SECTION III -- Finance

SECTION I

SITUATIONAL ANALYSIS

Chapter 1

INTRODUCTION

National Capital Territory of Delhi can today boast of some of the best equipped hospitals and some of the most qualified medical personnel across the world. It is becoming a hub of medical tourism wherein patients across the borders pour in to get quality treatment at costs less than than those prevalent in the more developed nations. Ironically the same state is finding it hard to provide a reasonably sound and responsive Primary and Secondary healthcare system for those of its habitants who cannot afford to pay. “The Tale of two cities “ phenomenon is specially pronounced in Delhi.

1. State’s Social Sector developmental Challenges (as per Human Development report 2006 Delhi- UNDP Joint Report)

- 45% living in slums of which 1087 JJclusters with 30 lac population is one such of many impoverished settlements
- 25% population without access to piped water supply(2001)
- 1.99 million Households without toilet facility (2001).
- 45% population without any sewerage services
- Environmental pollution (fly ash power plants), solid waste management & improper handling of biomedical waste still remains a challenge
- 8% population BPL(2000)
- An estimated 1 lac street shelter less out of which > 50% are children & vulnerable women – lacking basic facilities.

2. Health Sector Challenges (as per UNDP report- 2006 on Human Development- Delhi)

- IMR though half of National average, it is still higher than 11/1000 live births in Kerala.
- Incidences of many communicable diseases though dropped significantly yet remains potent threat to vulnerable groups- slums ,constuction sites, inadequate drainage, deteriorating water quality, sanitation , environmental degrading
- Life style disease load steeply increasing (affluence interspersed with deprivation)
- 29% population in Delhi depends on Public Medical facilities out of which 39% are households from ‘poor’ living standards
- Overcrowded hospitals & facilities needing improved management
- 53% population seeks private medical care

- 44% population seeking private care & 21% of those seeking Govt care facilities are satisfied with services received– need for quality assurance & regulations
- Bed: Patient ratio = 2.07 per 1000 patients
- Life expectancy at Birth=69.6 years (against 62.9 at National level)

Although the State is fully alive to its responsibility and intensive effort has been on, but the investment in terms of planning and resources has not shown proportionate results . There are multiple reasons for this . Arrival of Mission provided the opportunity to take stock and formulate a road map. No ready answers / quick solutions are available but if we are honest and committed to find solutions , persevere in our efforts , acknowledge mistakes and make online corrections , things will change.

Over Last one year :

1. Issues which were always there as major bottlenecks but were taken for granted as insurmountable have been flagged off for finding solutions .
2. A State level , District Level and Ground level task force is emerging which feels passionately about improving things. All the District level NRHM officers are engaged in the programme with great enthusiasm and sincerity. It is borne out by the fact that none of the districts have taken any extraneous help in writing their DHAPs and all the districts have prepared them. There is still a lot of scope for improvement and it will come.
3. State and District Programme Management Units are in place .
4. ASHA Scheme is being implemented in the State . 2266 ASHAs have already been selected and are undergoing training.
5. MAMTA Scheme is being implemented and Nursing Homes have started coming forwarded for entering the scheme.26 MOUs have already been signed.
6. Developing PPP for diagnostics scheme is in its final stages.
7. Facility Surveys for the Primary Healthcare facilities and Maternity Homes completed.
8. Handholding between major stakeholders ie. Delhi Govt / MCD/ NDMC begun.
9. Facility specific strengthening plans for the Maternity homes prepared and will be implemented in the current year.

10. The Public health standards applicable to urban structures – PUHC and Maternity Homes are being laid downand will be available by March end 2008.

11. GIS Mapping of health facilities and the populations is being done and will be available by March end 2008.

Chapter 2

Planning Process

The Principal Secretary Health & Family welfare Govt of Delhi, the Mission Director ,the State Health Society supported the efforts & Consultation processes at the level of the States Directorates of Health & Family welfare with their respective State Programme officers & the teams of respective Integrated District Health Societies from the 9 districts facilitated by continuous interactions, main among them being the two day workshop at Delhi secretariat organized for DHAP formulation. The micro level inadequacies of the system / bottlenecks in implementation were listed through such consultative .

At the district level , district programme officers have been identified for various programmes . State and District Nodal officers have also been identified by MCD for coordination of planning activities .

The District Health action plans have been formed through the consultative process amongst all stakeholders , State and district programme officials, and DPMU Staff.

State PIP has been based on the requirements projected by the districts. Also wherever necessary , gap addressal has been left to the parent agency.

Revitalisation of the existing health facilities has been stressed upon rather than setting up new structures.

Solutions are not so simple to find in Delhi. Detailed situational analysis and the emerging road map are stated in chapter on situational analysis.

Bottlenecks which the plan seeks to address are:

- Lack of benchmarks and standards especially for the primary health care facilities where the IPHS are not applicable.

- No population wise/geographical assignments and hence no accountability and a compromised service delivery. This is being addressed in phased manner under the plan.

- Large unserved and underserved areas because of increase in population and inequitable distribution of health infrastructure -- geographically and Population wise and large continuous influx of migrant population from neighboring States- being addressed in phases.

- **Suboptimal functioning** of the existing units because of various constraints.

- Lack of emphasis on Preventive and Promotive services.

- Paucity of FRUs and therefore Lack of defined referral linkage leading to overburdened Tertiary care facilities.

- Major determinants of health – Nutrition , Water and Sanitation needing more focus

- Delhi being peculiar, **having the very rich** and **the very poor** population co-existing, reflecting **problem of health due to plenty** and **problem of health due to deprivation,** under the NRHM planning, for the present, the state prioritizes giving attention to the under-privileged, deprived, malnourished, marginalized, previously un-served or underserved populations.

- **No PRIs / scant CBOs .** Delhi being a predominantly urban state (94% urban population.), with only 6% being rural leaves the state without any Panchayati Raj Institution as against other states in the country and hence the model of NRHM has to be dovetailed to this urban setting peculiar to Delhi.
- A high level of **dynamic migrant population** from other states visiting and also settling in the state for livelihood. Most of this population settles in unorganized, unauthorized urban slums and JJ Clusters thereby imposing on itself a high burden of morbidities and mortalities due to gross deficiencies in basic necessities of life including health services in these areas.
- The **district wise Administrative demarcation of Delhi is a relatively new development** .The revenue districts and the municipal zones are not co-terminus. The process of firming the essential administrative infrastructures in all the nine districts so that decentralization in all aspects

of administrative functioning including health service becomes a reality, is gradually happening.

The *district health action plans 2007-08 designed in the state have been an effort towards a true example of decentralized planning involving all the important stakeholders, trying to capture for reflecting the grass-root necessities & requirements.*

- The state can take credit for ensuring that the **health resource allocation has been above 10% of the total state budget during the 11`th plan period with** >95% of the states budgetary resources in health having been absorbed & effectively utilized. It can boast of having some of the world class health facilities in Super specialties like Liver and Biliary diseases (Institute of Liver and Biliary Sciences is coming up at Vasant Kunj through state funding), Cancer Institute at Shahdara, Trauma Care facility at LNJP and DDU Hospital, high class dental care at Maulana Azad Institute of Dental Sciences (all above being in the public sector) and Institute like Apollo, Escorts / Fortis, Ganga Ram, etc. in the private sector is all turning out as attraction for medical tourism, generating petro-dollars to the state exchequer.

Chapter 3

State Demographic Profile

Geography

The national capital territory of Delhi with an area of 1483 sq.km is situated between the Himalayas and Aravalis range in the heart of the Indian sub-continent. It is surrounded on 3 sides by Haryana and to the east, across the river Yamuna by Uttar Pradesh. The major part of the territory lies on the western side of the river Yamuna, only some villages and the urban area of Shahdara lie on the eastern side of the river. Its greatest length is around 33 miles and the greatest breadth is 30 miles. Delhi's altitude ranges between 213 to 305 metres above the sea level.

History

Delhi, the capital of India before and after independence has perhaps seen, more of history than any other city in India. It was 1st created as the capital of an independent kingdom by Tomars in 736 AD and gradually it became the principal city of India and eventually its capital. Delhi changed hands at the end of the 12th century and passed on to the hands of the Muslim conquerors. Qutab-ub-din, Iltumish, Khiljis, Tughlaqs and Mughals ruled Delhi in succession. The city of Delhi passed on to the hands of the British in 1803 AD. It was only in 1911, when the capital of British empire was shifted from Calcutta to Delhi, that Delhi got its present prestige. After independence also, a kind of autonomy was conferred on the capital but it largely remained a chief commissioner's regime. In 1956 Delhi was converted into a Union territory and gradually the chief commissioner was replaced by a Lt. Governor. In 1991, the National Capital Territory Act was passed by the parliament and a system of diarchy was introduced under which, the elected Government was given wide powers; except law and order which remained with the central Government. The actual enforcement of the legislation came in 1993.

The state of Delhi has an area of 1,483 sq. km. and a population of 13.85 million (2001 Census). There are 9 districts, 14 blocks and about 400 villages. The State has population density of 9,340 per sq. km. (as against the national average of 324). The decadal growth rate of the state is 47.02% (against 21.54% for the

country) and the population of the state continues to grow at a much faster rate than the national rate owing to a high rate of migration from other states.

River Yamuna remains the main source of water supply to the >90 % population of Delhi with some neighboring states of Haryana & UP contributing to some raw water to treatment plants in Delhi. Piped supply through the DJB is available to >90 % population in the state including in the urbanized villages & slums.

Map depicting the Urbanized Rural Blocks/Villages (Rural Areas) of Delhi spread over 9 districts in the state.

Transport sector in Delhi has been the first in initiating major public health measure by introducing the CNG use in public transport as mandatory, resulting in reduced pollution levels over the last 5 years now.

Sanitation in Delhi state is managed by the local bodies MCD, NDMC, Railways & Cantonment Board & the situation generally is relatively better than many bigger states, though, great scope of improvements in slums & rehabilitation colonies remains a challenge for the planners.

Table below highlights certain important demographic characteristics of the state.

Demographic Characteristics

Variables	1991	2001	Latest available Figures
Total population	94.2 lacs	138.5 lacs(1.3% of India's Population)	170.76 lacs(Projected Figures for 2008 March)
Total Area	1483 sq Km	1483 sq Km	1483 sq Km
%Urban Population	89.93	89.18	
% Rural Population	10.07	6.82	
Annual exponential Growth Rate	3.8	4.2	
Decennial Growth %	46.87	52.34	
Total Sex Ratio	827	821	831(RGI 2006)
Rural Sex Ratio	810		
Urban sex Ratio	822		
Population Density	6352 per sq Km	9340 per Sq Km	
Total Literacy Rate	75.29%	81.73%	82%(RGI 2006)
Male Literacy Rate	82.01%	87.33%	87%(RGI 2006)
Female Literacy Rate	66.99%	74.71%	75%(RGI 2006)
Rural Literacy Rate	82%		
CBR	28.48	21.24	18.4(SRS 2007)
CDR	6.35	5.81	4.7(SRS 2007)
IMR	32.37	23.93	37(SRS2007)
Population Increase over the Previous Year	3.89 lacs	4.9	
Total Births	2.72lacs	2.96lacs	3.22lacs
Total deaths	0.61lacs	0.81lacs	0.98 lacs
Natural Increase	2.11lacs	2.1	2.24lacs
Increase due to Migration	1.78 lacs	2.75 lacs	2.24lacs

Selected Demographic, Socio-economic and Health profile of Delhi State as compared to India figures (latest available)

S. No.	Item	Delhi	India
1	Total population (Census 2001) (in million)	13.85	1028.61
2	Decadal Growth (Census 2001) (%)	47.02	21.54
3	Crude Birth Rate (SRS 2007)	18.4	23.5
4	Crude Death Rate (SRS 2007)	4.7	7.5
5	Total Fertility Rate (SRS 2004)	2.1	2.9
6	Infant Mortality Rate (SRS 2007)	37	57
7	Maternal Mortality Ratio (SRS 2001 - 2003)	NA	301
8	Sex Ratio (RGI 2006)	831	933
9	Population below Poverty line (%)	8.23	26.10
10	Schedule Caste population (in million)	2.34	166.64
11	Schedule Tribe population (in million)	0	84.33
12	Female Literacy Rate (Census 2001) (%)	75	54.28
13	Use of piped drinking water	83.3	42.0
14	Have access to toilet	92.4	44.5
15	Have TV at home	83.0	44.2
16	Own agriculture land	22.0	45.6
17	Have electricity access	99.3	67.9

18	No education at all	women	21.0	41
		men	10	18
19	Media exposure	women	93	87
		men	95	93
20	Have motorized vehicle		39.8	18.6

Chapter 4

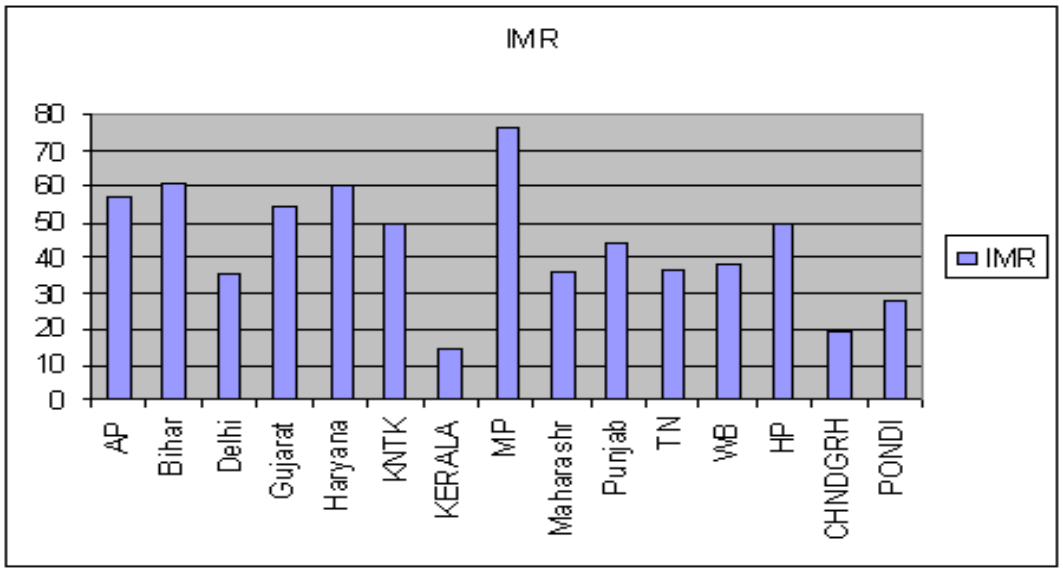
HEALTH INDICATORS

Trends in Contraceptive use		
	Total	
NFHS-1	60	41
NFHS-2	64	48
NFHS-3	67	56
Trends in Any Antenatal Care		
	Total	
NFHS-1	85	65
NFHS-2	84	66
NFHS-3	92	77
Trends in Institutional Deliveries		
	Total	
NFHS-1	45	26
NFHS-2	59	34
NFHS-3	61	41
Trends in Vaccination Coverage		
	Total	
NFHS-1	58	36
NFHS-2	70	42

NFHS-3		63				44
Trends in Children's Nutritional Status						
	Stunted	Wasted	Underweight	Stunted	Wasted	Underweight
NFHS-1	40	13	41	na	Na	52
NFHS-2	37	13	35	45	16	47
NFHS-3	35	16	33	38	19	46
Trends in Infant Mortality						
NFHS-1		65				79
NFHS-2		47				68
NFHS-3		40				57
Trends in HIV/AIDS Knowledge						
Women						
NFHS-1		36				Na
NFHS-2		79				40
NFHS-3		88				57
Men						
NFHS-3		97				80

NFHS III DELHI INDIA

COMPARATIVE IMR OF SELECTED STATES IN INDIA (as per NFHS-3)



Slum Data *

Indicator	March 07(%)	
ANC Registration	98.5	MIS estimates
Early Registration	39.66	
Three Visits	33.44	
IFA Prophylaxis given	38.54	
TT 2 , Booster	56.99	
Institutional Deliveries	26.77	
Deliveries by Trained Dais	37.69	
BCG	75.5	
DPT3	65.48	
Measles	57.32	
Birth Rate	33.6	End line survey 2002
IMR	52.6	
Total Fertility Rate	3.8	
Couple Protection Rate	41.7	

Trends in prevalence of Diseases of Public health Importance in Delhi

DENGUE (2002-2006)

2002		2003		2004		2005		2006	
cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths
*45	2	2882	35	606	3	1023	9	3366	65
1926	33	12754	215	4153	45	11985	157	11308	171

National Health Profile 2006 , Source : Directorate of National Vector Borne Disease Control Programme. *Delhi **India

CHOLERA Cases and deaths due to Cholera in 2006								
Jan to March		Apr to June		July to Sept		Oct to Dec		
cases	deaths	cases	deaths	cases	deaths	cases	deaths	

43	0	461	0	439	0	109	0	Delhi
210	0	651	0	815	2	263	1	India

Source: Weekly Reports of Directorate of Health Services of States / UTs.

DISTRICT LEVEL HOUSEHOLD SURVEY.(2002-04)

District level household survey done in 2002 - 04 gives information about the district specific parameters .

Sl. No.	MAIN PARAMETERS	North West	North	North East	East	New Delhi	Central	West	South West	South
1	Mean age at marriage for boys	22.9	24.9	23.5	24.7	24.5	25.4	22.9	25.2	23.3
2	Mean age at marriage for girls	19.7	22.4	20.5	22.1	20.9	21.9	19.8	21.8	19.7
3	Boys married below legal age at marriage 21 years	25.8	10.9	15.5	12.4	19.7	7.7	21.5	7.5	19.1
4	Girls married below legal age at marriage 18 years	20.0	4.4	8.6	2.2	22.1	7.2	9.6	3.5	17.8
5	Knowledge of any modern family planning method	97.3	98.1	99.4	99.6	94.1	98.8	98.7	97.3	98.5
6	Knowledge of any modern spacing family planning method	95.9	93.9	98.5	98.6	90.7	97.2	97.3	94.9	96.6
7	Knowledge of all modern family planning methods	69.8	64.9	84.0	84.3	56.6	62.2	86.1	76.8	73.8
8	Knowledge of any traditional method	73.7	41.2	79.9	46.9	31.8	52.0	81.1	58.0	76.6
9	Current use of any family planning method	62.1	62.1	64.8	67.3	60.0	60.6	66.0	65.5	62.2
10	Current use of any modern family planning method	58.1	56.0	50.4	56.1	53.3	52.6	60.6	52.2	56.2

11	Current use of any traditional family planning method	**4.0**	**6.2**	**14.4**	**11.2**	**6.8**	**8.1**	**5.4**	**13.4**	**5.8**
Sl. No.	**MAIN PARAMETERS**	**North West**	**North**	**North East**	**East**	**New Delhi**	**Central**	**West**	**South West**	**South**
12	Current use - Female sterilization	**27.5**	**22.0**	**21.6**	**19.9**	**25.8**	**21.8**	**26.5**	**27.7**	**25.6**
13	Current use - Male sterilization	**1.2**	**1.6**	**0.5**	**0.2**	**1.5**	**0.6**	**1.3**	**1.0**	**0.4**
14	Current use – IUD	**4.4**	**7.4**	**6.3**	**7.8**	**5.9**	**6.0**	**4.1**	**5.0**	**6.0**
15	Current use – PILLS	**4.2**	**3.8**	**3.9**	**6.3**	**4.4**	**3.8**	**5.8**	**3.8**	**6.8**
16	Current use – CONDOM	**20.8**	**20.3**	**17.9**	**21.5**	**15.5**	**20.2**	**22.3**	**14.0**	**17.5**
17	Unmet need for limiting-1	**11.6**	**13.4**	**8.8**	**13.6**	**14.5**	**13.0**	**10.4**	**10.9**	**12.0**
18	Unmet need for spacing-1	**1.5**	**2.4**	**1.4**	**0.8**	**2.9**	**0.5**	**0.7**	**0.8**	**2.0**
19	Unmet need -total-1	**13.1**	**15.8**	**10.2**	**14.4**	**17.5**	**13.5**	**11.0**	**11.7**	**14.0**
20	Unmet need for limiting-2	**11.6**	**13.4**	**8.8**	**13.6**	**14.5**	**13.0**	**10.4**	**10.9**	**12.0**
21	Unmet need for spacing-2	**6.3**	**4.9**	**3.8**	**4.2**	**7.2**	**3.2**	**4.5**	**3.5**	**6.7**
22	Unmet need -total-2	**17.9**	**18.4**	**12.6**	**17.8**	**21.7**	**16.2**	**14.9**	**14.4**	**18.7**
23	No antenatal check up	**19.1**	**8.2**	**20.8**	**5.0**	**19.5**	**7.5**	**24.4**	**10.2**	**26.4**
24	Any antenatal check up	**80.9**	**91.8**	**79.2**	**95.0**	**80.5**	**92.5**	**75.6**	**89.8**	**73.6**
25	3 or more antenatal check ups	**67.7**	**83.3**	**68.5**	**81.6**	**62.5**	**80.0**	**61.5**	**77.1**	**52.9**

