
	• Enable Vector control by ensuring adequate supply of anti-larval sprays and pesticides
	• Facilitate districts to design innovative projects for improving health and living standards in urban vulnerable areas
	REVIEW MEETINGS:
	• Facilitate meetings of urban frontline workers from NUHM (ANMs, ASHAs and MAS) with ground level workers of other programs like Self Help Groups (SHGs) from National Urban Livelihood Mission (NULM) and Swacchagrahis from Swachh Bharat Abhiyaan (SBM) etc.
	• Chair(by DM) regular convergence meeting of health officials with ULBs and related departments and ministries

Role	Responsibilities
	CAPACITY BUILDING/PPP Model
	• Explore the possibilities of PPP models with private providers and partnerships with NGOs and academic institutions to fill the gaps in service deliveries if any.
MONITORING 	• Ensure UPHCs are providing patient friendly, high quality comprehensive primary health care services.
	• Ensure the formation of RKS in urban health facilities and regularly monitor fund utilization
	• Ensure maintenance of proper channel of waste collection from source (Household/ commercial establishments) to solid waste management plant, which will avoid development of waste dumping grounds in community areas and open spaces
	• Regular check on air, water, land and noise pollution and make regulations to charge penalties from people/institutions violating them
	• Regularly check the condition of drinking water pipelines and sewerage pipelines for any leakage/ damages

NHM- IMPLEMENTATION MONITORING PROFORMA (YEARLY REVIEW SHEET with MONTHLY REPORT FORMAT)
[For District Level Functionaries based on the District Action Plan (DAP)]

Below are Yearly Review Sheet format and Programme wise monthly monitoring formats of Key Performance Indicators used at District Level. Financial Monitoring Report (FMR)[87] is uploaded on HMIS by the district regularly
Expenditure reports, Utilization Certificate and MIS are also submitted to the State level regularly.

Summary Yearly Review Sheet Format for Districts (From Data Analysis reports of HMIS) [88]

State ……..-District…….Year……

1	Proportion of ANC registration against Estimated pregnancy: % - ……Total reported: ……
2	Proportion of ANC registration in first trimester against reported ANC registration: ……..% - Total reported: ……
3	Proportion of 3 ANC Check up against reported ANC registration: …….. % - Total reported: ……
4	Proportion of Deliveries (Home + Pub + Pvt) against Estimated Deliveries : ……..% Total reported :…….. , Home Deliveries : ……., Institution Deliveries (Pub) : ……. Institutional Deliveries (Pvt): ……..
5	Proportion of Institutional Deliveries (Pub + Pvt) against Estimated Deliveries …% - Total reported : ……
6	Proportion of C-Section Deliveries (pub + Pvt) against total Institutional Deliveries(Pub + Pvt) : ……..% - Reported C-Section Deliveries :……..; in pu facility : ……. and in private facility : ……
7	Percentage Newborn visited within 24 hours of Home deliveries: ……. -Total Visited: ……. Total Home Deliveries: …….
8	Percentage PNC Visits within 48 hrs of delivery against total deliveries is…….. %
9	Sex Ratio at Birth: …… Male Live Births: …….. and Female Live Births: ……
10	Percentage Newborn weighed less than 2.5 kg against total live births : …….. %
11	Measles (……..) given is less than BCG (……..) by ……..%
12	Percentage fully immunised infants (0 to 11 months) against Estimated live births: ……..% Total fully immunised infants (BCG, 3 doses of OPV, DPT & Measles) : ……
13	Total sterilisations reported : …… ; Male sterilisation :……% (……number) ; Female sterilisation :……% (……number)
14	Total IUD Inserted (Pub + Pvt): ……
15	Deaths due to sterilisations - Male: ……; Female: ……
16	Total OPD reported = …….. which is …….. OPD per 1000 population; Total IPD reported = ……..which is …….. IPD per 1000 population
17	Infant deaths = …… Under 5 deaths = …… Maternal Deaths = …… and Deaths due to other causes = ……..

Monthly Status of OPD, IPD and Bed Occupancy rate

Name of the Health Facility /Block wise(depending on number of the units)	OPD Status		IPD Status		Bed Occupancy Rate, BOR: (Total Patient bed days *100/Functional beds*days in month	
	No. Of OPD Month Last Year	No. of OPD same month Current Year	No. Of IPD Month Last Year	No. of IPD same month Current Year	Month Last Year	Same Month Current Year
1	2	3	4	5	6	7

Monthly Status of Janani Surakhsha yojna Scheme

Facility /Block wise(depending on number of the units)	Number of estimated deliveries/year	Total number of institutional deliveries in Government facilities till this month	Number of deliveries in registered private institutions till this month	Number of deliveries in non registered private institutions till this month	Total number of institutional deliveries (column3+4+5)	Percentage Target achieved (6/2)	No. of patients paid Rs 1400 incentive (Rural)	No. of patients paid Rs 1000 incentive (Urban)	% of Patients paid incentives(8+9/3)	No. of ASHA who had to be paid incentives	No. of ASHA who were paid incentives	No. of Total home deliveries beneficiaries	No. of beneficiaries out of column 10 who have been paid	No. of estimated Maternal Mortality in this month	Actual reported number of Maternal Mortality Cases	No. of cases audited by the CMO herself
1	2	3	4	5	6	7	8	9	10	#	12	13	14	15	16	17