26	Antenatal check up at home	**0.4**	**0.0**	**0.3**	**1.2**	**1.6**	**0.0**	**0.3**	**0.0**	**1.4**
Sl. No.	**MAIN PARAMETERS**	**North West**	**North**	**North East**	**East**	**New Delhi**	**Central**	**West**	**South West**	**South**
27	Who had no TT injection during pregnancy	**13.1**	**7.0**	**8.5**	**6.7**	**21.4**	**4.8**	**10.4**	**7.4**	**16.8**
28	Who had one TT injection during pregnancy	**6.9**	**6.1**	**4.0**	**4.8**	**7.7**	**11.3**	**7.4**	**16.3**	**8.4**
29	Who had two or more TT injection during pregnancy	**71.7**	**79.6**	**84.1**	**84.8**	**64.9**	**75.2**	**75.5**	**70.4**	**69.0**
30	Who consumed one IFA tablet regularly	**29.8**	**29.0**	**22.4**	**32.6**	**24.2**	**32.2**	**28.7**	**35.4**	**20.3**
31	Who consumed two or more IFA tablets regularly during pregnancy	**34.9**	**45.1**	**40.2**	**39.4**	**38.3**	**47.2**	**33.7**	**25.8**	**41.4**
32	Who received 100 or more IFA tablets during pregnancy	**45.1**	**43.5**	**47.3**	**53.6**	**43.0**	**56.0**	**43.3**	**50.0**	**40.3**
33	Full ANC1 - (Atleast 3 visits for ANC + atleast one TT injection + 100 or more IFA tablets)	**45.1**	**43.5**	**47.3**	**53.6**	**43.9**	**56.0**	**43.5**	**50.0**	**40.3**
34	Received	**34.6**	**35.1**	**42.4**	**43.5**	**30.8**	**43.0**	**37.1**	**41.4**	**26.0**

	adequate IFA tablets/syrup									
35	Full ANC2 - (Atleast 3 visits for ANC + atleast one TT injection + 100 or more IFA tablets / syrup)	**34.6**	**35.1**	**42.4**	**43.5**	**30.9**	**43.0**	**37.3**	**41.4**	**26.0**
Sl. No.	**MAIN PARAMETERS**	**North West**	**North**	**North East**	**East**	**New Delhi**	**Central**	**West**	**South West**	**South**
36	Institutional delivery	**44.3**	**73.8**	**48.0**	**69.4**	**60.8**	**75.9**	**33.8**	**68.7**	**42.3**
37	Institutional delivery – government	**22.4**	**48.4**	**31.1**	**35.5**	**47.4**	**36.0**	**20.6**	**44.9**	**26.1**
38	Institutional delivery – private	**22.0**	**25.4**	**17.0**	**34.0**	**13.4**	**39.9**	**13.2**	**23.8**	**16.2**
39	Home delivery	**54.8**	**26.1**	**51.3**	**28.8**	**38.7**	**23.2**	**65.5**	**31.3**	**56.5**
40	Safe Delivery (Either institutional delivery or home delivery attendant b y Doctor/Nurse/TBA)	**70.5**	**81.7**	**77.9**	**82.2**	**71.2**	**89.0**	**67.1**	**80.9**	**64.5**
41	Safe Delivery (Either institutional delivery or home delivery attendant by Doctor/Nurse)	**58.8**	**77.6**	**59.7**	**77.6**	**63.4**	**80.6**	**41.4**	**76.1**	**52.8**
42	Breast feeding within 2 hours (children age below 36 months)	**26.2**	**26.0**	**30.3**	**26.6**	**37.2**	**23.6**	**14.2**	**36.2**	**28.5**

43	Percentage whose mother squeezed out the first breast milk (children age below 36 months)	**58.6**	**32.6**	**48.3**	**24.3**	**62.3**	**17.6**	**61.7**	**17.7**	**63.2**
44	Exclusive breastfeeding atleast 4 months (children age 4-12 months)	**23.6**	**11.6**	**14.7**	**7.5**	**47.1**	**18.9**	**6.6**	**29.8**	**29.2**
45	Percentage of children age 12-35 months received Polio 0	**65.6**	**82.0**	**65.4**	**74.6**	**75.3**	**81.7**	**54.5**	**88.3**	**56.4**
Sl. No.	**MAIN PARAMETERS**	**North West**	**North**	**North East**	**East**	**New Delhi**	**Central**	**West**	**South West**	**South**
46	Percentage of children age 12-35 months received BCG	**95.5**	**92.9**	**89.2**	**90.2**	**76.3**	**91.9**	**92.1**	**97.0**	**82.5**
47	Percentage of children age 12-35 months received DPT 3	**71.4**	**69.6**	**79.3**	**78.3**	**55.3**	**68.3**	**76.9**	**71.5**	**56.7**
48	Percentage of children age 12-35 months received POLIO 3	**74.5**	**65.2**	**79.3**	**75.7**	**64.8**	**70.8**	**77.2**	**73.2**	**57.6**
49	Percentage of children age 12-35 months received Measles	**76.3**	**86.3**	**72.5**	**79.3**	**64.6**	**77.0**	**82.2**	**81.0**	**68.4**
50	Percentage of	**62.2**	**56.3**	**69.4**	**68.6**	**42.2**	**53.7**	**74.4**	**60.4**	**40.6**

	children age 12-35 months received Full Immunization									
51	Percentage of children age 12-35 months not received any vaccination	**3.4**	**5.0**	**7.3**	**6.7**	**11.6**	**5.2**	**6.2**	**3.0**	**11.4**
52	Aware of diarrhea	**87.3**	**84.1**	**66.9**	**78.9**	**59.8**	**79.6**	**68.4**	**71.0**	**60.9**
53	Knowledge of ORS	**27.5**	**52.7**	**30.3**	**49.0**	**28.5**	**48.9**	**23.5**	**54.3**	**24.2**

54	Who had diarrhea (two weeks prior to survey)	**15.9**	**10.7**	**10.7**	**8.0**	**15.1**	**11.1**	**6.4**	**4.4**	**15.6**
Sl. No.	**MAIN PARAMETERS**	**North West**	**North**	**North East**	**East**	**New Delhi**	**Central**	**West**	**South West**	**South**
55	Given ORS to children during Diarrhea	**33.9**	**49.2**	**37.2**	**48.6***	**56.3***	**21.7***	**27.9***	**45.0***	**39.6**
56	Sought treatment for Diarrhea	**70.0**	**72.2**	**66.3**	**85.6***	**72.5***	**79.1***	**59.1***	**100.0***	**82.6**
57	Aware of danger signs of Pneumonia	**34.8**	**37.0**	**46.6**	**39.4**	**35.2**	**51.8**	**38.6**	**30.6**	**46.1**
58	Who had Pneumonia (two weeks prior to survey)	**8.2**	**6.1**	**7.1**	**1.6**	**18.8**	**11.8**	**7.2**	**4.3**	**13.1**
59	Sought treatment for Pneumonia	**71.4***	**90.2***	**70.8***	**100.0***	**85.8**	**87.1***	**43.1***	**100.0***	**71.8**

60	Women aware of RTI/STI	**7.3**	**23.0**	**14.1**	**16.3**	**33.4**	**31.6**	**4.4**	**28.6**	**15.9**
61	Women aware of HIV/AIDS	**62.0**	**80.0**	**66.6**	**78.8**	**69.9**	**79.9**	**64.0**	**84.3**	**62.7**
62	Women who had pregnancy complications	**37.8**	**22.2**	**27.3**	**18.6**	**42.7**	**31.3**	**29.7**	**19.6**	**29.9**
63	Women who had delivery complications	**32.6**	**22.8**	**28.4**	**17.6**	**31.4**	**23.8**	**37.5**	**24.1**	**39.7**
64	Women who had post delivery complications	**19.4**	**8.3**	**13.4**	**8.0**	**33.3**	**12.0**	**19.6**	**9.5**	**27.2**
65	Women had side effects due to use of female sterilization	**13.3**	**3.8**	**11.6**	**1.0**	**10.9**	**8.2**	**16.3**	**5.1**	**15.2**
Sl. No.	**MAIN PARAMETERS**	**North West**	**North**	**North East**	**East**	**New Delhi**	**Central**	**West**	**South West**	**South**
66	Women had side effects due to use of IUD	**10.0**	**5.6**	**4.3**	**5.5**	**2.8**	**11.4**	**13.7**	**5.4**	**21.8**
67	Women had side effects due to use of Pills	**16.9**	**0.0**	**4.7**	**0.0**	**6.0***	**4.5**	**4.0**	**7.3**	**15.6**
68	Women who had Menstruation related problems	**14.3**	**10.5**	**16.5**	**8.5**	**12.0**	**10.9**	**18.1**	**9.4**	**10.5**
69	Abnormal vaginal discharge	**10.8**	**17.1**	**15.3**	**11.4**	**8.9**	**19.6**	**17.9**	**8.5**	**16.1**
70	Women who had any symptom of	**28.6**	**12.5**	**34.8**	**8.3**	**32.0**	**15.0**	**34.4**	**13.6**	**38.9**

	RTI/STI									
71	Sought treatment for Pregnancy complications	**49.9**	**57.3**	**45.2**	**51.8**	**68.7**	**55.3**	**54.3**	**26.5**	**44.4**
72	Sought treatment for Post delivery complications	**48.3**	**54.7***	**54.1**	**47.0***	**60.3**	**41.0***	**55.9**	**36.9***	**39.1**
73	Sought treatment abnormal vaginal discharge	**53.3**	**47.6**	**46.4**	**47.8**	**48.9**	**48.2**	**44.1**	**48.8**	**47.6**
74	Women visited by ANM/Health worker	**0.3**	**0.6**	**0.2**	**0.2**	**3.0**	**0.5**	**0.0**	**0.0**	**1.0**
75	Women who had said worker spent enough time with them	**50.0***	**3.9***	**100.0***	**54.4***	**77.7***	**18.3***	**NA**	**36.2***	**66.8***
Sl. No.	**MAIN PARAMETERS**	**North West**	**North**	**North East**	**East**	**New Delhi**	**Central**	**West**	**South West**	**South**
76	Women who satisfied with service/advice given by health worker	**100.0***	**89.3***	**100.0***	**100.0***	**62.2***	**68.6***	**NA**	**0.0***	**100.0***
77	Women who utilized government health facility for antenatal care	**53.3**	**60.7**	**53.4**	**53.7**	**62.3**	**49.5**	**62.0**	**63.4**	**43.7**
78	Women who utilized government	**48.6**	**49.4**	**50.5**	**38.8***	**72.3**	**44.7**	**71.4**	**87.5***	**42.7**

	health facility for treatment of pregnancy complications									

79	Women who utilized government health facility for treatment of post delivery complications	**26.5***	**39.6***	**38.1***	**27.3***	**59.8**	**56.2***	**39.4**	**84.4***	**31.5**
80	Women who utilized government health facility for treatment of RTI/STI (vaginal discharge)	**56.8**	**47.6**	**47.1**	**41.3**	**90.4***	**34.6**	**39.3**	**55.5**	**79.3**

Chapter 5

EXISTING HEALTH & RELATED INFRASTRUCTURE

Existence of multiple agencies with their own independent Health facilities & structures in the public sector makes Delhi as one Complex, yet ,challenging state to implement NRHM within the permissible framework.

MCD, NDMC, CGHS, ESI, RAILWAYS, CANTONMENT BOARD& DELHI GOVERNMENT FACILITIES are all trying to take care of the health needs of the state's populations. All National Health Programmes get implemented at each agency level through technical support provided by the State govt. department of Health & Family welfare including release of the Central funds flowing through the State Programme structures.

These structures also account for monitoring & dissemination of policy directives to the agencies. The individual programmes, as per their own Societies have been guided by the policies given by Govt of India, which get percolated through the state apparatus.

Some of the National programmes run by the state such as Polio Eradication, Leprosy control, RNTBCP etc have been doing very well & the same has been even recognized by the GOI.

Now after the constitution of the State Health Society subsuming the individual vertical programme's society henceforth, will be having stronger teeth for providing a statewide perspective to the various programmes without in any way impinging upon the autonomy of the programmatic strengths. The CGHS, Railways, Cantonment Board & ESI are practically catering to the defined captive populations of its own employees.

It is the Delhi Government & MCD/NDMC hospitals & dispensaries which are taking care of the vast groups of Populations from the un-organized & organized sectors irrespective of the areas & boundaries demarcations. This, while serving the Social concerns & responsibilities of a welfare state, imposes certain very peculiar practical challenges such as:

- Lack of any Referrals system
- Lack of any linkages of populations with Health facilities resulting in overcrowded (with quality compromises), poorly managed resource starved facilities with many a time, people resorting to seeking services from multiple places for a single illness, further draining the systems of resources (window shopping in health is an emerging issue with awareness levels going up in the state!).

- Improving the physical infrastructures including the service environments within these facilities along with defining linkages of populations to facilities are some of the programmatic & Policy issues that the State would be striving to address through the NRHM mode.

The facilities that exist are tabulated below:

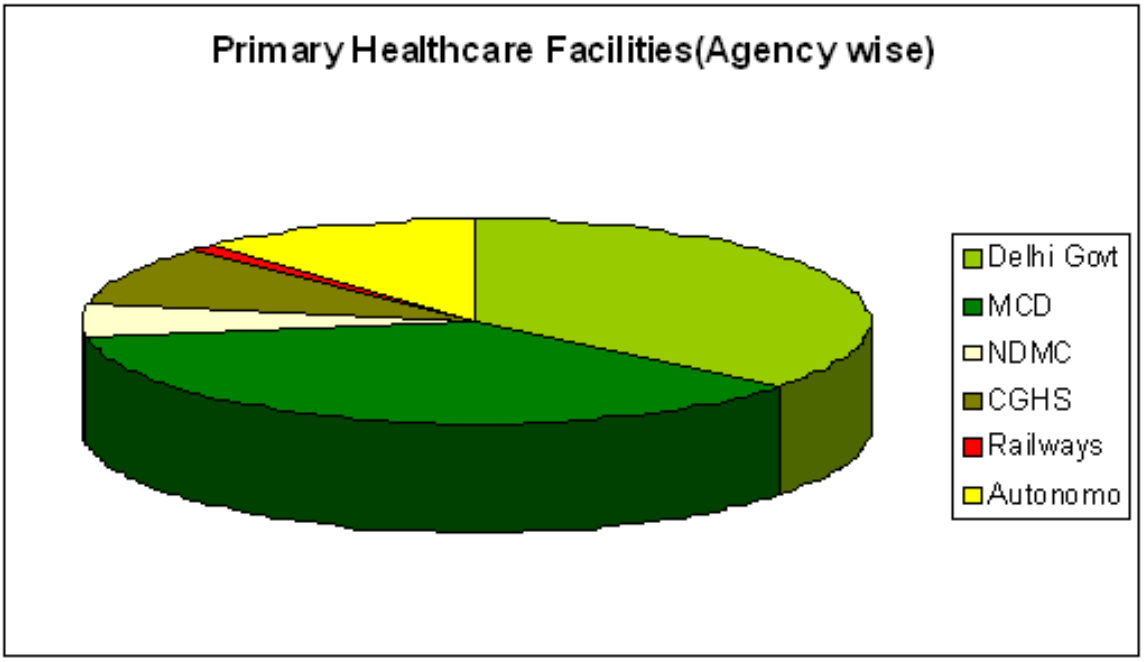
S. No.	**Item**	**Nos.**	**Beds**
A)	**HOSPITALS**		
1	Delhi Government	31	6375
2	MCD	59	4064
3	NDMC	04	220
4.	Govt. of India	23	9970
5.	Other Autonomous Bodies	01	20
6	Private Voluntary Organisation	607	14905
	TOTAL	725	35554

B)	**DISPENSARIES**	Number	Beds
1	Delhi Govt. including ISM&H	363	xx
2	MCD including MCW centres and ISM&H Centres	307	xx
3	NDMC including M&CW centres and ISM &H Centres	48	xx
4	Central Government including ISM&H Centres	100	xx
5	Railways	12	xx
6	Statutory Bodies including ESI	117	xx
	TOTAL	947	xx

C)	Primary Health Centres	07	79
D)	Sub Centres attached to	48	xx

	PHCs (Norms:6PHCs)		
E)	Maternity Homes(MCD-23, NDMC-2)	25	321
F)	Poly Clinics	05	xx
G)	Special Clinics(TB/STD/Leprosy)	44	xx
H)	Family welfare Centres	125	xx
	TOTAL	259	400
	GRAND TOTAL		

This does not include the large number of private practitioners /RMPs



- **Other resources in the State:**

1. NGOs A number of small & bigger NGOs are operating in health & related sectors in various parts of the 9 districts. Under the RCH2programm Mother NGO scheme the state has listed support from them. In addition to continuing building on this resource for partnering in health & Nutrition activities under NRHM the State plans to rope in their services in areas of immediate concerns such as: PNDT Act implementation (education, behavior change, Decoy Client activity), Promoting JSY scheme in JJ Clusters (IEC, Health education to women, actual accompanying a pregnant women for delivery in institution after having ensured timely ANC registration & care all through . for this the NGOs will be provided Logistics of MCH services free of any charges. Details are in the proposal on NGO involvement.

Proper trainings to such NGOs are planned.

A sum of Rs 5 LACS towards building NGO base which is trained is proposed to be kept aside.

2. **Private Nursing Homes** in Delhi are governed by the NH Registration rules & byelaws. Directorate of health services is the Nodal department for this regulation.

- Total **608 registered N Hs with 14500 beds** are registered & are being regularly monitored.

Under the NRHM of the state, PPP models for institutional deliveries are being planned.

Similarly scores of Private Laboratories in Delhi are providing quality diagnostics & keeping the interest of the patients as important the plan includes providing free services to certain selected tests for women & children from BPL/SC /ST families as apart of funding under the plan under PPP venture (innovations)

3. ICDS Structure:

Being a Centrally sponsored Welfare Scheme the structure at the state level is same as in other parts of the country with Department of Social Welfare as the Nodal Agency. Community Development Blocks (31 exist) in Delhi with about 4536 AWWCs in the state mainly located in slums & resettlement habitations. Now many more anganwadis are being set up as a result of universalization of ICDS as per the Directives of Hon'ble Supreme Court. Existing arrangements at the state with health department are mainly restricted to the MCD as the main stakeholder whereby the AWWCs are linked to the MCWCs of MCD for maternal & Child health service linkages.

At the block level the interactions with the Most of other health facilities like DAD, will now be redefined through building linkages under the state health society mode of which Social Welfare is a major stakeholder. Capacity building of the Skills of AWWs & also through equipping the Selected AWWCs as Mother AWW is planned as per details under Inter sector Convergence.

The outcome expected through building the above linkage is:

- Significantly higher detection rate of PEM Gr 3 & 4 in < 3 children,
- Significant reduction in Gr 3 & Gr 4 through interventions
- Reduced Infant & Child Mortality (through higher referrals to PUHCs for management of Complications of Severe Malnutrition.

Chapter 6

SITUATIONAL ANALYSIS

BOTTLENECKS AND WAY FORWARD

Delhi is one of the best equipped states in terms of health infrastructure and health expenditure of Govt Of Delhi has been Rs.2381.5 Crores in 10th Plan. However these advantages have not translated into equally impressive health indicators as they are mainly offset by a high population density of 9294 per sq Km (highest in the country), heavy inmigration from the neighboring states, weak referral systems and multiplicity of authorities.

Major Bottlenecks :

a). Health facilities with no uniformity in terms of assured service delivery and infrastructure with different controlling authorities . These structurally heterogeneous units are functioning without any coordination / synergy as they are under different administrative controls . They are providing fragmented services with no standardization.

b).Lack of benchmarks and standards especially for the primary health care facilities where the IPHS are not applicable.

c).There are no geographical / population wise assignments to health facilities which leads to a lack of accountability and a compromised service delivery.

d). Large unserved and underserved areas. Due to inequitable distribution there are large areas with little or no healthcare facilities and areas where health facilities are clustered inappropriately.

e).Sub optimal functioning of the existing units due to constraints especially those of manpower.

f).Monitoring and evaluation mechanisms require strengthening.

g). Preventive and promotive components of the healthcare delivery at the primary level not getting due emphasis.

h).Addressal of parameters directly related to health need more focus– especially Nutrition , safe drinking Water and Sanitation. A large segment of population lives in difficult areas – Slums / JJ C lusters / resettlement colonies / unauthorized colonies and villages. These people live in crowded , unhygienic conditions with meager sanitation facilities , paucity of safe drinking water and consequently carry a high disease burden in terms of of water borne diseases like diarrhea, dysentery and typhoid , acute respiratory illness especially in young children ; vector borne diseases like malaria . dengue and a high incidence and prevalence of Tuberculosis

i). Paucity of FRUs and therefore Lack of defined referral linkage leading to overburdened Tertiary care facilities.

j). Migrant population adding five lacs every year.

k). Continuous influx of patients from neighboring states . At any given time, 30 % bed occupancy is by patients from the neighboring states.

l).No PRIs / scant CBOs **.** Delhi being a predominantly urban state (94% urban population.), with only 6% being rural leaves the state without any Panchayati Raj Institution as against other states in the country and hence the model of NRHM has to be dovetailed to this urban setting peculiar to Delhi.

l).The revenue districts and the municipal zones are not co-terminus which hampers effective decentralization of the planning and implementation of district level activities.

Increasingly the need for devising an effective blueprint for optimization of healthcare delivery has been felt by the State . Arrival of National Rural Health Mission provided the opportunity to take stock and brought into sharp focus the need for long term holistic policy yielding sustained improvement in our healthcare delivery and provision of Accessible , Affordable , Accountable quality healthcare for all.

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THE WAY FORWARD

The State PIP and annual plan of action has been prepared in the backdrop of the bottlenecks mentioned above with the aim of providing accessible ,affordable and accountable healthcare for all. The perview of the State Health Mission in the current plan has been restricted to the Primary Health care and of the Maternity homes (Secondary healthcare). Other secondary and Tertiary care facilities are being strengthened as a part of State Plan Schemes.

KEY Strategies & Interventions.

1. Standardization of Primary Healthcare Facilities and upgradation of existing health facilities to these standards. This will take care of the multiplicity of agencies and bring uniformity and quality assurance in the primary healthcare tier. This would have following components.

a). Laying down the Standards for a Primary Urban Health Centre (PUHC). Recognition of the basic primary healthcare facility as a Primary Urban Health Centre. and standardizing this PUHC in terms of the population to be catered to, assured services to be provided at the centre, the infrastructure -- both physical and in terms of human resource and system reforms required to deliver the mandated services optimally.

Indian Public Health Standards (IPHS) for PHCs have been recommended by GOI , but the PUHC of Delhi is different from a PHC of the rural states as providing round the clock services and indoor facility is not a mandate of the PUHC., The existing Indian Public Health Standards for PHCs need to be modified to become applicable to a PUHC.

A Committee had been formed and is already working on laying down the Standards for a PUHC.

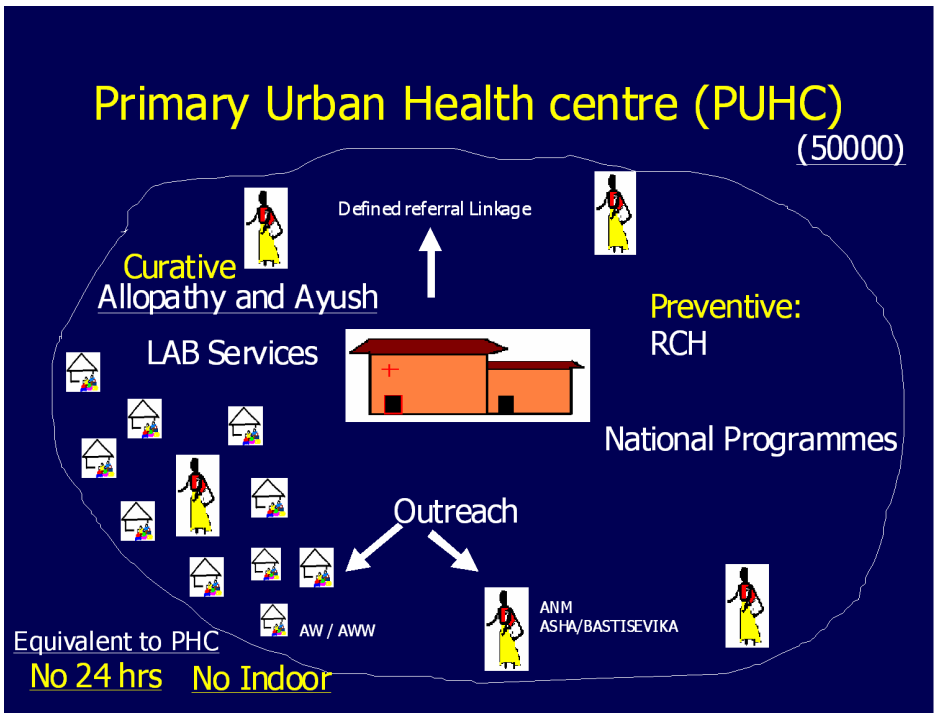


Fig 1This model is being evolved and adopted at state level with Public Health Standards laid down accordingly to serve as benchmarks.

Services to be provided in PUHC:

a).Curative Care
b).Preventive and Promotive Care : RCH Package , National Programmes Implementation. With Outreach component.
c).Basic Lab Services .
d). Referral Services .
e). AYUSH Component .
f). Trainings .
g).Monitoring of field Activities, Reporting and Recording.

b). Facility survey of the Primary Health care units belonging to different agencies . This survey will help in identification of the existing better equipped facilities which can be upgraded to PUHCs for 50,000 population around them . A preliminary facility survey has already been done and more detailed facility surveys are ongoing in all the districts.

c). Upgradation of the identified units to the Standards laid down. Once a PUHC has been identified it will be upgraded to the standards laid down and will be recognized by a common insignia / board recognizing it as a PUHC for the linked 50,000 population. The unit will retain its parental identity and be under the same administrative control. The performance will be monitored by Integrated

District Health Society to assess if the objective of strengthening the unit has been achieved or not. This activity will entail strengthening all the identified units in terms of infrastructure / manpower and will be phased over next four years.

d).**Facility wise population linkages**. The upgraded unit will be assigned 50,000 population around it. Facility and population mapping is already underway. Over time the households of the attached population will be linked to the facility by family health cards. Formalization of linkages with Family Health Cards will be staggered and synchronized with upgradation .

Standardization and upgradation is being taken up on a priority basis as the vision of accessible, affordable and accountable healthcare for all is directly linked to it.

2. Penetrating the underserved / unserved areas / populations / services.

There are areas – geographically, demographically and service delivery wise which need thrust with immediate attention .These are:

a).Coverage of unserved / underserved areas.

A preliminary exercise was done to identify the underserved and unserved areas. A more detailed and comprehensive mapping is underway to map the existing health facilities and populations. The ultimate objective is to provide a PUHC for every 50,000 population. For immediate relief it was decided to set up outreach primary healthcare units to be subsequently subsumed by permanent and comprehensive structures – Primary Urban Health Centres. These will be linked to the nearest existing health centres for logistics and support. Such a unit will provide preventive and promotive healthcare along with basic curative services.

Twenty five of these centres will be operationalised in the near future.

The possibility of entering into partnership with willing private partners / NGOs is also to be explored to cover these areas. One such partnership in Northeast district is to be finalized soon.

Over next four years all unserved areas to be provided with PUHCs.

b). Reaching the vulnerable Populations : Below poverty line population / SC / ST women and newborns. There are two schemes for the current year :

(i). Janani Suraksha Yojana : Is a GOI Scheme whereby the pregnant women belonging to BPL / SC / ST are given financial assistance to help her in meeting the delivery related and post delivery expenses. The scheme is already operational .

(ii). MAMTA Scheme: An important component of healthcare aimed at reducing the Maternal and Infant Mortality is provision of Institutional Delivery. The Government is trying to universalize institutional deliveries, a major constraint being the lack of Government health facilities equipped and functional to provide the comprehensive obstetric services for the mother and the newborn. The present scheme is a step to address this gap through a Public Private Partnership whereby private hospitals / nursing homes will be invited to provide a comprehensive package of Maternal Health Services including institutional deliveries in underserved areas of slums / JJ clusters.

Hospital / Nursing Home that registers under the scheme will be called Mamta Friendly Hospital (MFH) and will be paid a fixed remunerative package for each institutional delivery, it carries out in respect of a pregnant woman eligible as a beneficiary under the scheme – a woman from below poverty line family or belonging to SC/ ST.

In view of low institutional delivery rate in the slums, JJ Clusters , resettlement colonies and paucity of public health facilities providing obstetric services near these areas , the MAMTA Scheme has been formulated and will be operational in CFY.

c). Healthcare Services. Weak service areas prioritized for action for current financial year are :

(i). **Maternity and new born care services**.

Strengthening of existing MCD Maternity Homes to make them optimally functional. There are 34 Maternity Homes under MCD / IPPVIII/NDMC . Many of them are not fully functional due to various constraints, the main one being shortage of manpower. According to the existing infrastructure these maternity homes can be upgraded to two types of facilities . Category one which already has an operation theatre and can be upgraded to provide emergency obstetric services like caesarian section etc . and a second category which has labour room only and indoor facilty to provide round the clock obstetric services .A facility survey has already been carried out and these maternity homes will be upgraded according to facility specific plans over next two years.

(ii). Diagnostic Services .

All Primary health facilities should be able to provide diagnostic services specially for conditions which can be managed at the PUHC level. This, diagnostic backup is not available and the patient has to be referred to higher level facility which is already overburdened. This entails long waiting time and frequent visits to the hospital.

To address this problem :

(a). Labs in 33 dispensaries (1 each for 5 to 6 dispensaries) were equipped with a semi autoanalyser for the second level diagnostic tests and designated

as Mother labs by the Directorate of Health Services . These 33 designated Mother labs are being strengthened with Lab technicians .To oversee the functioning of basic labs / Mother labs , each district will be provided with a pathologist. This will be completed in CFY.

(b). The Maternity and Child Welfare centres of MCD , catering to women and children do not have a basic lab facility. Fifty of these centres will be provided with basic lab facilities in the current year. They will be provided with a LT and basic lab equipment / lab reagents.

©. A scheme of Partnership with Private Labs is being worked out wherein a lab will be identified for a given population to provide certain tests for patients being referred from peripheral health centers. The tests coming in purview of the scheme and the fixed remuneration for each test will be defined in the scheme. The scheme will become operational in next financial year.

3. Convergence with Key stakeholders:

One of the core strategies of the Mission is effective ground level Convergence of key stakeholders

(a).Inter Agency Convergence

Presence of multiple health agencies under different administrative controls with structurally different health facilities providing different spectrum of services without any standardization has been a major bottleneck in providing quality healthcare with equitable distribution through the state.

The agencies have been aware of the fact for a long but it is for the first time that the two main stakeholders have come together. Delhi Govt and the MCD have been involved together in preparation of the district health action plans. Identification and strengthening of the most appropriate health units irrespective of the agency they belong to is envisioned in a phased manner in the current plan. The agencies shall also pool in their resources in terms of technical resource and training portals to provide trainings for all categories of staff.

(b).Inter Programme Convergence

Convergence with National AIDS Control Programme (NACP)

Although NACP is not directly under the umbrella of NRHM , for the effective implementation of the Programme the areas for ground level convergence have been identified and incorporated in District Health action Plans. The areas include trainings / setting up of blood storage units and ICTCs.

(c). Intersectoral Convergence.

i). With Department of Social Welfare thru Integrated Child Development Services (ICDS).

Nutrition along with availability of safe drinking water and sanitation are the most important determinants of health .

Integrated Child Development Services (ICDS) under aegis of Social Welfare Department is the only major National Programme that is engaged in Nutritional Surveillance and supplementation activities. Its widespread network of anganwadis can also provide the valuable linkage and field foothold to positively impact community health .

Identification of one anganwadi for **every 5-6 anganwadis and designating it as mother anganwadi has been done by ICDS .** All anganwadis where weighing scales are not available will be provided with weighing scales and required cards and referral slips in CFY as Mission activity . In addition mother anganwadis will be provided IEC/ BCC Material . These anganwadis can and are providing venue for monthly Health and Nutrition Days conducted by the three member team (Doctor / ANM/ NO) of the attatched Health centre (along with area ASHAs once they are place).

(ii).Convergence with Department of Education :

NRHM is committed to providing support for School Health Programmes in each and every district based on specific proposals prepared as part of the of District Health Action Plans.

(i).Conduct of School health fairs.

(iii).Realizing the importance of a robust School Health Scheme with sufficient focus on adolescent health and a vital / relevant health education component for this captive audience, a pilot proposing amalgamation of healthcare / adolescent health education and YUVA scheme of dept of education has been proposed in the State PIP.It is likely to be launched early next year.

(iii).Convergence with the water and sanitation department

The Mission relates good health to nutrition , sanitation , hygiene and safe drinking water .

Strategies :‘

1.Provision of adequate water for domestic use.

2.Ensuring the safety of water used for domestic purposes.

3.Ensuring personal and domestic hygiene necessary to prevent spread of water borne diseases.

4. Ensuring safe disposal of excreta

5.Ensuring safe solid waste disposal.

6. Ensuring safe disposal of waste / excess water.

Application of some of these strategies have constraints but in the long run they have to implemented for permanent sustainable solutions and sooner the uphill process is begun , the better.

Interventions proposed are :

1. Setting up of health and sanitation committees in all the villages along with finalization of an urban prototype.

2. Ensuring that the NVBDCP takes care of the water collections / other mosquito breeding places.
3. Facilitate setting up of household and community toilets. (activity incentivised for ASHA)
4. Behaviour Change Communication regarding
   a). storage / usage of available water.
   b). Chlorination of water.
   c). Personal and Domestic hygiene.

4.Capacity Building :

Institutional and individual capacity building is an important activity in the State PIP.
This includes equipping the State and Districts with the required skills in:
a).Setting up of State and District Programme Managewment Units in CFY .
b).Establishing District Training Centres.
c).Establishing District BCC Units.
d).Ensuring continuous updating of its different functionaries.

5. Communitisation :

Community involvement in planning, implementing and monitoring their healthcare delivery system is an important intervention to ensure practical planning , ground level implementation and utilization of the activity and their effective monitoring. This involvement is envisaged through introduction of the following :

(i).The ASHA Scheme: At present **t**he linkage of the community with the healthcare delivery system has huge gaps. Under the ASHA Scheme , ASHAs will provide this linkage and help to improve the health indices.

The ASHA Scheme is an incentive based scheme wherein women who volunteer from local community will be selected and trained to reinforce community action for universal immunization, safe delivery, newborn care, prevention of waterborne and communicable diseases , improved nutrition and promotion of household / community toilets. She will inform, interact, mobilize and facilitate improved access to preventive and promotive healthcare , and also provide basic curative care through her drug kit.

Depending upon health indicators, poor sanitation and water supply, prevalent malnutrition and communicable disease burden and an adverse female sex ratio , areas for ASHA intervention have been identified and prioritized to be covered over a period of next two years in a phased manner. In the CFY , 2700 ASHAs will be selected , trained and provided with basic kits .

(ii). Rogi Kalyan Samitis:

Rogi Kalyan Samiti (RKS) or (Patient Welfare Committee) is a simple yet effective management structure. It is visualized as a registered body comprising of members from local representatives, community leaders & elected representatives, NGOs and officials from Government sector who are responsible for proper functioning and management of the health facilities .In addition to participation in various planning and implementing functions , the RKS will have the mandate to generate and use the funds for smooth functioning and maintaining the quality of services at the health facility.

The structure of RKS in State is yet to be formalized. Once it is done, RKS will be operationalised for health facilities of different categories in a phased manner.

(iii).Health and Sanitation Committees
Under NRHM Health and sanitation Committees are to be formed in every village with panchayat being the peg or the nodal agency around which this peripheral institution is to take root. In Delhi there are no PRI akin structures and therefore State appropriate model which can be replicated in the slums / resettlement colonies / JJ Clusters has to be developed. Meanwhile in the 165 villages in Delhi, HSCs are to be formed in the next financial year along with the formalization of an urban prototype .

6. Systems Reforms

a). Decentralised Planning / implementation / financial controls is the basic requirement of Mission. Integrated District Health Societies have been formed and are functional in all districts of the state. The State PIP is a document based on District Health Action Plans prepared by the districts.

b). Effective monitoring mechanisms with mandated online review and corrective actions are being developed .

c).Simplification of procedures / protocols by providing flexibility / delegation of powers and duties.
With an intent to facilitate the districts in taking up various activities in a decentralized fashion, necessary guidelines are being provided .The duties / financial powers are being disseminated to the peripheral most functionaries.

The above mentioned activities are aimed at strengthening the systems / structures and individuals through whom the healthcare activities are flowing.

7. Integration of various National Health Programmes under one umbrella.

To ensure a better coordination , implementation and monitoring , the various National Health Programmes have been brought under the umbrella of State Health Mission with decentralization of planning , funding and implementation to the districts. These individual disease specific programmes are contributing with their primary healthcare level interventions.

Chapter 7

GOALS & OBJECTIVES

Health Concerns & Mechanisms for addressing them:

Increasing Wasted Children<5 due to malnutrition, a relatively low (61%) institutional deliveries despite predominantly Urban structures, a high Infant Mortality (40) per thousand of live births & decreasing Immunization coverage's as reflected in the above survey results, are going to be States challenges & priority attention areas, through the following policy directions:

1. Defining & setting Goals & progress Monitoring Indicators
2. Reorganization of existing health services delivery systems(through Coordination amongst agencies)
3. Strengthening the existing facilities for effective service delivery
4. Building linkages between primary, Secondary& Tertiary health facilities
5. Creating new facilities & service delivery Channels(Mobile dispensaries, Private sector partnerships,etc)
6. Capacity Building of service providers
7. Increasing demand for services
8. Monitoring for quality assurances

GOAL & KEY INDICATORS SET FOR THE STATE

OUTCOME INDICATOR	NFHS1	NFHS2	NFHS3	GOALS				Actions / Strategy Planned
				2007-08	2008-09	2009-10	2010-12	
IMR	65	47	40	30	25	20	<15	Improved SBA Increased Institutional Delivery & PNC, Implementation of IMNCI / IYCF Strengthening Immunization outreach sessions, Increased use of ORS in Diarrhea management PEM Reduction-ICDS capacity building& health coordination, Institutional strengthening for Slums / un-reached groups
Institutional Delivery	45.3	59.1	60.7	66.5	70.5	80	>90	PPP for BPL women delivery at NHs, JSY, BCC, Strengthened Referral System, Emergency transport, Capacity

								building of providers
TFR	3.02	2.40	2.13	2.12	2.11	2.1	2.1	Meeting Unmet needs, BCC, Institutional strengthening, Coordination, Training for skill improvement of providers
<5Child Stunted	39.7	36.8	35.4	33	30	25	<20	Strengthening ICDS delivery & capacity, coordinated care of Gr3/4 <5 children with health sector & ICDS Awareness on healthy weaning practices,IYCF
<Child Wasted	12.7	12.5	15.5	15	14	12	<10	Same as above. ASHA as health facilitator,IYCF
<5Child **Underweight**	40.9	34.7	33.1	30	25	22	<20	Same as above. ICDS& ASHA to coordinate with healthsector& community
Initiated Breastfeeding within first hour	6.3	23.8	19.3	25	30	35	>50	Health education for BCC, IMNCI/IYCF
EBF 6Months	NA	NA	34.5	40	45	50	>60	BCC,ASHA,Trainings,IMNCI
Vit A 12-35	NA	NA	17.1	25	50	65	>75	-same as

months								above-
Healthy Weaning practices (6 - 9 months)	NA	NA	59.8	65	75	85	>90	-same as above-
ANC 3	72.2	68.9	74.4	78	82.5	85	>95	Institutional strengthening , Awareness, Skills trainings, ASHA , Accountability /Supervisory practices improved
IFA Consumption	NA	NA	38.3	45	50	65	>80	Same as above
Full Immunization	57.8	69.8	63.2	70	75	80	>90	Strengthening out- reach , Prioritizing the previously unreached,Capacity building & Effective Monitoring systems in place
Measles	69.6	77.5	78.2	80	85	90	>95	Same as above

Contrac ep-tive use	54.6	56.3	56.4	58.5	60	62	65	Improving male participation, Improving availability of NSV & Lap Sterilization at increased number of facilities with quality ingrained in them.
PNC with in 48 hr	NA	NA	50.4	53.3	57.2	60.0	65.0	ASHA, IMNCI, IPC of workers, Supervision & Improved Community awareness
2daughters considered by family as complete	43.8	52.9	70.7	72	72.8	73.5	>75	Effective regulation of PNDT Act, Large scale Awareness on Moral, Ethical, Demo-societal issues for providers &

								service seekers(community), Recognizing virtues of girl child & creating 'role models' amongst families
IUD insertion rate	7.8	6.2	5.0	6.0	8	10	>15	Facility strengthening, improved service delivery, BCC, Trainings
Unmet needs	15.5	13.4	8.0	7.5	<6	<5	<2	Same as above
Condom use preventive for HIV (Knowledge in Women)	NA	NA	77.0	80	85	90	100	BCC & strengthening, easy availability through Depot holders in community & at strategic habitations (high risk population)
Condom use as	NA	NA	92.4	95	96	97	100	Same

Preventive for HIV (Knowledge in Men)								as above
ORS use in diarrhea	18.9	39.1	34.4	45	55	65	>75	IMNCI, Trainings, Mass awareness campaigns & easy availability of ORS
< 3 Children anemic	NA	69.0	63.2	60	50	45	<30	ICDS & Health strengthened coordination, IFA promotion in ICDS & at all PUHCs
Pregnant women anemic	NA	34.7	29.9	25	20	15	<10	PUHCs services delivery strengthened, IFA availability improved