Monthly Status of Janani Shishu Suraksha Yojna Scheme

Sno./Name of Block	No. of deliveries conducted in Block levels and above facilities		No. of beneficiaries who have stayed for 48 hours			No. of beneficiaries who have received free diet		No. of beneficiaries who have received drop back facility			Total number of pregnant ladies who have come to any government facilities		No. of pregnant ladies who have received free consultation			No. of pregnant ladies who have received free drugs & Diagnostic services			Average percentage of all services provided under JSSK
	Month	Cumulative till now	Month	Cumulative till now	Percentage %(5/3)	Month	Cumulative till now	Month	Cumulative till now	Percentage %(11/3)	Month	Cumulative till now	Month	Cumulative till now	Percentage %(16/14)	Month	Cumulative till now	Percentage %(19/14)	(6+9+1+2+17 +20)/5
1	2	3	4	5	6	7	8	10	11	12	13	14	15	16	17	18	19	20	21

Monthly Status of Routine Immunization

District:							
Month:							

S. No./Name of Block/Facility	Target children in Current Financial year	Children registered on MCTS portal in Current Financial year	Percentage of Children registered on MCTS portal in Current Financial year (Percentage:3/2)	Target for fully immunized children (0-12 months) on MCTS portal last Financial year	Total number of fully immunized children(0-12 months) on MCTS portal last Financial year	Percentage of fully immunized children (0-12 months) on MCTS portal last Financial year : (Percentage : 6/5) (cumulative)	Percentage of fully immunized children on HMIS portal (0-12 months) (cumulative)	District level immunization task force meetings held till date
1	2	3	4	5	6	7	8	9

Revised National Tuberculosis Control Program Monthly Monitoring Format

S. No.	Description	Target	Achieved	Percentage
1-	Total Chest symptomatic patients referred from OPD	More than 2%		
2-	Total New Adult OPD			
3-	Total Cases	256/Lac		
4-	Total Patient detected per Lac			
5-	New sputum positive patients	95/Lac		
6-	New sputum positive patients per Lac per year			
7-	Conversion rate (NSP) - %	90%		
8-	Cure rate (NSP) - %	85%		
9-	Default Rate NSP (%)	Less than 3%		
10-	Death Rate NSP (%)	Less than 4%		

* Dummy data entered in the above table for better understanding

Pre Conception, Pre Natal Diagnostic Technique Act (PCPNDT)								
Sno.	As per census 2011	Total Centres registered under PCPNDT Act	Total number of centres suspended	No. of Inspections done by competent authority	Total number of inspection done by Decoy	Action taken by inspector	Advisor committee meetings held	Comments

	Sex ratio in the district	Sex ratio between 0-6 years			In this Month	Till month end	Percentage(7/4)	In this Month	Till month end	Total number of unregistered clinics caught	Total number of clinics closed	Total number of appeals received by competent authority	Total Number of clinic suspended	Total number meetings held in a month	Total number of meetings held till month end	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17

Monthly MCH tracking by MCTS System

S.no	Indicators for Name based Tracking of Pregnant Mothers and Children	Numbers (during month)	Cumulative number till this month	Annual Target
1	Total Number of Women registered for ANC			
2	Total Deliveries (sum of 2.1 to 2.3)			
2.1	Total deliveries at Home			
2.2	Total deliveries at Public Institutions			
2.3	Total deliveries at Private Institutions			
3	Total Women given PNC Check-up			
4	Total Live Births (4.1 + 4.2)			
4.1	Male			
4.2	Female			
5	Total number of Children given BCG			
6	Total number of Children given Measles			

ABBREVIATIONS

AMG	Annual Maintenance Grant	IMR	Infant Mortality Rate

ANM	Auxiliary Nurse Midwife	JSY	Janani Suraksha Yojana
ASHA	Accredited Social Health Activist	MIS	Management Information System
ATR	Action Taken Report	MO	Medical Officer
AWW	Angan Wadi Worker	MoHFW	Ministry of Health and Family Welfare
BAM	Block Accounts Manager	MOIC	Medical Officer In Charge
BCHC	Block Community Health Centre	MMR	Maternal Mortality Rate
BEE	Block Extension Educator	MPW (M)	Multipurpose Worker (Male)
BMO	Block Medical Officer	MSW	Master in Social Work
BPHC	Block Primary Healthcare Centre	NA	Not applicable
BPM	Block Programme Manager	NDCP	National Disease Control Programme
BRS	Bank Reconciliation Statement	NPCC	National Programme Coordination Committee
CA	Chartered Accountant	NRHM	National Rural Health Mission
CDMO	Chief District Medical Officer	PHC	Primary Health Centre
CEO	Chief Executive Officer	RCH	Reproductive and Child Health
CHC	Community Health Centre	RKS	Rogi Kalyan Samiti
CMO	Chief Medical Officer	RoP	Record of Proceedings
CM&HO	Chief Medical & Health Officer	SAM	State Accounts Manager
DA	Data Assistant	SFM	State Finance Manager
DAM	District Accounts Manager	SFP	Statement of Fund Position
DHAP	District Health Action Plan	SHS	State Health Society
DHS	District Health Society	SPMU	State Programme Management Unit
DPM	District Programme Manager	SPIP	State Project Implementation Plan
DPMU	District Programme Management	SoE	Statement of Expenditure
FMG	Financial Management Group	SC	Sub- Centres

FMR	Financial Monitoring Report	ToR	Terms of Reference
GOI	Government of India	UF	Untied Fund
GFR	General Financial Rule	UC	Utilization Certificate
IDHAP	Integrated District Health Action Plan	VHSC	Village Health Sanitation Committee

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