7.2 Detailed Planned Phasing out of targets (to be achieved)

Key Indicators Planned to be achieved basing on the NFHS1, 2&3 reports	*Phased out Indicative Targets to be achieved between 2007-12*						
	NFHS 1(1992-93)	NFHS2(1998-99)	NFHS 3(2005-06)	2007-08	2008-09	2009-10	2010-12
Marriage and Fertility							
1. Women age 20-24 married by age 18 (%)	28.7	19.8	21.2	18.0	16.0	14.0	<10.0
2. Men age 25-29 married by age 21 (%)	NA	NA	19.4	17.0	15.0	13.0	<10.0
3. Total fertility rate (children per woman)	3.02	2.40	2.13	2.1	2.1	2.1	2.1
4. Women age 15-19 who were already mothers or pregnant at the time of the survey (%)	NA	NA	5.0	4.50	4.0	3.0	<2
5. Median age at first birth for women age 25-49	20.9	21.2	21.7	22.2	23.0	23.4	23.5
6. Married women with 2 living children wanting no more children (%)	78.2	84.3	91.6	92.0	93.0	93.5	95.0
6a. Two sons	86.8	90.1	95.2	94.4	93.8	93.0	90
6b. One son, one daughter	86.0	89.3	94.6	93.0	92.2	91.5	<90
6c. Two daughters	43.8	52.9	70.7	72.0	72.8	73.5	>75
Family Planning (currently married women, age 15–49)							
Current use							
7. Any method (%)	60.3	63.8	66.9	70.0	73.0	75.5	80.0
8. Any modern method (%)	54.6	56.3	56.4	58.5	60.0	62.0	65.0
8a. Female sterilization (%)	20.0	26.3	23.0	25.0	26.8	29.2	31.0
8b. Male sterilization	3.2	2.3	0.8	1.5	2.8	4.0	6.0

(%)							
8c. IUD (%)	7.8	6.2	5.0	8.0	10.0	12.0	15.0
8d. Pill (%)	2.9	4.0	4.5	5.2	6.1	6.8	8.0
8e. Condom (%)	20.5	17.5	23.3	25.0	27.0	28.5	30.0
Unmet need for family planning							
9. Total unmet need (%)	15.4	13.4	8.0	7.5	<6.0	<5.0	<2.0
9a. For spacing (%)	7.6	5.9	3.3	3.0	2.5	2.0	<1.0
9b. For limiting (%)	7.9	7.5	4.7	4.0	3.8	3.2	<1.0
Maternal and Child Health							
Maternity care (for births in the last 3 years)							
10. Mothers who had at least 3 antenatal care visits for their last birth (%)	72.2	68.9	74.4	78.0	82.5	85.08	>95.0
11. Mothers who consumed IFA for 90 days or more when they were pregnant with their last child (%)	na	na	38.3	45.0	50.0	55.0	>60
12. Births assisted by a doctor/nurse/LHV/ANM /other health personnel (%)[1]	65.9	53.8	65.1	70.0	73.5	77.5	>80.0
13. Institutional births (%)[1]	45.3	59.1	60.7	63.0	66.5	70.5	>80
14. Mothers who received postnatal care from a doctor/nurse/LHV/ANM /other health personnel within 2 days of delivery for their last birth (%)[1]	na	na	50.4	53.3	57.2	60.0	65.0
Child immunization and vitamin A supplementation[1]							
15a. Children 12-23 months fully immunized (BCG, measles, and 3 doses	57.8	69.8	63.2	70	75	80	>90

each of polio/DPT) (%)							
15b. Children 12-23 months who have received BCG (%)	90.1	92.0	87.0	90	93	95	100
15c. Children 12-23 months who have received 3 doses of polio vaccine (%)	75.6	81.0	79.1	85	90	95	100
15d. Children 12-23 months who have received 3 doses of DPT vaccine (%)	71.6	79.9	71.7	75	80	85	>95
15e. Children 12-23 months who have received measles vaccine (%)	69.6	77.5	78.2	80	85	90	>95
16. Children age 12-35 months who received a vitamin A dose in last 6 months (%)	na	na	17.1	25	50	65	>75
Treatment of childhood diseases (children under 3 years)[1]							
17. Children with diarrhoea in the last 2 weeks who received ORS (%)	18.9	39.1	34.4	45	55	65	>75
18. Children with diarrhoea in the last 2 weeks taken to a health facility (%)	66.2	80.1	75.1	>80	>85	>90	100
19. Children with acute respiratory infection or fever in the last 2 weeks taken to a health facility (%)	na	na	93.1	>95	98	100	100
Child Feeding Practices and Nutritional Status of Children[1]							
20. Children under 3 years breastfed within one hour of birth (%)	6.3	23.8	19.3	25	30	35	>50
21. Children age 0-5 months exclusively breastfed (%)	na	na	34.5	40	45	50	>60
22. Children age 6-9	na	na	59.8	65	75	85	>90

months receiving solid or semi-solid food and breastmilk (%)							
23. Children under 3 years who are stunted (%)	39.7	36.8	35.4	33	30	25	<20
24. Children under 3 years who are wasted (%)	12.7	12.5	15.5	15	14	12	<10
25. Children under 3 years who are underweight (%)	40.9	34.7	33.1	30	25	22	<20
Nutritional Status of Ever-Married Adults (age 15-49)							
26. Women whose Body Mass Index is below normal (%)	na	12.0	10.6	8	5	3	<2
27. Men whose Body Mass Index is below normal (%)	na	na	10.4	8	5	3	<2
Anaemia among Children and Adults							
28. Children age 6-35 months who are anaemic (%)	na	69.0	63.2	55	35	25	<10
29. Ever-married women age 15-49 who are anaemic (%)	na	40.5	43.4	35	30	20	<5
30. Pregnant women age 15-49 who are anaemic (%)	na	34.7	29.9	25	15	10	<2
31. Ever-marrried men age 15-49 who are anaemic (%)	na	na	18.9				
Knowledge of HIV/AIDS among Ever-Married Adults (age 15-49)							
32. Women who have heard of AIDS (%)	35.8	79.2	88.1	90	92	95	100
33. Men who have heard of AIDS (%)	na	na	97.0	98	100	100	100
34. Women who know	na	na	77.0	80	85	90	100

that consistent condom use can reduce the chances of getting HIV/AIDS (%)							
35. Men who know that consistent condom use can reduce the chances of getting HIV/AIDS (%)	na	na	92.4	95	96	97	100

BLINDNESS: The prevalence as on date is 1.1% and goal set for the terminal year of 11th plan is to reduce the prevalence of blindness to 0.8% by 2012.

Goiter /IDDCP: a). in age 6-12 yr s reduced from 7.1 to < 5 %

b).Median Iodine in urine levels from 100 microgmin/l in 2004-06 to 100- 200 microgm/l

c).Proportion with urine iodine , 50 microgm /l from 24% in 2004-06 to <20%

d).Proportion of Households consuming salt with >15ppm increased from current level of 84% to >90 %.

Chapter 8

SYSTEMS REFORMS

1.Simplifying processes / protocols.For any endeavour to succeed the processes have to be simple , transparent with no room for any ambiguity . Only then the officers / functionaries will have the confidence and take the initiative to implement proposed schemes.

Arrival of NRHM has unfolded a whole arena of opportunities which will be wasted if tenets of simplicity and timeliness are ignored . The three key areas where inputs from NRHM are going to flow are

i). Recruitments.
ii). Construction and repair of Infrastructure.
iii). Procurement of logistics and equipment.

The processes for all three are cumbersome , difficult to implement in the existing form. Govt of India has provided enough support by way of hiring staff and setting up management and financial structures. But that does not obviate the need for building sensitive / transparent and broad based systems for these activities.

All stakeholders have to be consulted so that State / District Level systems can be evolved .Procurement can be centralized to retain the benefit of numbers but the demand has to come from the districts and they will make the orders through this centralized unit which is broad based with members from all districts. The delivery will be made to the districts and payments released from there.

Similarly the policy of accrediting the private agencies / govt agencies for civil works categorizing them for different level of work by a monitoring committee comprising of members of different districts which will also monitor the quality and timeliness of work done will save a lot of time and unnecessary protocol. The districts can approach these agencies and get their work done.

As far as the recruitments are concerned they have to be definitely decentralized and at a fixed time in the year, all categories of contractual staff required can be advertised and recruited. This decentralization is important as the demand is clearly framed and approved by the IDHS. The staff recruited gets posted in the district which hires it and the problem of manipulating transfers is minimized. The IDHS can closely monitor the postings / work progress .

These mechanisms are planned to be put in place for the Mission on a priority basis.

2. Communitized monitoring mechanisms Ensuring accountability by effective monitoring and evaluation of work to be done at all levels by internal mechanisms and external mechanisms with community participation and grading of institutions by their performance. With empowerment comes accountability and institutions being upgraded are to be monitored very closely for improvement in performance. Communitised monitoring mechanisms have to form an important part of the healthcare delivery system.

3. Capacity building is to be taken as a mandatory exercise for all categories of staff. The skill development has to be relevant and appropriately timed. and linked to career promotion avenues whenever possible.

SECTION II
INTERVENTIONS

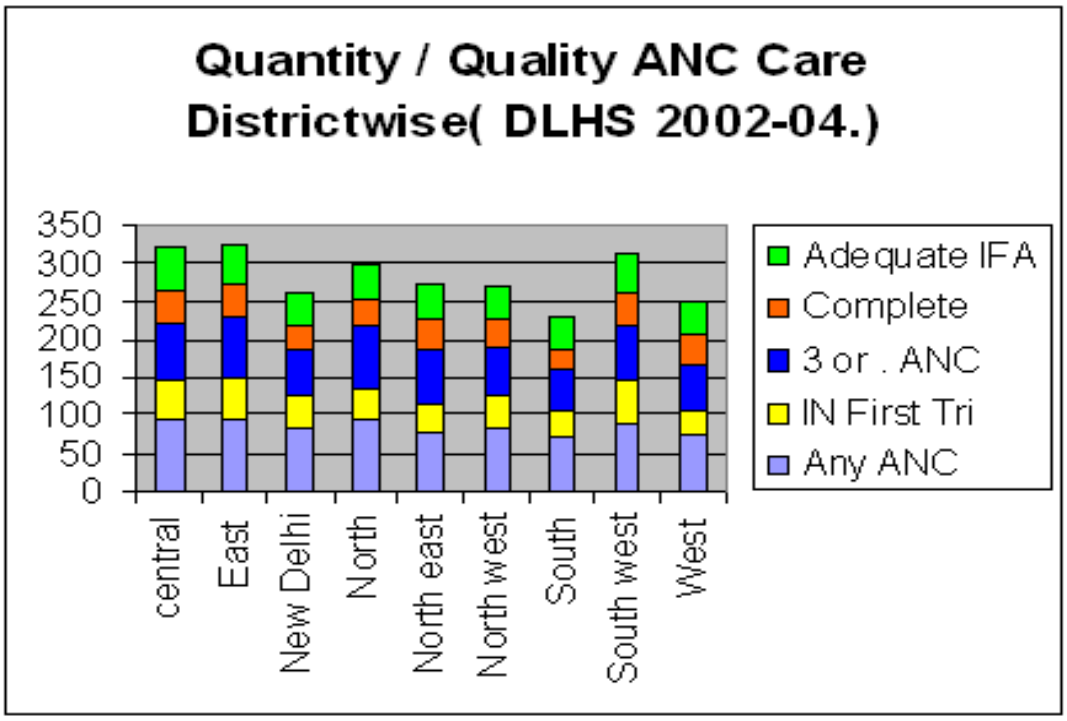
Chapter 9

REPRODUCTIVE AND CHILD HEALTH CARE II

A).Maternal Health

Main causes of maternal mortality are :

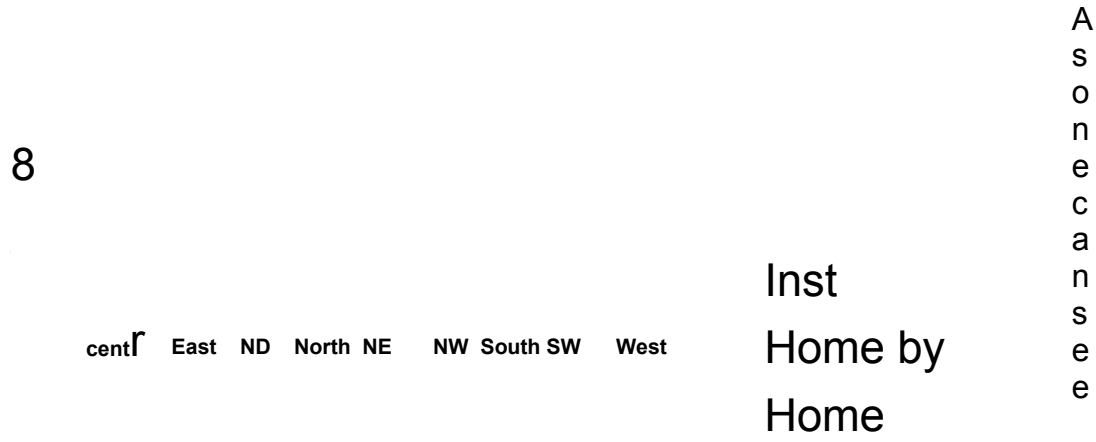
Heamorrhage., Anemia , Sepsis , Obstructed labour , abortions and toxemia . A relatively small percentage is contributed by other causes. A good antenatal , natal and postnatal care , safe abortion facility , prevention of unwanted pregnancies , Prevention and management of RTI / STIs ,Prevention and treatment of Anemia will take care of the mortality and morbidity associated withthese common conditions.



As can be seen majority of the districts are providing above 80 to 90 % coverage in terms of any ANC . ie at one point of time or the another the woman comes in contact with the health facility for ANC coverage . But reporting in first trimester for first ANC is poor and likewise the figures for complete ANC (three appropriately timed ANCs+ Inj TT + 100 tab IFA)is even lesser. Similarly only a small fraction of pregnant women are getting the desired amount of IFA . Hence the importance of improving the quality of antenatal care and emphasis on first

trimester registrations . The strategies to be focusing on healthcare providers MOs / PHNs / ANMs and the community link – ASHAs and ANMs.

Institutional & home delivery – District wise.



Central , New Delhi , and East, North are doing well in their institutional deliveries. The rate is low in Northeast , Northwest South and West. This is directly linked with the paucity of round the clock maternity services.,

Hence the emphasis on strengthening Maternity centres in these districts.

Prevalence of Mild , Moderate , Severe anemia in pregnant women (DLHS 2002-04)

Therefore the emphasis on tackling anemia.

A. MATERNAL HEALTH	
Situation Analysis/Current Status **Data : DLHS 2002-04.**	**Antenatal care-** Out of the 81.4% women who had any antenatal checkup, only 40.9% received an antenatal checkup in the first Trimester. Only 67.3% received three or more antenatal checkps Only 45.7% received adequate amount of IFA. And only 36.2% received full antenatal checkup**.** (**Data : DLHS 2002-04)**. **As one can see from the above data, provision of timely and complete antenatal care is a priority thrust area to address maternal mortality .** **Institutional deliveries –** 50% of women had institutional delivery and 49.3% had home delivery. 20.2% women delivered at home assisted by skilled persons . Out of all deliveries 59.9% were safe deliveries. **There is a paucity of functional Govt institutions providing round the clock delivery services.** **Complications** in **Post natal period** : DLHS (2002-04) revealed that 17.5% -women had post delivery complication , out of which 47.5% sought treatment for these complications. These were mainly in the form of lower abdominal pain , high fever , headache , foul smelling vaginal discharge, excessive vaginal bleeding , and rarely convulsion. **Strengthening of postnatal care needs inputs.** **Anaemia** is an important contributory factor in Maternal Morbidity and Mortality 46.5%-. --women suffer from mild anemia . 47.3% suffer from moderate anemia and 1.3% suffer from severe anemia. (DLHS 2002-04). **Reducing prevalence of anemia is an important priority area.** **RTI / STI** 26.2% of currently married women reported a symptom suggestive of RTI / STI (13.8%reported abnormal vaginal discharge) 48.% of those with abnormal vaginal discharge sought treatment for it. 15% of currently married women were aware of RTI/STIs, whereas 69.6% were aware of HIV / AIDS. 15.4% of men were aware of RTI / STI, whereas 87.8%were aware of HIV / AIDS.(DLHS 2002-04).

	NACP is making inroads with its IEC strategy but the awareness regarding RTIs / STIs has to be built along with provision of accessible treatment. **<u>AGE at marriage</u>** Mean age at marriage for girls 20.6yrs years and 23.8 for boys and more than 80% marriages take place above the legal age of marriage.
Objectives : **(Targets** **(Already laid down in the Goals and Objectives chapter in section one. To set Goals, NFHS 3 has been used.)**	1). Ensuring the increase in number of early registration of pregnant women.. 2). Improving coverage in terms of 3 antenatal checkups. 3). Ensure complete and Qualityassured antenatal care which must include all components of ANC and should be able to segregate high risk pregnancies with appropriate referral / and to detect complications well in time with appropriate management & referral. 4). Increase in the number of institutional deliveries 5). Provision of Post Natal Care (PNC) to monitor the post natal recovery of the women and to detect complications, early, followed by appropriate management & referral. 6). Decrease the prevalence of anemia. 7). Decrease the incidence of RTI / STIs and increase the health seeking behaviour for these.

Strategies for each / objective.	**<u>Objective (1):</u>** Ensuring the increase in number of early registration of pregnant women.. **Strategies** A).Have One ANM for every 10000 population. B).Have one ASHA for every 2000 population. C).Have BCC emphasizing the role of timely and complete ANC. **Activities:** 1).Recruitment , training and positioning of ASHAs. 2). IPC by PHNs, ANMs, AWWs & ASHAs 3).IEC through Pamphlets, Hand bills, Calendars, Flip cards etc. **Monitoring Indicators:** **Outcome:**Increase in First Trimester registrations (data from records /reports). **Process :**a).Number of ANMs / ASHAs in place against those required. b).Number of IPC sessions / Quantity and Quality of other IEC Material used. **<u>Objective (2). & (3).</u>** 2).Improving coverage in terms of 3 antenatal checkups. and 3).Ensure complete and Qualityassured antenatal care which must include all components of ANC and should be able to segregate high risk pregnancies with appropriate referral / and to detect complications well in time with appropriate management & referral. **Strategies** A).Strengthening the existing units to provide complete and quality antenatal care. B). Capacity building of care providers. C). Ensured one fixed day for ANC activity / clinic. D). Have health and nutrition days in the identified mother anganwadi every month. E). Screening of high risk cases.

F). BCC for promotion of service seeking for Complete antenatal care

Activities :

1). Recruitment of MOs to provide atleast 2 MOs for each centre.
2). Recruitment of ASHAs / ANMs.
3). Provision of Basic Lab for M&CW Centres.
4).Assuring availability of ANC Cards , TT Vaccine and IFA Tablets.
5). Refresher Trainings for MOs / LHVs / ANMs.
6). Provision of weighing scale / cards and training for AWW s.
7). Linking of Mother anganwadis with fixed centres.
8). IPC by PHNs, ANMs, AWWs & ASHAs supported by IEC Material.
9). Mahila Mandal meetings / Nukkad nataks .
10. RCH Camps / Health Melas .

Monitoring Indicators :

Outcome :a).Number of 3 ANCs .
b).Number of women receiving complete ANC Checkup.

Process: a).Number of PUHCs having 2 MOs / fixed ANCdays.
b).Number of mother anganwadis identified and equipped with weighing machines / cards / trained AWWs.
c).Number of health and nutrition days conducted.
d).Number of M&CW centres provided with basic labs .
e).Number of Nukkad nataks/ mahila mandal meetings held.
f). % of women aware of need of ANC checkup, place of availability of the services.
g). Number of units having stockout of IFA / TT/ other essentials for more than a month.
h). Population not having field ANM .

Objective 4).. Increase in the number of institutional deliveries .

<u>Strategies</u>

1). Strengthening of existing Maternity homes.
2). Providing new facilities through PPP.
3). Establishing definite referral linkages.
4). Implementation of JSY.

5). Multiskilling of personnel working in labour rooms.

Activities:

1). Strengthening of MCD Maternity Home to provide round the clock basic obstetric care / Basic Lab .

2). Tying up with NGO / Pvt organizations under PPPs (see details of MAMTA Scheme under Innovations.)

3).Prividing funds for hiring obstetricians / anesthetists for emergency caesarian sections.

4). Operationalizing 24 hrs. referral transport for transporting Obstretic emergencies from the community to the referral centres.

Tie up with CATS Ambulances has already been made wherein the ambulance transports the patient on an SOS basis and is later reimbursed on a per transfer basis.

5). Training of ANMs working in maternity home.

6). Publicity of JSY in Mahila Mandal Meetings / IPC by PHNs / ANMs / ASHAs/ RCH Camps.

7). Posting of PHNs in major hospitals for facilitating implenetation of JSY.

8).Meeting of M.S. of hospital and peripheral units, one per month.Once linkages are established the frequency of meetings can be decreased

Monitoring Indicators.

Outcome Indicators: Increase in Institutional Deliveries.
Increase in number of deliveries in the Maternity home strengthened.

Process Indicators: a). Number of Maternity homes made functional.
b). Number of PPPs for Institutional deliveries.
c). Number of JSY Beneficiaries paid for Institutional deliveries.
d). Number of SBAs trained .
e). % of deliveries where CATS Ambulance was used as a means of transport.

Objective 5. To detect any complications so that appropriate care including referral can be given on time.

Strategy / Activity

1). To strengthen the postnatal care by home visits by ANMs / ASHAs .

Monitoring Indicators :

Process Indicators: Number of postnatal visits made by ANM / ASHA within 48 hrs(upto one week of delivery).

Objective 6. Decrease the prevalence of anemia.

Strategy

1). Prevention of anemia by prophylactic supplementation.

2). Diagnosis of anemia and management according to severity.

Activities

1). Basic screening by the ANMs / ASHAs (trained)..

2). Provision of basic lab in units doing ANC.

3). Assured supply of IFA / Deworming agents.

4). BCC for nutritional councelling / awareness regarding symptoms and cosequences / prevention and treatment of anemia. By IPC/ Mahilla Mandals / Hoardings / Flip charts / Postors / handbills / RCH Camps.

Monitoring Indicators :

Outcome Indicators : a).Decrease in number of women with mild/ mod/sev anemia.
b).Increase in number of women aware of anemia /prevention/ treatment / consequences**.**

Process Indicators: a). % of units not having Hb% estimation facility.
b). Number of units not having IFA for more than 2 weeks.
c). Number of Mother anganwadis stocked with IFA in a need based fashion (ie. A Women

identified and being followed up in AWW).

Objective 7). Decrease the incidence of RTI / STIs and increase the health seeking behaviour for these.

Strategy/ activity

1). Training of MOs / LHVs / ANMs / ASHAs in RTI / STIs.
2). Provision of logistics like gloves / specula and medicines .
3). Recruitment of Skin / VD Specialist to visit the mother labs twice a week and from here will cater to attatched dispensaries.
4). To bring the partmer / ensure compliance of treatment by ASHA is an incentive activity.
5).Promotion of use of Condoms – Ensure availability of Condoms

Monitoring parameters:.

Process Indicators: a).% of units not having gloves / required medicines / condoms for more than 2 weeks during past one year
b).Number of staff trained .
c). Number of cases identified by ASHA and brought for treatment.

* Means of verification.

From records/ registers / monthly reports and inspections available .
In addition from time to time surveys will have to be performed.

Budget

Activities with financial implications:

a. Strengthening of existing units with MOs /PHNs/

ANMs/pharmacists/ staff nurse

Year	Number	Expenditure 2008-09	Remarks
No. of MOs recruited for RCH Programme.	150+84	= 706.5 lacs	RCH Flexi
No. of ANMs recruited for RCH activities	(4 7 0 + 2 0 5) old +375 (new) (1050)	=1112.175 lacs	RCH Flexi

b).**Provision of Lab for M&CW centre**

Year	Number	Expenditure in 2008-09	Remarks
Basic Lab including Lab Technician. One basic lab will cost 2.5 lacs in first year as it includes one time expenditure also,	50	125 lacs	From NRHM Flexipool. M&CW centres do not have a basic lab. 50 will now be strengthened.

c). Provision of referral transport

Activity	Anticipated referrals	Cost per visit	2008-09	Funds
Shifting of patients by CATS	600 tr per quarterx4	300 per transfer	**7.2 lacs**	**RCH Flexi**

d.Training of the relevant staff in quality ANC care.

Trainings	Trainee Category	2008-09	Remarks
SBA Training , MTP Training	MOs	**7.8 lacs**	**Funds from RCH Flexi**
Nutritional monitoring Training	AWWs	**90,000**	**NRHM Flexi**
RTI / STI	MO	**94,000**	**NRHM Flexi/ DSCAS**

	Paramedics		
IPC	MOs /PHNs/ ANMs/ ASHAs	**12.40**	**NRHM Flexi**

e). Provision of weighing machines , Cards , regular IFA supplies . in mother anganwadis

Item	Number	Exp per Unit	2008-09	2008-2009
Weighing machi\nes / cards	**3200**	**X 1000**	**3200 x 1000 = 32.00**	**NRHM Flexi**
Provision of IFA & Vit A, & ORS packets.	**800 units**	**5000/-**	**40 lacs**	**NRHM Flexi**
Condoms &OCs	**800 units**	**xxxxx**	**xxxxx**	**DFW**
Health and nutrition days in mother anganwadi	**400 X 12**	**X900**	**43.20 lacs**	**From RCH Flexipool.**

f).Recruitment of ASHAs

Year	Number	2008-09	2008-09
Recruitment of 5450 ASHAs to be Completed by the next year.	**Expenditure in detail in NRHM Additionalities**		

g). JSY Implementation :

JSY Implementation	2008-09	
Money for the beneficiary	**72 lacs**	**JSY Funds**
HR for Implementation	**7.2 lacs**	**RCH Flexipool**

h).Strengthening of Mat Homes

	Exp per unit	Number	2008-09	Remarks
Strengthening of Mat Homes	**Details in Additionalities.**	**20**	**508.46 lacs**	**N R H M Flexipool**

i). Setting up of RCH (M&CW) Outpreach centres in unserved / unserved areas for RCH Services.

	Exp per unit	Number	2008-09	Remarks
M & C W (R C H) Outreach Centres	See details in Additionalities	**25**	**157.5 + 90 lacs**	**N R H M Flexipool**

j). Conduct of RCH Camps

	Exp per unit	Number	2008-09	Remarks
RCH Camps	30,000/-	**70**	**21 lacs**	**R C H Flexipool**

k).BCC Activities SEE BCC

BCC activity	Exp per unit	Number	2008-09	Remarks
Mahila Mandal meetings Talks by MO / PHNs Nukkad Natak IEC material RCH Camps Health Melas Hoardings Handbills	BCC Specific budget to be taken as per proposal. State Level + background material will be provided by state.		See in section on BCC.	20 lacs in maternal Health has been prposed by RCH.

***Emergency Transportation Mechanism for Pregnant woman:** Delhi state has already initiated a very highly subsidized ambulance service through the CATS (Centralized Accident and Trauma Service) which are placed at strategic locations all over the states in each of the nine districts. The drivers are fully trained in managing medical surgical emergencies and on receipt of telephonic information (they all are wireless connected) reach the site within five to ten

minutes. Services of CATS have been taken for transporting Obstetric emergencies.

CHILD HEALTH INTERVENTIONS

With an IMR of 37/1000 live births & a total of about 3.5 lac births occurring annually in Delhi a projected 13000 infants die by the time they reach 1st birthday. Out of this 2/3rd (8000- 9000) die within first 28 days of life. Further on an average out of the 1000 infants deaths per month in the state (about 110-120 per district /month), between 600-700 are comprised of NBs who die per month at the state level meaning thereby that 70-80 NB deaths /district /month .

Simple to implement low cost antenatal, natal & Post natal activities if followed & practices universally in the state, are now recognised as international evidence for averting 3/4th of these deaths.(Lancet series – Child Survival June 2003 onwards)

The **strategies** therefore have to be balanced:

- NB Care (Home based, community based—IMNCI approach)
- At Birth—SBA capacity improvement of service providers- described under Maternal Health
- Increasing the Institutional Delivery acceptance & take- described under Maternal Health
- Promotion of Exclusive Breast Fedding & Weaning practices- IMNCI includes this aspect comprehensively and also the concept of IYCF centers in district hospitals
- Improving facilities for care of common childhood illnesses (Diarroea, ARI, Malnutrition—through trainings, equipments & adequacy of essential supplies)—IMNCI includes this aspect comprehensively
- Emergency transportation of women in pregnancy complication & also of the home delivered premature NB to secondary hospital in time—described under Maternal Health

- Improved Referral mechanisms between primary & Secondary care- described under Innovations
- PPP for maternal & Child health services (indoor facility for the BPL, SC, ST women & Children)--- Described under JSY & also below mentioned activities
- Improved coordination between ICDS & Health for timely detection & treatment of Gr 3 /4 Malnourished Children & subsequent rehabilitation—described & funded under the Convergence activity
- Routine Immunization Coverage improvement in previously un-reached – described & budgeted under RI
- Improved Monitoring at State, District, PUHC levels –described under Monitoring plan

STRATEGIES PLANNED:

Since Neonatal Mortality reflects 2/3rd of the Infant Mortality & since the IMR is planned for significant reduction over next 5 years from 35 to < 15 /1000 live births the followings are being planned:

1. **Phased Implementation of HBNCare & IMNCI in all the nine districts of the state over the next three years**: In the year 2007 – 08 no district could be taken up, however, in 2008-09, two districts wil be taken up for this intervention. In year 2007-08, a sum of Rs. 10 lac was given to 5 medical colleges for including pre service IMNCI curriculum in undergraduate trainings. In year 2008 –09, another sum of Rs. 10 lac will be given for same.

Activities/ timelines/budget:

- Recruitment of Training Coordinator for each district by June 2008—@ Rs 20,000/- -- Budget reflected under Training Head
- Training Facilities identification & trainers including scheduling their ToT by June 08 – budgeted seperately
- ToT completed in coordination with GoI by September 08 @ 10-12 per district- to be budgeted by GoI

- Training load of ANMs/LHVs/ Staff Nurses & MOs & schedule to be finalized between April 08 to June 08- field reports, data analysis, meetings
- Sourcing training material (including printing if required) & logistics(AV materials) by June 08
- Providing essential supplies, drugs, reporting formats, equipments (if any) to the PUHCs& the referred hospitals in the district
- Implementation starts in two districts supported by Supervision & Monitoring for referrals & their care at secondary facility by 3rd quarter of 2008.
- **EXPECTED OUTPUT: IMNCI IN ACTION**

OUTCOME Expected: two districts IMPLEMNTING IMNCI—EBF rates start improving, premature & sick babies are now refered to hospitals for appropriate care

Hospitals servces for refrred children improves (as per records)

Capacity of workers in identifying & also imarting the same knowledge to families improves significantly – resulting in increased child load at facilities (PUHCs& Hospitals – records)

Impact : Systemic Improvement in Coordination between Workers of health,ICDS & facility – finally resulting in decreased <6 child mortality in the long term

Budgetary requirements

Rs: 29.5 LACS (including Rs. 10 lac for pre service IMNCI)

2. Strengthening the Neonatal care facilities:

Since the infant mortality rate in the State is around 37 per 1000 live birth as per the SRS 2007 report, yet there is wide variation within districts (it ranges between 30 to75) and for making an impact, ***phased out*** **strengthening of neo-natal care services (through private sector participation) is an important component of this perspective plan.**

Activities/timelines/budget:

- Seeking Private Sector Participation in NNcare through inviting expression of Interest from the Registered NHs through open advertisement detailing the ToRs framed by the Neonataologist Experts group--- to be completed by June 08
- Finalisation of tie-up arrangements for selected slums with the Private NH finalized per district—by August 08
- Widespread focalized/differential IEC/ publicity on the Private facility (s) in each district so that parents/ women & families seek services from here without delays so as to serve the purpose/objective of saving Neonatal deaths
- Monitoring reports/field visits Rs 2.16 Lac
- **Results expected: Around 200 NBs delivered outside but having some** complication/health problem (identified & referefered by the ASHAor IMNCI trained, AWW, ANM,) or empowered families-detecting danger signs in NB (through IMNCI/HBNBcare project) seeking services directly once well informed through IEC/Publicity.
- **Budget:** Rs. 60 Lac

3. Trainings of All categories of service providers in Malnutrition management: Budgeted under capacity building separately

4. PEM management facility Strengthening

Malnutrition in the state continues to cause morbidity& mortality in the under 6 child cohort with the children in slums being most susceptible & vulnerable.

Through the concept of strengthened ICDS /Mother ICDS included in the State plan, it is expected that referral through timely detection of gr 3 & 4 PEM children coupled with capacity built through IMNCI trainings, increased number of children will be coming to the facilities for medical/surgical complications care.

Arrangements for Medical treatment & Nutritional Rehabilitation are thus critical.

Strategic Interventions planned

Creating Nutrition re-habilitation facility in atleast 1 hospitals per district

Provision of Paediatrics care directed towards management of malnutrition complications

Activities with timeleines & Budget:

- **L**isting of one hospitals /district for strengthening— June 2008 (Budget – Rs. 3 lac per hospital for 8 hospitals – total: Rs. 24 Lac)
- Establishing counseling centers (IYCF) at each hospital @ Rs 1 lac x 8=Rs 8 lacs.
- Training of the line staff by September 08- Budgeted under RCH trainings
- Identification of Nodal from ICDS for overseeing the Referral arrangement & Community based follow-up of treated & discharedged cases to prevent any relapse back

Total budget: Rs 32 Lac + Training budget shown separately

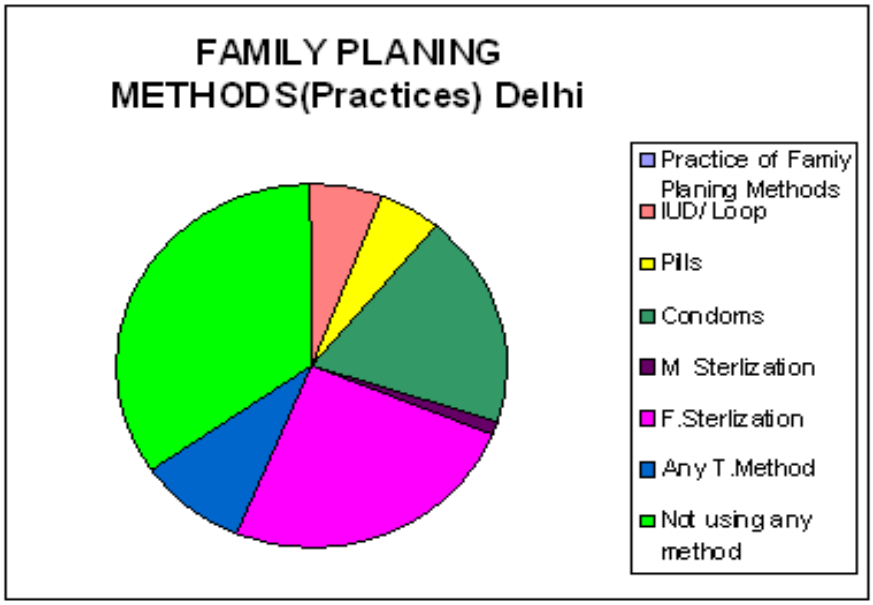
Child Health MONITORING INDICATORS

- Number of live births by sex and caste
- % of live births weighed
- % of infants underweight/ LBW
- % of such LBW referred in the two IMNCI district to hospitals (as reflected in the hospital data)

- Number of gr 3 & Gr 4 Malnourished children identified& referred to PUHCs/Hospital
- Number of 9-36 month old given Vit A by sex and caste
- Number of children severely malnourished children (<6 yrs by sex and caste) referred to institutions.
- Number of children who suffered from diarrhea / ARI and % who sought treatment.

FAMILY PLANNING

Although the NFHS 3 says that Delhi is almost there with a TFR of 2.1, there is no room for complacency. As Delhi is a tale of two cities the TFR in the affluent areas may be 1 and that in the slums being 3 or even 4 .



Highlights: High female sterilization, negligible male sterilization (therefore NSV strengthening & take/acceptance, to be improved), (condom use though relatively good is no guaranteed contraception); IUCD increase is a potential area for improvement.

Strengthening the Family Planning Services.
Goal to be achieved:

- Total Fertility Rate of 2.1 in an equitable pattern. (To reduce area specific CBR , TFR
- To provide services to couple in need-- 100 % coverage

Objective

1. To increase the use of planning methods from 62% to 65% by march08

65 to 68% by March 09

68 to 72 by 2010

72 to 75 by 2011

Between 75 to 80 % by 2012

2. To reduce the Unmet needs from 8% at the state level to < 2 % by 2012

Based on the situational analysis & scientific evidence we know that the limitations of Lack of Knowledge on benefits of small family, safety & simplicity of the procedures now available & poor coordination between the PUHCs & the secondary facility for the referral for availing of these services are important factors in addition to capacity of the facilities(overcrowded & larger focus on curative services) & even skills deficiency in workers for adequately addressing the issue over & above the social mindsets against the male sterilizations are reasons for low/ unsatisfactory performance & even for the existing unmet needs.

State Specific Micro- Challenges on Population Stabilization Front:

- Low or incomplete coverage due to large migratory population and difficult areas.
- Lack of proper linkage between community and health services.
- Lack of skilled surgeons in NSV
- Lack of facilities in all FRUs (Tubectomy & NSV)
- Relatively lower % of institutional deliveries thereby missing opportunity for family planning advocacy
- Lack of faith in Govt. services. Large unmet needs
- Lack of monitoring and evaluation

Micro- Actions Required:

- Extensive surveys of difficult areas.
- Difficult areas to be covered by
- ASHAs/RCH ANMs Supervision of the above by PHNs/MOs
- Outreach sessions.

- recruitment of more staff (RCH MOs and ANMs) thus filling up of vacant posts
- Refresher training of all categories of staff.
- IEC activities/BCC
- Monitoring & evaluation by BCC expert staff.
- Training/Awareness of adolescents in school ASHA, RCH ANMs, Anganwadi Workers
- PPP
- Involvement of NGOs
- Training of the surgeons for NSV
- Maintenance of regular logistic supply.
- Face-lifting of Govt. health centres
- RCH camp, NSV camps, Village Heath days.
- Counseling centre at all FRUs and tertiary Hospital

Strategy:

1 Strengthening the existing arrangements of service delivery

(sterilization cases to be accorded priority at the facility level)

Activities planned:

- making available female doctors at the Rural & high load dispensaries (through re-scheduled postings & newer appointments on contract)
- Ensuring uninterrupted supplies of contraceptives & implements
- Laparoscopes repairs& maintenance to be augmented
- Manpower to be trained & contracted wherever deficient
- Coordination through IDHS for systemic reviews amongst the service providers for making improvements in gaps

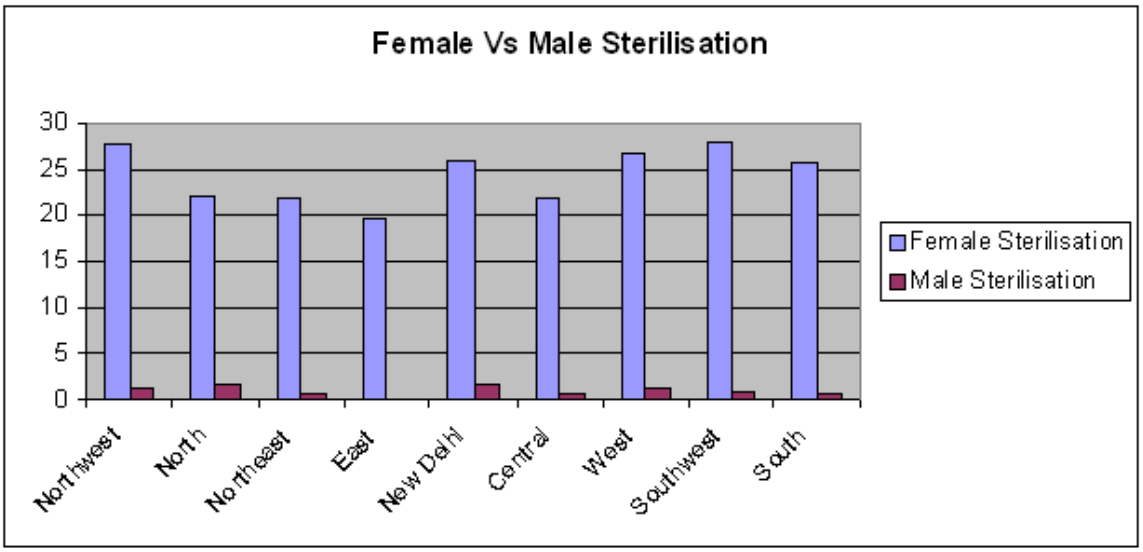
2.Increase the availability of Sterilization facilities in the districts:

Activities/ timelines:

- Creating & identifying & then strengthening more than one hospital in the district for the Lapro Sterilization
- Accreditation of facilities in the private sector- by June 08
- Equipments procurement by JULY 2008

3. Extensive Behavior Change Communication strategy:

- Design of Effective 'impact generating' messages propagating the benefits of small families through exemplifications of selected personalities at the National & International levels
- Benefits of the procedures & their safety to be disseminated through variety of channels
- Health Education to the target population visiting the health facilities for other reasons
- To conduct survey for assessing factors that could enhance Male Participation in Sterilization (NSVs)
- **To enhance camp approach for promoting NSV**
- **To provide transport facilities to sterlization acceptors to and fro from the hospital**
- **To strengthen the program implementation unit at Directorate of Family Welfare**
- **To enhance the monitoring at field level.**
- **Capacity building of service providers in terms of skill enhancement**



- Advocacy Efforts with policy planners

Progress Indicators

- % Increase in number of laparoscopic sterilization during the year
- Number of facilities now providing facilities of Sterilization in the district (% increase over last year)
- Percentage of female doctors freshly recruited for the dispensaries over projected/planned numbers
- % Increase in IUD insertions at the PUHCs at the end of 2008 march, 2009 March
- Number of doctors trained in Laparoscope's use for sterilization

- Number of centers accredited for sterilization
- % of weeks contraceptives 'Not Available' at the district stores during the year
- Number of FGDs conducted & supervised
- % Increase in demand seeking at select hospitals
- % Decrease in unmet needs over one year period

Total Budget: Rs. 75.13 lac

1. Incentive Compensation amount:

- Lap Sterilization incentive money for women operated = Rs 1.4 crores
- NSV compensation money for male surgery done -- 75 lacs

2. Training of ASHA, ANMs,AWWs etc on the communication strategy & Promotional messages for increasing the demand .

3. Innovation : Transportation cost to beneficiary for availing the services of the hospital (to be done by the referring PUHCs) @ Rs 200 per beneficiary

4.BCC: Comprehensive IEC budgeted separately under IEC budget.

Gender Equity & PNDT Act issues:

Goal: To Arrest & Reverse the Adverse Sex ratio in the State.

Objective:

To bring up the ratio from 826 to 875 by 2012 through creating a gender sensitive society/community /provider pool.

Strategies:

a).Constitution & activation of the State & Districts Committee

b).Intensifying the BCC through promoting the Gender equity issues at important platforms/Events through advocacy. Important Successful Women personalities—listing the Toppers Girls/Achievers girls of Secondary& Sr Secondary classes & recognizing them publicly. For this support from Development partners/ Corporate would be considered.

c).Training & Sensitizing the Service providers (all categories) on the moral, ethical, biological, soci-demographical & regulatory aspects of the issue & the Act so that the same gets disseminated & also acted upon by the workforce in day to day life.

Activities:

1. Listing important public events during the year

2. Listing support from personalities within/outside the district (especially women achievers) of prominence in public life

3. Designing appropriate messages (differential for different population groups within the district) through technical inputs of the district task force experts.

4. Strengthening the PNDT cell at the HQ

5. Workshops & training

Sub activities:

Short listing an agency professionally sound for the message designing job (BCC expertise)

Repeated consultations of the core group Approval of the IDHS

Conducting trainings

Implementing BCC activities

1. BUDGET: Rs 17.55 LAC required from GoI
2. State provided Rs 12 lacs in year 2007-08

D).ADOLESCENT HEALTH

ADOLESCENT HEALTH	
Situation Analysis / Current Status	**Important Issues:** **1). Nutritional : Anemia is highly prevalent , especially in adolescent girls. According to DLHS 2002-04, around 18.8% adolescents suffer from mild, 51.6% suffer from moderate anemia and 28.7% from severe anemia.** **2). RTIs / STDs** **3). Early Marriage** **4). Unsafe abortions .** **5).High Risk Behaviour. Around 70% of adult deaths are a result of some habit / aberrant behaviour acquired during adolescence.**
Objectives	**1. Decrease the prevalence of anaemia among adolescent girls to half of the current levels by 2010.** **2. Having an established system for provision of Counseling/ help for adolescents and all issues related to them. Councelling on high risk behaviour / promiscuity and Reproductive Tract infections and STDs. Increase awareness of hazards of substance abuse including alcoholism among adolescents and provide help where needed.** **3.Reduce the (prevalence) /incidences of early marriage leading to teenage pregnancies by half of the current levels by 2012.**
Strategies & Activities	**Objective 1. Decrease the prevalence of anaemia among adolescent girls by half the current levels by 2010.** **Strategies** 1. Screening and Diagnosing anemic adolescent girls by the ANMs. ASHAs ,AWWs , Severe cases referred.

Activity

a). Trainings of

i).ANMs. (as an important component of RCH Training)

ii).ASHAs (part of their induction and refresher Training).

iii). AWWs – Trainings to be specifically organized.

iv). Provision of basic lab facility to diagnose anemia

Monitoring

Process Indicators	Output Indicators	Outcome Indicators
1). Number of ANMs / ASHAs / AWWs trained (from records) 2).Number of primary healthcare units not having hemoglobinometer . 3). Number of these which have been provided with required equipment.	**1).Number of adolescents screened . 2). Number of mild , moderate and severe anemics recognized.**	

Strategies

2.Treatment of Mild to moderate anemia . Referral of severe cases.

Activity;

a). Provision of sufficient stock of iron and folic acid/ deworming agents with the ANMs / PUHCs.

Monitoring:

Process Indicator	Output Indicator	Outcome indicator
% of primary healthcare units not having sufficient stock of iron / folic acid / deworming agent.	**Number of severly anemic adolescents referred and received treatment.**	**Actual decrease in prevalence of anemia in adolescent boys and girls. (Baseline , Midterm / Endline surveys).**

Strategies

3). Convergence with School Health / ICDS

Activity:

a). Involve the ICDS department in providing IFA tablets and nutritional

advice to all anaemic adolescent girls. See multi sectoral convergence .

Monitoring:

Process Indicator	Output Indicator	Outcome indicator
a). Number of mother anganwadis having iron and folic acid supplies	**a). Number of identified anemic adolescent girls being given Fs/Fa by AWW**	

Strategies:

4. BCC/ IEC regarding awareness about causes/ effects / symptoms/ prevention/ diagnosis / T/T of anemia.

Activity:

a). 1). BCC thru ANMs/ ASHAs in the field using IPC.
2). Issue to be a part of Adolescent clinic conducted once a week.
3).Visual aids / AV aids to be provided to the the field workers / MOs / School Health staff and ICDS workers.

Monitoring:

Process Indicator	Output Indicator	Outcome indicator
a). Number of ASHAs / ANMs / Anganwadis / School health Units having IEC material on anemia issues and using it. b). % of Schools where session on anemia has been conducted for secondary classes. b). % of Units having fixed day Adolescent Clinics.	a). Number of mothers and adolescents who have become aware of the causes / effects / symptoms/ prevention of anemia. (Survey).	

Objective 2. Councelling on high risk behaviour and Reproductive Tract infections and STDs. Increase awareness of hazards of substance abuse including alcoholism among adolescents and provide help where needed.

Strategies:

a).Having fixed day adolescent clinics in PUHCs.
b).To hold hands with the department of Education to address adolescent

issues through " YUVA".
c). For adolescents not having access to school , through ANMs / ASHAs.

Activities:
a).Training of MO/ ANMs/ AWW / ASHA in adolescent health issues
b).All ASHAs and AWWs will be oriented on problems faced by adolescents, signs and symptoms of the problems and where to refer these cases.
c).Organise regular adolescent clinics in PUHCs / counseling sessions at schools SEE CONVERGENCE.
d).Adolescent health sessions / clinics will be held in PUHCs / YUVA swasth clinics in schools with service delivery & referral support
At PUHCs weekly clinics to be held for two hours where only adolescent's problems will be solved. Untied funds can be used for organizing field activities . Circulate information on services provided at these clinics and setup referral system
e).Identification of de-addiction centers in the state/district
f).Referrals to de-addiction centers for treating alcoholism/drug addiction
The state / district will identify NGOs or other de-addiction centres in the state and through the health workers will refer the cases in need to these centres for treatment.
g).Risk reduction counseling for STI/RTI
During the monthly or weekly interactions through health sessions and clinics, counseling for preventing STI/RTI will be also be done. This will include single partner sex and use of condoms for safe sex.

Objective 3. Reduce the incidences of early marriage leading to teenage pregnancies by half of the current levels by 2012.

Strategies;
a).Prevention of early marriage .
b).Delaying first pregnancy
c).Improve access to safe abortions

Activities:
a).Special advocacy of appropriate contraceptive methods to delay first pregnancy. ASHA , AWW , ANM should specially focus on teenage marriages.To have an adolescent health session at youth / adolescent meetings / nutrition and health days .Newly married adolescents will be registered in the eligible couple register and counseled for adopting temporary methods of family planning.
b).Ensure availability of condoms / OCPs / Emergency contraceptives.Depot holders among adolescent groups/youth organizations

c).YUVA Doctors can deliver talks at these meetings.
d).In addition to the ASHA and the AWW, youth organizations and others will have depot holders who will provide condoms /OCPs and Emergency contraceptive pills and maintain confidentiality.
e).MTP services made available at identified subdistrict and District hospital. Training of select medical officers and the availability of these services will be publicized through ASHAs / AWWs/ANMs in the district.

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Objective 4
To increase awareness levels on adolescent health issues

Strategies
a).YUVA swasth to be taken up, initially as a pilot in selected schools in two districts.
b).Organizing Behavioural Change Communication campaigns on specific issues of adolescence.

Activities
a).IEC activities along with take-home print material to be organized by ASHA in coordination with PUHC staff.
b).One of the monthly theme meetings will be related to adolescent health problems, signs and symptoms, treatment and referrals.
c).YUVA will have an important BCC Component.

Activity	**Exp per Unit**	**Expenditure in 2007-08**	**Remarks**
Trainings	See capacity building	3.6 lacs	**RCH Flexi**
Y U V A Component		See Convergence	**N R H M Flexi**
Monitoring the school health		See convergence	**NRHM Flexi**
Providing IFA , d e w o r m i n g agents.at the m o t h e r anganwadi		See convergence	**NRHM Flexi**

	Youth meetings / vocational sessions	**Xxxx**	**xxxx**	**Untied fund of attatched PUHC.**

Activities not carried out in RCH during 2007-08

Maternal Health

Cessarian delivery by Pvt. Doctors
For 1000 deliveries at rate of Rs. 2000/- per case
Total Budget 1000 x 2000 - 20 lac

Child Health

1. Printing of Manuals Rs. 1000 per set for 400 sets - 4.0 lac
2. Equipment like baby warmer, phototherapy unit Rs. 70,000 per unit x 25 sets -17.5 lacs (20 MH + 5 FRUs)
3. PPP for New Born Care -10 lacs.
4. Care of sick & malnourished - 18 lac
5. Management of Diarrhoea/ARI/Micronutrient - 1.0 lac
6. Depot holder 250 center at rate of Rs. 1000/- - 2.5 lac

Family Planning

Printing of Family Planning Manual on Quality Assurance - Rs. 15000/-
One Workshop on Family Planning - Rs. 2.0 lac
Support to DMA on Family Planning (sponsorship) - Rs. 4.0 lac
Laprocator procurement (20) at rate of 3.5 lac - Rs. 70.0 lac
CuT Insertion kit (400) at rate of Rs. 2500/- - Rs. 10.0 lac
Light source (100) at rate of Rs. 800/- - Rs. 8.0 lac
Repair of Laproscopes - Rs. 20 lac
Transport cost of BPL Male & Female for NSV/Tubectomy - Rs. 20.0 lac

ARSH
Printing of Manual on Adolescent Health - Rs. 1.0 lac

NGO
For Anaemia correction PPP with VHAI - Rs. 30.0 lac

IMEP (Bio Medical Waste)
Manual for 500 centres of MCD at Rs. 100/- per centre - Rs. 0.50 lac

DFW Store rent at rate of Rs. 8000/- per month - Rs. 9.6 lac

Shifting of Store from 2 battery lane to Pitam pura - Rs. 5.0 lac

Vehicle for supply of vaccine & drugs from 2 Battery Line to various Delhi Govt. Dispensaries/Hospitals - Rs. 3.0 lac

Testing of RCH drugs – Rs. 2.0 lac

Generator for store – Rs. 5.0 lac

M & E
Evaluation of RCH Programme by external agency - Rs. 5.0 lac

Procurement	Quantity	Total
Foetoscope	100	
BP apparatus	200	12.0 lac
Weight Machine	200	
Baby Wt. Machine	200	

IMEP supplies like gloves, masks, bleaching powder etc. - Rs. 10.0 lac

Drug Kit A/Kit B, PHC Drugs, STI/RTI drugs - Rs. 40.0 lac

ORS with Zinc, Iron suspension and Vit. A - Rs. 10.0 lac

Activities Omitted from this years' PIP (2008-09)

1. **Maternal Health:** Ceasarean Deliveraies by Private Doctors in Govt HospitalsBudget in 2007-08: Rs 20 lacs

2. **Child Health:**

a) Printing of Manuals Rs 4 lacs(2007-08)

b) Management og Diarrhea/ARI/Micronutrient Rs 17.5 lacs(2007-08)

c) Depot Holder Rs 2.5 lacs(2007-08)

3. Family Planning:

a) One workshop on FP Rs 2.0 lacs(2007-08)

b) Sponsorship to DMA Rs 4.0 lacs (2007-08)

4. NGO

For Anemia Correction PPP with VHAI Rs 30 lacs

5. Evaluation of RCH Programme Rs 5 lacs

Note: Equipments/Drugs etc. could not be procured in 2007-08 as Govt. of India did not allow it. However in March 2008 only permission is provided and procurements will be done in 2008-09.

SUMMARY BUDGET OF RCH for 2008-09

S.No.	Activity	Budget Prepared (Rs. in Lac)
1.	Maternal Health	70.56
2.	Child Health	119.68
3.	Family Planning	75.13
4.	Adolescent Reproductive & Sexual Health	0.80
5.	Urban RCH	48.00
6.	Tribal RCH	Nil
7.	Vulnerable Group	Nil
8.	Innovations/PPP/NGO including PNDT	17.55
9.	Infrastructure & Human Resources	1892.609
10.	Institutional Strengthening	45.22
11.	Tranings	102.6
12.	BCC/IEC	143.72
13.	Procurement	107
14.	Program Management	122.22
	TOTAL	**2745.089**

OTHER ACTIVITIES UNDER RCH in 2008-09

S.No.	Activity	Budget Prepared (Rs. in Lac)
1.	Janani Suraksha Yojna	72
2.	Compensation Funds	215
3.	Mother NGO Scheme	145
	TOTAL	**432**

Grand Total = Rs. 3177.089 Lac

Chapter 10

STRENGTHENING IMMUNIZATION

Since the introduction of UIP in the country during the year 1984-85 great achievements have been made in controlling and curtailing the vaccine preventable diseases. Infant Mortality Rate (IMR), under 5 child mortality rate and Maternal Mortality Rate have a direct co-relation with immunization. Immunization is a useful tool recognized the world over in bringing down the IMR directly and reducing the maternal mortality/morbidities.

INTRODUCTION

Delhi is an old city and slowly expanded over the years to acquire its present status to metropolis. The total population has increased from 94.2 Lacs in 1991 to 138.5 Lacs in 2001 (1.3% of all India Population) with an area of 1483 Sq. K.M. and density 9294 per Sq. K.M. which is highest in India. More than 76% population lives in the difficult areas including more than 50% in the urban slums. Delhi comprises of 9 revenues districts, 27 Sub Divisions, 3 statutory towns. 59 census Towns, 165 Villages, 70 Legislative Assemblies, & 14 Municipal Zones. Multiple health agencies such as Delhi Government, Central Government, Local bodies (MCD, NDMC, Delhi Government), CGHS, Autonomous organizations such as ESI, Railways, Defense, besides non governmental organizations & private health sector are involved in the implementation of RCH programme at the primary, secondary & tertiary care levels. The major health agency for the primary health care services is the MCD, which is responsible for 93% areas and 96% population but is presently catering to only 50% population (77 Lacs through its 136 M C & W Centers and 25 Maternity Homes. The unique problems of Delhi are large migratory population (5 Lacs per year), daily influx of lacs of people for health services and employment from the neighboring states, multiplicity of health agencies, uneven distribution of facilities at all the three levels of the health care, 76% population living in the unorganized areas and 33% patients at the health facilities are from neighboring states. The health being the priority sector of the planned development of Delhi Government and major provider of the health care, the public health expenditure of Government of Delhi had been kept at 10.3% of the planned outlay for the 10th Plan (Rs.2381.3 Crores).

A unique challenge faced by the state under the UIP is migration of partly immunized or totally unimmunized populations adding to the susceptible pool of vaccine preventable disease. The survey conducted by ICMR for district in Delhi,

indicates that 80% of the children in the age group of 12- 23 months are fully immunized. However within the districts wide variations exist on the coverage levels with children living in slums having very low levels ranging between 25-48 % fully immunized stratus. This calls for some focus to the vulnerable through mobile immunization services & also partnering with small service NGOs with credible presence within the districts. It means that out of 3 lac children annually, around 60,000 are left out, meaning thereby 6-7 thousand in every district, or say, 500-600 children every month every district. Recruitment of ASHA and ANMs under RCH II will facilitate the immunization of these missing children and activities as proposed under the PIP will facilitate the coverage as well as sustain it.

Currently the IMR in Delhi is 40/1000 live births (NFHS3) while the National average is 57/1000 live births.

Ultimate Goal : To reduce < 5 mortality
To reduce IMR & improve child survival

Intermediate Goal: -

To reduce incidence of vaccine preventable diseases thereby reducing the IMR.

To achieve Measles Coverage's to >95 by 2012

Objectives:-

1. Achieve agreed level of DPT-3 coverage of 95% from the current DPT coverage of 73.7%
2. Increase FI RI from 63 % in 2005 (NFHS3) to >95% by 2012
3. Reduce BCG to measles dropout rate to the agreed level of less than 10 % from the current level of more than 15 %.
4. Achieved the agreed level of 100 % coverage of pregnant women with two doses of TT from the current level of 75.6 %.
5. Increase access to safe injection

STRATEGY PLANNED FOR IMPROVING RI COVERAGE:

1. **Focusing on Missed Vulnerable (distances, mental barriers, resistance etc):**
    - Activities planned: Listing & identifying pockets unreached (mapping)
    - Micro planning sessions for this group regularly
    - Mobile immunization services regularly through partnering with the existing Mobile health Clinics under the DHS with some facilitatory support to be provided under the scheme.
- Deployment of additional trained ANMs & Supervisors

2. **Effective Systematic Monitoring & Tracking of Drop-Outs:**

- Provision of Tickler bags for keeping the Counterfoils
- Training of ANMs& Supervisors in its use
- Proper record entry& retrievals for review
- Training to ASHA for tracking & facilitating in mobilizing

  Differential IEC & BCC towards accepting services

  Quality Assurance : ADS,Trg. To workers,Cold Chain, Monitoring

3. **Convergence** with important stake holders (amongst PUHCs) & ICDS strengthened
4. **Onsite Supervision** strengthened
5. Focus on quality immunization service in dispensaries/MCW centres/FRUs/Tertiary hospitals
6. Focus on **biweekly immunization** services in dispensaries /MCW centres/FRUs/Tertiary hospitals.
7. Fixed days for immunization during '**Outreach Session**'.
8. Involvement of **Private Sector** (Nursing homes/clinics/hospitals) for providing immunization services.
9. Bringing **NGO's** to fillup gaps in unserved underserved areas.
10. Strengthening the **Cold Chain System.**
11. Strengthening MIS/ reporting system.
12. **Focus on Monitoring of programme.**

ACTIVITIES TO REACH THE UN-REACHED/VULNERABLE

ACTIVITIES TO REACH THE UN-REACHED/VULNERABLE

1. Mobilization of Children by ASHA: Around 2300 ASHAs are in place in Delhi working in difficult areas. ASHAs are the crucial link between MCH care providers and the community. Each ASHA is looking after 2000 population in Delhi. Therefore it is proposed that ASHAs may be provided Rs. 100/- per month for mobilizing the children in their area for immunization sessions. Therefore, the cost implication for the whole year starting from April 2007 to March 2008 is: 2300 x 100 x 12 = **Rs. 27, 60,000/- (rupees Twenty seven lac Sixty thousands only)**

2. Immunization services in slums and underserved areas:

The scheme is planned for implementation through public as well as private service providers (mostly NGOs). The scheme will be monitored by health officials at the District level of Govt. of Delhi, health officials of Municipal Corporation of Delhi, and state officials.

In last financial year i.e. 2006-07 a total of 8 NGOs catering to only 5.6 lac population in 5 districts were supported by the department under the scheme for providing immunization services in slums, however due to ever increasing migration leading to slums, in the year 2007-08, it is proposed to outsource immunization to NGOs for10 lacs population. District have been sensitized on the process to be followed for selection of credible NGOs.The selection of the NGO shall be based on representation of the NGO to the State or District followed by verification of the antecedents, intent and capability of the NGO as well as need by the District CMO. The sum permitted by Govt. of India, under the scheme for immunization sessions in 2007-08 has been Rs 400/- per session for maximum of 4 sessions in a month for population of 10,000 (ten thousand) and additional Rs. 400/- (four hundred) as contingency for the whole month. The cost of **the Rs 24.00 lacs for** the whole year.

The proposal for additional coverage of five lac population is based on the positive results obtained from the experience for past one and half year. Initially the selection of NGOs was based on the observations of field volunteers of NPSP, WHO, Assembly Coordinators working for PPIP in 70 assembly segments of Delhi and location & past work of NGOs in that particular underserved location.

3. Monitoring and supervision:

Delhi is having 9 districts, therefore, mobility support for all the districts and state level officials may be provided @ Rs. 50,000/- per district. The total cost implication is **Rs. 5, 00,000/-** (Rupees five lac only).The districts will be additionally delegating the supervisory practices to the medical officers of the peripheral centers such as MCWC & DAD for their participation, sense of involvement, ownership of the program & better results. For monitoring purposes a check list has already been in use in every district for uniformity in monitoring activities as well as to cover most of the essential checks.

In Delhi there are two immunization days, namely Wednesdays and Fridays for every health facility, however the hospitals are providing immunization services on daily basis. Moreover, the NGOs as mentioned above and also the RCH ANMs are providing immunization on more than two occasions in the week as outreach sessions in the field. The schedule of these immunization sessions is usually made available to the district for monitoring on the regular basis. In the year 2007-08 more than 450 sessions have been monitored and documented. The feed back provided on the spot as well as at the state level has been shared with the respective stake holders. Since the funds for RI were released late in October-November, 2007 the exact expenditure under various activities during the year so far has been on lower side. However, continuing the activities in the coming year is proposed and the improved infrastructure due to the DPMU's is likely to improve the efficiency of utilization of funds.

District level programme officers were also imparted master level trainings in Immunization Hand book for Health Workers so as to facilitate supportive supervision as well during monitoring visits. The rates for hiring the vehicles will either be State Transport Authority Rate or the rates as finalized by the Health Society/ SCOVA or finalized by the department as per GFR. The officers entrusted with the monitoring job may also be authorized to use their own cars and be given reimbursements as per the rates for TA as per rules and entitlements.

4. Review Meetings:

Review meetings are essential component of any plan/scheme to review the progress as well to find out the constraints in implementation as well as the performance. The occasion can also be utilized to educate train and apprise the officials about change in guidelines, policies etc. The review meetings are planned both at District level and State level to review the progress made in front of Routine Immunization and allied interventions. At District level the meetings will be held every two months and at State level every six months. Total Budget proposed is **Rs.5.00 lacs**

5. Cold Chain Maintenance:

In Delhi there are 55 Regional Vaccine Stores having twin set comprising of one ILR and one deep freezer each. In Delhi cold chain machines position is as follows:

ILR (Lit.)				DEEP FREEZER (Lit.)			
70	140	300	Not functional	140	300	280	Not functional
25 no.	81 no.	10	1 (140 lit.)	94	18	6	10 (140 lit.) 1 (300 lit.)

There are three refrigerator mechanics with the state but none with any of the districts. Despite the constraints, the down time for cold chain equipments is not more than 48 hours. It is being felt at the district level that the funds that are allocated for minor & major repairs and maintaince of equipments fall short of actual requirement. Therefore, we proposed allocation of Rs.50000/- per district per year along with another Rs.50000/- at the State level for the above purposes. In addition the State needs provision of 1 Cold Chain Officer and 1 Refrigeration Mechanics to provide support to the districts in maintaining and correcting the faults in the Cold Chain Equipments on day to day basis. Salary of CCO @ Rs.25000/-X12 =Rs.3.00 Lacs per year. Salary of Refrigeration Mechanics Rs.15000/-X12X1 = Rs.1.80 Lacs
Total Budget is required is **Rs.9.80 Lacs.**

6. Printing of Immunization Cards, Immunization Register and other stationery:

In Delhi, there are more than 3 lac births every year and the state has to make provision for immunization related stationary viz. Immunization cards, registers, temp. Charts and tickler boxes etc. Since the budget allocated last year for the purpose are now in the process of utilization we propose building a buffer stock of 3.00 lacs immunization cards at a cost of **Rs.5.00 Lacs**.

7. Computer Assistant at State Level:

Already a Computer Assistant cum Steno has been contracted at the State H.Q. Services of the same are proposed to be continued during the year 2008-09. However, since the qualification and also the job requirements of the Steno cum Computer Asstt. are multiple and job intensive, we proposed a hike in the salary to Rs.12000/- p.m. as was also proposed in the previous year. This may be considered favorably in the light of the fact that quality inputs desire suitably qualified and experienced person to man this job. Budget required @ Rs.12000/-X12 = **Rs.1.44 lacs.**

8. Computer Assistant at District Level (a):

9 Computer Asstt. already recruited during 2007-08 for working at the districts @ Rs.7000/- p.m. are proposed to be continued during the year 2008-09. Budget required @ **Rs.7000/-X9X12 = Rs.7.56 lacs**.

9. Computer Analyst at State H.Q.:

As the system of MIS is strengthened and now initiatives are undertaken in the field of VPD Surveillance, AEFI Surveillance and monitoring. The various forms, formats etc. are to be designed for data entry and later on analysis for the same. Besides, now public private partnership is envisaged in immunization programmes. Therefore, a database of the same has to be maintained. To streamline all these activities, there is a need of Computer Analyst, who knows the computer languages and be able to design, operates, maintain the programmes and train people. Also, the programmer will be able to help in designing and maintenance of the interactive website which is proposed at S. No. 13 of this note. Therefore, it is proposed that a Computer Analyst is hired on contract @ Rs. 15,000/-. p.m. **Budget required @ Rs.15000/-X12 = Rs.1.80 lacs.**

10. Capacity Building / strengthening the infrastructure for VPD Surveillance:

At present at State Headquarter, the infrastructure at State Immunization Office requires strengthening in form of One Fax Machine along with exclusive telephone line for surveillance and reporting. The cost implication for all the strengthening is **Rs. 1.00 lacs.**

11. Mobility support to LHV's & Other Health Supervisors for field/Outreach Sessions

For effective monitoring of the immunization sessions, it is proposed that field level supervisors like LHVs and PHNs be provided with mobility support @ Rs. 4 per k.m. for maximum of 25 km. upto eight days in a month. In Delhi it may be required for 200 Supervisors. Budget required **= Rs.19.20 Lacs.**

12. The State Initiatives from its own resources:

Delhi state has its own plan schemes in the area of Immunization and Child Health with outlay of Rs. 312 lac. However, the major portion of this outlay is for procurement of Typhoid Vaccine, Birth dose of Hepatitis-'B' and MMR Vaccine, which are Delhi specific antigens. The part of this budget is also spent in improving the quality of the Immunization Programme by way of provisions of Syp. Paracetamol for recipient of DPT vaccination, Alcohol swabs, IEC, trainings, research activities and demand

generation activities including catch-up rounds etc. Some of these funds are also utilized for the activities of VPD Surveillance

IMMUNIZATION PIP --- reflected through the log frame

GOAL	OBJECTIVES	STRATAGIES	ACTIVITIES	O IND
Improve the Routine Immunization Coverage to 90% by the end of 2009	To increase the availability and accessibility of services for Routine Immunization.	Strengthening of Routine Immunization services in slums under served areas and other areas with the help of NGOs	1. Identification of NGOs capable of providing services in underserved areas. 2. Identification of new areas needing services. 3. Allocation of area and signing of TORs. 4. Monitoring of immunization sessions by DIOs 5. Awareness and demand generation by link workers including Asha & Basti Sevikas of IPP VIII 6. Supportive supervision by supervisory visits by LHV/PHNs.	
Creation of Database on health facilities, VPDs, performance of RI & related data district wise and also the feed back mechanism	To improve the quality of immunization services	Capacity Building	7. Review meetings at District levels on bimonthly basis. 8. Review meetings at state level every six months	
		Cold chain Maintenance	1. Trainings to H.W. (F) in safe immunization	

			practices. 2. One telefax facility at State ((HQ), exclusively for VPD Surveillance
		Printing of Immunization cards register of Tickler Box/bags and other related stationary	1. Imprest, repair work, Procurement of compressors & accessories/parts etc.
	To improve the reporting/MIS of Routine Immunization services as well of vaccine Preventable Diseases and to develop feedback mechanisms.	Provision of Computer Assistant at state level	1. Limited/open tender enquiries Procurement & distribution
		Provision of Computer Programmers at State Level.	Already Working
		Provision of CDEO at district level.	1. Formulation of Recruitment Rules. 2. Press advt. for vacancy and recruitment 3. Consultation Process at all trends and modification of existing MIS for RI 4. Training of district level CDEO 5. Maintenance & updating of interactive website
		Creation of Distt. Wise list of health facilities for data	1. Formulation of

		flow to state HQ strength districts		RRs & recruitment of CDEO, Data Entry of RI reports. Regular consultation & interaction with state	
		Interactive website for RI		1. Inviting expression of interest from organizations carrying out survey work. 2. Entrusting work of enlisting health agencies facilities carrying out RI, district wise and agency wise 3. Calling a consultation meeting at distt. HQ/ state HQ for all agencies having health facilities in the district wise. 4. Receiving data district wise in contrast to the present agency wise system.	
				1. Finalizing terms and conditions, contents etc. for the website 2. Inviting expressions of interest and commissioning of website, allocating pass	C b N re ti H 3.

			ward/codes to district for entry of data of Govt. health facilities as well as for private health facilities in graded manner like Hospitals, Nursing Homes, members of IAP than GPs, on monthly basis district wise. **3. Making available the circulars policy decisions etc. related to RI on web**	**C p c d th R th D** **2.** **3.** **1. the we**

Total Budget for Routine Immunization Proposed for 2008-09 = Rs. 112.4 Lac

1. NGO participation for un-served areas = **Rs.24.00 lacs**
2. Data entry support to the districts = **Rs.7.56 lacs**
3. **Computer Assistant at State Level: Rs. 1.44 lac**
4. Cold chain maintenance support to the districts = **Rs.5.00 lacs**
5. Mobility support for supervision (at District + State)= **Rs.5.00 lacs**
6. Mobilization support to ASHA and Basto Seweka = **Rs.27.60 lacs**
7. Review Meetings at state and district level = **Rs.5.00 lacs**
8. Printing of immunization cards = **Rs.5.00 lacs**
9. Field Mobility support to supervisors (150 LHV's) = **Rs.19.20 lacs**
10. Computer Analyst at State Headquarter = **Rs.1.80 lacs**
11. Infrastructure for VPD surveillance = **Rs.1.00 lac**

12. To provide enabling environment and working space for Mobile Health Clinics during Outreach Immunization (folding chairs, tables, folding shade umbrellas, plastic banners and one Public Address System in each vehicle) = **Rs.5. 00 Lacs**.
13. **Cold Chain Officer 1 @ Rs.25000X12 = Rs.3.00 Lacs**
14. **1 Cold Chain Technician @ Rs.15000X12X1 = Rs.1.80 Lacs**

Requirement of Funds for implementation of State PIP on Immunization for 2008-09

S.No.	Activity	Amount Required (Rs.)
1	Mobilization of Children by ASHAs	27,60,000
2	Immunization services in slums and underserved areas	24,00,000
3	Monitoring and supervision	5,00,000
4	Review Meetings	5,00,000
5	Cold Chain Maintenance	9,80,000
6	Printing of Immunization Cards, Immunization Register and other stationery	5,00,000
7	Computer Assistant at State Level	1,44,000
8	Computer Assistant at District Level (a)	7,56,000
9	Computer Analyst at State H.Q	1,80,000
10	strengthening the infrastructure including Mobile Vans	5,00,000
11	Mobility support for LHV's & Health Supervisors	19,20,000
	TOTAL	**112.4 lac**

Total Budget Required for RI = Rs.112.4 Lac

Progress Monitoring:

- **% of of outreach sessions conducted against planned**
- **% increase in reported immunization (will indicate both, the improved reporting & improved seeking of services)**
- **% decrease in reported gaps in DPT3 , DPT2 & DPT1 (will reflect the tracking system)**
- Number of cases of Measles reported during the last one year in comparison to previous years.

11.Other National Health Programs:

Under the State Health Mission, National Health Programs form part 'D' of the PIP. State Health Society headed by the Mission Director and chaired by the Pr.Secretary (H&FW) oversee the implementation and monitoring of National Programmes in Delhi in reference to Tuberculosis, Leprosy, Blindness, Iodine deficiency disorders, Vector Borne Diseases such as Malaria, Dengue and Integrated Disease Surveillance Project. The consolidated action plans of each National Program along with budgetary implications are provided in subsequent pages. It is pertinent to mention that under the mission now most of the activities in most of the programs are planned district wise and will be implemented at the district level

Programme Implementation Plan NLEP Delhi – 2008-09

1. Introduction:

The National Capital Territory (NCT) of Delhi is one of the fastest growing agglomerations in the world. State is spread over 1483 sq km with a population (projected) of over 17 million (2007). Population Density is 12000 persons/ Sq Km highest among other metropolis of India. Delhi is having better health care facilities, cosmopolitan culture and very well connected by Road, Rail & Air to all major cities in the country. About 40% of Delhi's population lives in slums. The rural area of Delhi comprises about 165 villages. In addition to State government, Delhi is governed by three local bodies, the New Delhi Municipal Council (NDMC) the Municipal Corporation of Delhi (MCD) and the Delhi Cantonment Board. Leprosy services are provided through general health care system (dispensaries and hospitals) under an integrated setup. To support national leprosy eradication programme of NCT of Delhi, International Federation of Anti-leprosy Associations (ILEP agencies) have played a key role since 2001. Leprosy services were integrated into general health care services in the year 2003. A Memorandum of Understanding (MoU) was signed between Govt. of India (GoI) & ILEP agencies in the year 2005, highlighting the areas of support to be provided, mainly in the form of District Technical Support Teams (DTSTs) besides support provided to hospitals, NGOs, for Reconstructive surgery (RCS) and Socio-Economic Rehabilitation. Following integration there was steep increase in the number of health care facilities providing leprosy services. This brought MDT services to the door step of the patients. To provide sustainable quality leprosy services to patients is a challenge due to continued migration of population from neighbouring states.

High case load is mainly due to migrant cases from endemic states, causing transmission to continue. New cases detected in NCT of Delhi contribute to 2.26% of national aggregate. Proportion of Female among new cases is 21.8 % way below the national average of 34%. Proportion of Deformity among new cases is 6% much

higher than the national average of 2%. Administratively there is Multiplicity of authority in health sector with parallel reporting system. There is high turn over of HC staff (DLO, Medical officer, and support staff). NLEP is given less priority compared to other national program. Operationally, high population mobility, poor treatment completion rate (due to treatment irregularity) causing high defaulter rate and Poor referral mechanism. There is lot of social stigma due lack of awareness in the community

2. Situation analysis

2.1 Problem description:

NCT of Delhi is still recognized as a problem state, because of its urbanization and being a capital of the country. The state has contributed 3146 new cases during 2006-07, with Disability Grade II of 5.91 %. MB & child proportion is 58.3 & 4.39 % respectively. Proportion of female patients reported last year is 18.53%.

Though the political commitment is high, funds/resources are available, strong and committed SLO and DLOs are in position in all the nine districts of Delhi, main problems identified through participatory SWOT analysis are as under:
Infrastructure and manpower:

- Inadequate medical and paramedical staffs proportionate to the population
- Overburden programme managers and service providers
- Lack of motivated and skilled manpower
- Counseling to the patients and family members is lacking
- Hospital staff is overloaded, also lack of interdepartmental coordination
- Untrained contractual staff.

Administrative and Operational factors:

- Funds are underutilized due to absence of decentralized plans
- Disparity between fund norms of NLEP and other programme
- In-coordination among different health governing authorities
- Poor case holding
- Referral system is not in place hence management of difficult cases is delayed
- Rudimentary secondary level referral units
- Deformity management is lacking in major hospitals.
- Supervision and monitoring at district level is lacking
- Social workers are not sensitized about leprosy services so there is communication gap between consumers and service providers.

Social factors:

- There appears lack of awareness and persistence of stigma in the community.

- Leprosy Programme is given less priority due to more important national Programmes like Polio, Malaria, and TB etc.
- In-coordination among different health governing authorities
- IEC activities are insufficient

2.2 Main stakeholders:

Central Leprosy Division under Ministry of Health & Family Welfare constitutes the nodal organization to manage National Leprosy Eradication Programme (NLEP) in the country. State programme is managed by a State Leprosy Officer (SLO) and District Leprosy Officers (DLOs) respectively. MOs and PMWs in each of nine districts of the State are also working. There are public and private hospitals, dispensaries, providing leprosy services. There are consultants, dermatologists, physicians, leprosy assistants, engaged in providing leprosy services in major hospitals of Delhi. Dispensaries are managed by medical officers, pharmacists and ANMs. Community leaders, traditional healers, private practitioners, volunteers, representative of social welfare department also form the group of stakeholders.

To add value to the program, there are following coordination (partners, who are kept informed) and cooperation partners (with whom, the programme has to work closely):

Cooperation partners	**Coordination partners**
MCD	Social welfare department
NDMC	Rehabilitation NGOs
DefenceServices/ Delhi Cantonment	Education department
Central Govt. hospitals/CGHS dispensaries	
ESI	
Indian Railways	
Private hospitals	
ILEP Hospitals	
Delhi Vidyut Board/BSES/ NDPL	
Indian airlines	
Banks (State bank, Reserve bank)	
Delhi Jal Board	
Delhi Transport Cooperation	
Local NGOs	
Institute of Physically handicapped	
Autonomous bodies like AIIMS	

2.3 SWOT Analysis:

The stakeholders collectively carried out the SWOT Analysis. Following is the compilation of the outcome of SWOT analysis.

Strengths: - A very efficient, dynamic and dedicated state programme officer and, District Leprosy Officers. NLEP services are integrated into general health services. There is sufficient number (343 today as compared to 11 in 1999) of HCFs providing health (leprosy) services to the community. Adequate man power, logistics, MDT supply & funds are available to carry out activities in the state. There are number of tertiary health care unit providing specialized services. Leprosy assistants are also available in 11 major hospitals for record maintenance and counseling to the leprosy patients. Regular review of programme at state level via quarterly meeting and

monitoring of reports. There is also good internal coordination. Communication & transport facilities available for the programme managers. There is strong political will and commitment towards NLEP in the state

Weaknesses: - As the CDMOs, ACDMOs are not involved in the programme, DLOs (District nuclei) are overburden with other assignments, so monitoring & supervision aspect is lacking in the districts. Health care staff is also lacking motivation & skills. There are some newly untrained contractual health care staff under NRHM. In the hospitals, specialists are overburden because of insufficient support staff. There is also interdepartmental in-coordination.In most of the hospitals, special leprosy clinic day is fixed for the patients. There are no referral linkages between primary & tertiary level referral units. Secondary level referral units are rudimentary. POD services are lacking at the peripheral level. Planning is still not decentralized at district level. Recording & reporting system is complicated. Poor treatment compliance of leprosy patients due to lack of counseling. Patients follow up is poor because of incorrect or frequent changes of address. Less involvement of private hospitals/doctors in the programme. IEC is insufficient. There is lack of coordination among different health providing authorities e.g. DGHS, MCD & NDMC. Funds are also underutilized. There is also disparity between funding norms of different programmes in comparison to NLEP. NLEP is often side lined and neglected by DLOs because of additional responsibilities. Social stigma is still persisting in the community.

Opportunities: - There are number of HCFs (Governed by different authorities other than Delhi Govt.) for providing health care services to the people. Leprosy services are under NLEP, a centrally supported programme. In the state, number of NGOs & community volunteers, ILEP and WHO are also providing support to the state programme. Free supply of MDT and other aids to the patients. Leprosy assistants with computer skills are also available at 11 tertiary care/major hospitals to support the programme. Newly introduced programme, NRHM will provide extra support to the leprosy programme, as the NLEP is the integral part of the above programme. There is also strong political will behind the programme. Delhi Govt also has “Bhagidari” scheme to ensure community participation. RCS services are also provided by some tertiary care intuitions (GOs & NGOs). Communities are changing their behavior towards leprosy & its related services.

Threats: - Elimination targets are still in the minds of administrators and policy makers hence other aspects of the program are not paid attention. Sudden/frequent transfers of trained & skilled Medical officers, DLOs and other staff may adversely affect the programme. Discontinuation of external support from ILEP & WHO will create some gaps in the services. Beneficiaries are not aware about availing the services. Large number of migratory and floating population is the main problem of service providers.

4. Objectives, purpose, results

Through situation analysis, weakness and problems were identified, strategies were discussed, and objectives / purpose / results were formulated as under:

Hierarchy of	Objectively Verifiable	Means of	Assumptio

objectives		Indicators (OVI)	Verification (MOV)	
Overall Objective:				
Reduction of leprosy burden in line with National scenario				
Purpose:				
Sustainable & quality leprosy services available				
Results:				
1.	**Increased early self reporting**	1. Proportion of endogenous cases with disabilities (total of Gr. I and Gr. II) decreased from 13% to 10% by 2009, 2. Proportion of cases self reported within 6 months of observed signs/ symptoms 3. Number of patient registered with GR-0 disability i.e. without disability	1. MPR 2.Special data collection	
2.	**Quality of case management improved**	1. Proportion of HCF making correct diagnosis at registration - greater than 95% by March 2009 2. Proportion of patients developing new or worsening of current disability decreased to less than 2% by 2009 3. Proportion of patients with NFA done increased to 70% by end of 2008, 4. Proportion of patients completing treatment in time increased from 60 % to 80 % by 2009	1. Validation of cases 2. DPMR records reporting formats 3. Patient card 4. Cohort study treatment completion	-No disasters -no major changes -No delay NRHM - Limit transfers -Willingness major partne -ILEP suppo
3.	**Improved DPMR services**	1. Proportion of reaction cases treated adequately (with prednisolone) increased to 95% by 2009 2. Proportion of needy cases provided surgical treatment increased to 50% by end of 2008, 70% by March 2009, 3. Proportion of needy cases	1. DPMR reports	

		provided supportive appliances increased to 70% by 2008, 4. Proportion of disabled cases practicing self care increased to 30% by end of 2008, 40% by 2009,		
4.	**Improved referral system**	1. All H.C. units having guidelines for referral by Dec. 2008 2. Proportion of cases availing and complying the referral services 3. Proportion of cases provided services at secondary / tertiary level 4. Number of cases referred back to the primary health centers	1. Yearly data collection from community health center 2. DPMR reports	No disasters
5.	**Improved Supervision at all levels**	1. No. of districts fully formed & functional district nucleus by Dec. 2008 (9 districts) 2. All the identified HCF of the distt. is visited/supervised at least once in two months by end of 2008 3. All HCF should receive feed back at least once in two months 4. No. of review meeting involving all partners - (quarterly /yearly) 5. Proportion of correctly filled patient cards 100%	1. District nucleus i. SLO/DLO office report 2. Activity register at district i. Supervisory visits ii. Feed back 3. Minutes of meeting	
6.	**Improved Programme management**	1. Availability of annual action plan on LFA involving all stake holders by February of each year 2. Fund availability and utilization (SOE) monthly 3. Proportion of participating units (AV) submitting MPR in time (7th of following month) 4. Reports available in integrated Hospital Information Management System by December	1. SLO office, DLO (Action Plan document) 2. SLO, DLO (SoE) 3. SLO/DLO – MPR, MoM, SLO Office, 4. SLO – Information at SLO office 5. Meeting register at SLO 6. Supervisory visit	

		2008 5. Integration/advocacy meeting held with cooperation partners half yearly 6. No. of HSR projects completed 7. Fully equipped and functional SLO/DLO office		
7.	**Ownership of NLEP by existing agencies**	1. Proportion of identified agency wise HCF providing MDT / Leprosy services 2. Proportion of participating units (agency wise) indenting MDT from district stock 3. Proportion of participating units (agency wise) sending MPR to DLO 4. Proportion of participating units (agency wise) referring complicated case to referral hospitals 5. Joint quarterly meetings carried out	-SLO (MPR) -MPR -DPMR referral -SLO (Mo)	
8.	**Increased participation of leprosy patients in society**	1. Number of LAP getting employment in organized sector 2. Decreasing number of new LAPs in leprosy colonies 3. Increased participation of LAPs in social activities	1. Patient employment card a. KAP study of community 2. 'P' scale of patients study	
Preconditions:				
			Collaboration between State Partners continues (MOU si between GOI and ILEP Me Representatives)	

5. Infrastructure and Manpower: The State Unit will be located at Directorate of Health Services, F-17, Karkardooma, Delhi.-32. This will be assisted/ supported by State programme management unit. There is no regular vertical staff in Delhi. The staff required under NLEP at state and district level will be engaged on contract basis.

State Leprosy Cell: Contractual staff required at state level will be as follows:

Medical Officer. @ Rs.25000/-	1
NMS @ Rs.10000/-	1
Steno @15000/-	1
CDEO @12000/-	1
Clerk @Rs.11000/-	1
Drivers @ Rs.8000/-	2
Peon @ Rs.7000/-	1

District HQ: Recently Secretary Health government of India requested to all state to put two in district nucleus. Keeping in view the work load, there is a genuine need of two staff in district nucleus. Contractual staff required at district level will be as follows:

NMS @ Rs.10000/- one in each district	9
Leprosy Assistants @Rs10000/- in 11 major hospitals	11
PMW* @ Rs.9000/- one in each district	9
Drivers @ Rs.8000/- as per availability of vehicles	3

6. Training Plan: Number of staff to be trained district-wise are as follows:

Training	EA	NE	NR	NW	WE	SW	ST	ND	CE	State	Total
(i) Training of private practitioners, Dermatologist & other Registered Medical Practitioners. One day	30	60	30	60	60	30	30	30	30	90	450
(ii) Training for new entrants – HS and HW (M&F) 4days	30	60	30	60	60	60	60	30	30	60	480
(iii) Reorientation training of PHC MO 2 days	60	60	30	60	30	60	30	30	30	90	480
(iv) Training to Lab Technicians for smear examination. Physiotherapists/Occupational Therapists 5 days	6	6	6	14	10	6	8	6	6	10	78
(v) Other categories as per DPMR plan	30	60	30	60	60	60	60	30	30	60	480

need MO MCD/NDMC/ESIC others 4 days											
iii) Reorientation training of HS and HW (M&F) 2 days	60	60	60	90	60	60	30	30	60	120	630
(vi) Training of ASHA for one day.	200	250	200	100	150	200	250	200	60	100	1710

7. IEC plan

IEC campaign on the theme "Towards Leprosy free India" will be conducted round the year. The major heads to be covered are: Mass Media – TV, Radio, and Press Outdoor Media, Rural Media, Advocacy Meetings. "Special Campaigns" for selected marginalized groups with high New case detection rate. The detailed activities as per objective wise are mentioned below:

8. Activities:

Act. No.	Activities	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Who is responsible
Result 1: Increased early self reporting						
IEC						
1.1	Skin camps (general public)	√	√	√	√	DLO
1.2	Community leader (Pradhans, RWAs, Councilors) meetings	√	√	√	√	DLO ILEP
1.3	NGOs meetings	√	√	√	√	DLO
1.4	Mahila Mandal Meetings	√	√	√	√	DLO
1.5	School/college oriented activities, teachers and children	√	√	√	√	DLO
1.6.	AWW / ASHA meetings	√	√	√	√	DLO
1.7	Involvement of GRCs (gender resource centers) i. advocacy meetings with Social welfare and mother NGOs ii orientation in leprosy	√	√	√	√	DLO
1.8	Involvement of mass media	√	√	√	√	SLO
1.9	Involvement of outdoor media	√	√	√	√	SLO
1.10	Advocacy with media	√	√	√	√	SLO
1.11	Involvement of	√	√	√	√	SLO/DLO

	NSS/NCC/Religious organisation /Bharat Scouts and Guides/NYK/civil defense in IEC					
1.12	Painting competition				√	SLO
1.13	Health Melas	√	√	√	√	SLO/DLO
Training						
1.14	General practitioners	√	√	√	√	DLO
1.15	Service providers (Drs.)	√	√	√	√	DLO
1.16	Service providers (PMWs)	√	√	√	√	DLO
Result 2: Quality of case management improved						
2.1	Listing and training of new recruits 4 days for each category staff, including counseling	√				DLO
2.2	TNA and refresher training 2 day	√	√	√	√	DLO & MO
2.3	Training in DPMR	√	√	√	√	DLO
2.4	Reorientation of ASHA, 1 day	√	√	√	√	DLO & MO
2.5	Cohort analysis annually	√	√	√	√	DN
2.6	Review meetings	√	√	√	√	DLO
2.7	Monthly analysis of MPR and supervision visits report, feed back to MO I/Cs of PHCs	√	√	√	√	DLO
2.8	Validation surveys for correction diagnosis, annually (sample)	√	√	√	√	DLO
2.9	Follow up of patients by LAs	√	√	√	√	LAs
2.10	Identification of person /place / time for counseling	√	√	√	√	MOs/Phar/LAs
2.11	Examination of contacts	√	√	√	√	MO/LAs
Result 3: Improved DPMR Services						
3.1	Preparation of training plan / programme	√				SLO / DLOs
3.2	Procurement of training modules and manuals	√				SLO / DLOs
3.3	Training activities on DPMR - primary and sec. level	√	√	√	√	SLO / DLOs
3.4	Procurement of Prednisolone and other	√		√		DLO / MO I/Cs

	drugs and Dressing mat./ splints at primary level					
3.5	Disability assessment of all cases	√	√	√	√	ILEP/MO
3.6	Screening of cases for surgery and their pre-operative care	√	√	√	√	MO
3.7	Post operative care of RCS care at Primary and Secondary level	√	√	√	√	PT & MO
3.8	Procurement and distribution of protective aids and other appliances	√	√	√	√	DLO
3.9	Training of disabled and LAPs in self care	√	√	√	√	DLO/MO
3.10	Developing self care groups	√	√	√	√	ILEP + DLO
3.11	Supervision of DPMR activities (Result 3 + 4)	√	√	√	√	DN/DLO
3.12	Developing linkages with secondary/tertiary + rehabilitation centers	√	√	√	√	SLO / DLO
3.13	Generating reports and review meetings	√	√	√	√	MO / DLO
Result 4: Improved Referral System						
4.1	Design and Procure and distribution of GOI guidelines	√				SLO & DLOs
4.2	Mobilization of cases at all levels & their counseling as per GOI guidelines	√	√	√	√	Peripheral health workers & volunteers
4.3	Designing & using of referral slips	√	√	√	√	SLO / DLOs
4.4	Training of GHC staff on criteria & indicators for referral (part of DPMR)	√	√	√	√	DLOs
4.5	Maintaining records, reports & review	√	√	√	√	MO I/c of GHC & DLO
Result 5: Improved Supervision at all levels						
5.1	Formal order to identified district nucleus staff to function in DLO office	√				SLO & CDMO
5.2	Formulation of supervisory check list	√				DLO & SLO
5.3	Supervisory visits and	√	√	√	√	DLO & SLO

	feed back to every HCF at least 1 visit in two month					
5.4	Submission of quarterly supervision reports by DLO to SLO	√	√	√	√	DLO
5.5	Discussion on supervisory reports during review meeting (qrly)	√	√	√	√	SLO
5.6	TNA for supervisors (DLO,MO,PMW)	√				SLO/DLO
Result 6: Improved programme management						
6.1	First draft action plan for next year available by 30th September every year		√			SLO/DLO
6.2	Finalization of plan by November 30th			√		DLO / SLO
6.3	Fund availability / based upon SOE	√	√	√	√	SLO
6.4	Quarterly review meetings	√	√	√	√	SLO / DLO
6.5	Training manuals (from GOI)	√				SLO
6.6	Advocacy meeting with coordination/cooperation partners	√	√	√	√	SLO/DLO
6.7	MPR collection	√	√	√	√	DLO
6.8	Making MDT available (MPR based)	√	√	√	√	SLO/DLO
6.9	Computerization of records	√	√	√	√	SLO/DLO
6.10	Procurement of MCR footwear splints, equipment of RCS etc.	√	√	√	√	SLO
6.11	Random checks and feedback	√	√	√	√	SLO/DLO
6.12	Performance review of DLOs (Qtrly. including supervision capacity)	√	√	√	√	SLO
6.13	HSR	√	√	√	√	SLO/ILEP
6.14	Mid term review		√		√	SLO
6.15	End evaluation				√	ILEP
Result 7 Ownership of NLEP by existing agencies						
7.1	Communication within the health services	√	√	√	√	DLO
7.2	Random checks and	√	√	√	√	SLO/DLO

	feedback					
7.3	Performance review of DLOs (qtrly. including observation capacity	√	√	√	√	SLO
7.4	Communication within the stakeholders	√	√	√	√	DLO
7.5	Equipment / logistics	√				SLO
7.6	Making available Monitoring / reporting formats	√	√	√	√	SLO
7.7	Supervisory visits by existing agencies	√	√	√	√	SLO/DLO
7.8	Quarterly review meeting	√	√	√	√	SLO / DLO
Result 8: Increased participation of leprosy patients in society						
8.1	Identification of organizations (survey)	√				DLO & ILEP
8.2	Sensitization meetings with organizations	√	√	√	√	DLO
8.3	Sensitization meeting of community leaders (formal & informal)	√	√	√	√	DLO
8.4	Sensitization meeting of school principals	√	√	√	√	DLO
8.5	Meetings with community based organizations	√	√	√	√	DLO

9. DPMR:

This is a major activity during the year 2008-09. The operational guidelines will provide assistance on various actions to be planned and executed. Training and procurement of drugs are included in the respective heads. Procurement of MCR footwear and splint and appliances are also added here. Welfare allowance for RCS patients from BPL families and reimbursement to Govt. Hospitals is also proposed. Better co-ordination with departments like Social welfare, Labour & Education, Local Self Govt. etc. will be ensured in respect of rehabilitation of LAP.

10. Urban Leprosy Control:

There are 9 identified urban areas located in Delhi. The dermatologists / private practitioners will be involved for NLEP activities. For these urban areas for continuation of the activities fund is proposed under –

- Supportive Medicine: In addition to the district procurement plan.
- Honorarium to part time dressers
- Leprosy assistants in major hospitals
- MDT delivery services: Includes case follow up for treatment completion.
- Monitoring & Supervision: Includes periodic meetings & mobility.
- In addition, Training and IEC are also included in the respective heads for the district. While preparing Action plan, the marginalized urban poor groups and

also those who are not living in the slums and colonies are given priority.

11. Procurement Plan:
Procurement of different categories of items for the year 2008-09 are included in the plan. MDT supply will remain free from WHO during the year. State/District has to procure supportive drugs, laboratory reagents / equipments and printing of registers, forms etc. at the following rates:

- MCR Footwear @Rs.250X60 pairs
- Splints & crutches @Rs.7000 / Year / dist
- Patient welfare @Rs.10000 / Year / dist
- Printing cost @ Rs.20000 / year/ dist

12. Contractual services:
In addition to technical staff proposed under infrastructure and manpower, hiring of services from outside agency like the Auditors or the assistance from accountants is proposed here.

13. NGO services:
No NGO was sanctioned SET project during the year 2007-08. However this year it is proposed to give grant to 2-3 NGOs. A budget of Rs.500000/- has been proposed for supporting NGOs during the year 2008-09.

14. Incentive for ASHA:
The state has kept some provision for payment to ASHA as an incentive for assisting the Health Centres in completion of Treatment by the leprosy affected persons. Rates will be @Rs.300/- - PB cases (6 dose), @ Rs. 500/- - MB cases (12 dose).

15. NLEP Monitoring and Review:
Provision is made for supervision and travel costs for contractual staff like surveillance Medical Officer, BFO, NMS, drivers. Review meetings at State and District level. MDT supply and management cost (Transportation from State HQ to districts) are added here.

16. Vehicle operation and hiring:
As per number of vehicles available in running condition at State and District level separately, the cost required for POL and maintenance is proposed here.
The number of vehicle required for hiring at state and district level and cost involved is also proposed under this head.

17. Role of ILEP: ILEP will provide support the NLEP Delhi in the field of:

- Capacity Building of Programme officers and Core trainers
- Disability assessment survey
- Evaluation of NLEP on periodic basis
- Research activities including COMLEP/HSR
- Advocacy meeting at state level
- Strengthening of referral system
- Assist DLOs in implementation of NLEP activities

18. Support from NRHM Flexi Pool:

- Computer, printer , fax, telephone with broadband services

- Provision of Data entry operator at District leprosy officer's office
- Mobile Phone to state and district programme Officers

19. Office expenditure and consumable

Office expenditure and consumable are proposed as per need of the state and keeping in mind the inflation. The requirement in GNCT Delhi is definitely higher than the other states.

20. Total Budget requirements: The total budget required for Delhi is **Rs.11834000/-(**Rupees One Crore Eighteen Lacs Thirty Four Thousand only).

FUNDS REQUIREMENT FOR NLEP DELHI 2008-09

SN	Activities & PIP Norms	1	2	3	4	5	6	7	8	9	10	Allocation
1	**Contractual services**	**EA**	**NE**	**NR**	**NW**	**WE**	**SW**	**ST**	**ND**	**CE**	**State**	**Total (Rs.)**
	MO. 1 @ Rs.25000/-										300000	300000
	NMS 10 @ Rs.9000/-		108000	108000		108000			108000		108000	540000
	11 Leprosy Asstt @Rs9000/-	108000	108000	108000	216000	216000	108000	108000	108000	108000	108000	1296000
	PMW* 9 @ Rs.8000/-	96000			96000		96000	96000		96000		480000
	DEO @9000/-										108000	108000
	Drivers 5 @ Rs.7000/-	84000		84000						84000	168000	420000
	Peon @ Rs.6000/-										72000	72000
	TA/DA MO+Driver OTA	75000	75000	75000	75000	75000	75000	75000	75000	75000	150000	825000
	Hon for Acc work @Rs.1000/- pm	12000	12000	12000	12000	12000	12000	12000	12000	12000	12000	120000
	Audit Fee										40000	40000
	Total	**375000**	**303000**	**387000**	**399000**	**411000**	**291000**	**291000**	**303000**	**375000**	**1066000**	**4201000**
2	**Office Expenses**											
	SLSSHS (NLEP) @ Rs.30000/- per year										30000	30000
	IDHS @ Rs. 20000/- per year	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	200000

	Purchase of Fax LCD Projector										150000	150000
	Total	**20000**	**20000**	**20000**	**20000**	**20000**	**20000**	**20000**	**20000**	**20000**	**200000**	**380000**
3	**Consumables**											
	SHS (NLEP) @ Rs.30000/-										30000	30000
	IDHS @ Rs.20000/-	20000	20000	20000	20000	20000	20000	20000	20000	20000		180000
	Total	**20000**	**20000**	**20000**	**20000**	**20000**	**20000**	**20000**	**20000**	**20000**	**30000**	**210000**
4	**Vehicle operation / POL/hiring**											
	SLS @ Rs.75000/- x 2 vehicles/ year										150000	150000
	DLS @ Rs.60000/- x 2 vehicles/year	120000	120000	120000	120000	120000	120000	120000	120000	120000		1080000
	Total	**120000**	**120000**	**120000**	**120000**	**120000**	**120000**	**120000**	**120000**	**120000**	**150000**	**1230000**
5	**Supportive Medicines**											
	IDHS @ Rs. 15000/- per year	**15000**	**15000**	**15000**	**15000**	**15000**	**15000**	**15000**	**15000**	**15000**	**0**	**135000**
6	**Materials & Supplies**	**EA**	**NE**	**NR**	**NW**	**WE**	**SW**	**ST**	**ND**	**CE**	**State**	**Total (Rs.)**
	MCR Footwear @250X50 pairs	12500	12500	12500	12500	12500	12500	12500	12500	12500	0	112500

	Splints&crutches @5000 / Year / Dist	5000	5000	5000	5000	5000	5000	5000	5000	5000	0	45000
	Patient welfare @6000 / Year / dist	6000	6000	6000	6000	6000	6000	6000	6000	6000	0	54000
	Pronting cost @ Rs. 15000 / year/ dist	15000	15000	15000	15000	15000	15000	15000	15000	15000	0	135000
	Total	**38500**	**38500**	**38500**	**38500**	**38500**	**38500**	**38500**	**38500**	**38500**	**0**	**346500**
7	**IEC**											
	SLS										550000	550000
	DLS	200000	200000	200000	250000	350000	200000	200000	200000	200000		2000000
	Total	**200000**	**200000**	**200000**	**250000**	**350000**	**200000**	**200000**	**200000**	**200000**	**550000**	**2550000**
8	**Training**											
	4 Day training to MO PHC/Hosp @ Rs. 43500 for a Batch of 30	43500	43500	43500	43500	43500	43500	43500	43500	43500	43500	435000
	One day Refresher Training PP for a Batch of 30 @Rs13000/-	13000	13000	13000	13000	13000	13000	13000	13000	13000	13000	130000
	4 Day training to MO MCD/NDMC/ESIC/CGHS urban @ Rs. 43500 for a Batch of 30	43500	43500	43500	43500	43500	43500	43500	43500	43500	43500	435000

	Two day Refresher Training MO @Rs.25000/-for a Batch of 30	25000	25000	25000	25000	25000	25000	25000	25000	25000	50000	275000
	Two day Refresher Training Pharmacist @Rs.20500/-for a Batch of 30	20500	20500	20500	20500	20500	20500	20500	20500	20500	20500	205000
	5 day training to distt hospital Lab technician @ Rs.24625/- for 15 candidates										98500	98500
	One day training to ASHA @ 7000	28000	35000	14000	21000	28000	35000	28000	7000	14000	14000	224000
	Total	**117000**	**124000**	**103000**	**110000**	**117000**	**124000**	**117000**	**96000**	**103000**	**226500**	**1237500**
9	**Review meeting and workshop**	**EA**	**NE**	**NR**	**NW**	**WE**	**SW**	**ST**	**ND**	**CE**	**State**	**Total (Rs.)**
	State level quarterly @Rs. 25000 per quarter										**100000**	100000
	District level quarterly @Rs. 8000 per quarter workshop	8000	8000	8000	8000	8000	8000	8000	8000	8000		72000
	Total	**8000**	**8000**	**8000**	**8000**	**8000**	**8000**	**8000**	**8000**	**8000**	**100000**	**172000**
10	**Urban leprosy control Programme**											

	State level workshop @Rs. 50000x2										100000	100000
	IEC	15000	15000	15000	15000	15000	15000	15000	15000	15000	150000	285000
	Training	13000	13000	13000	13000	13000	13000	13000	13000	13000	26000	143000
	Incentive to ASHA	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	100000
	Honoraruium to dresser in leprosy colony @2000/pm				24000	72000	24000	24000				144000
	Total	**38000**	**38000**	**38000**	**62000**	**110000**	**62000**	**62000**	**38000**	**38000**	**286000**	**772000**
11	**SET scheme**											
	NGO Under SET											200000
12	**RCS support To BPI PT @Rs.5000/-**	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	200000
13	RCS Support to PMR Unit	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	200000
	Total	**40000**	**40000**	**40000**	**40000**	**40000**	**40000**	**40000**	**40000**	**40000**	**40000**	**600000**
14	**Grand Total**	**991500**	**926500**	**989500**	**1E+06**	**1249500**	**938500**	**931500**	**898500**	**977500**	**2648500**	**11834000**
		991500	**926500**	**989500**	**1E+06**	**1249500**	**938500**	**931500**	**898500**	**977500**	**2648500**	**11834000**

National Programme for Control of Blindness 2008-09

ANNUAL ACTION PLAN

National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100% centrally sponsored scheme with the goal of reducing the prevalence of blindness. The prevalence as on date is 1.0% and goal set for the terminal year of 11th plan is to reduce the prevalence of blindness to 0.8% by 2012.

2. The main objectives of the Programme

a) To provide high quality of eye care to the affected population;
b) To expand coverage of eye care services to the underserved areas;
c) To reduce the backlog of blindness by identifying and providing services to the affected population; and
d) To develop institutional capacity of eye care services by providing support for equipment and material and training personnel.

3. The programme objectives are to be achieved by adopting the following strategy;

- Decentralized implementation of the scheme through District Blindness Control Societies;
- Reduction in the backlog of blind persons by active screening of population above 50 years, organizing screening eye camps and transporting operable cases to eye care facilities;
- Involvement of voluntary organization in various eye care activities;
- Participation of community in organizing the services in underserved/rural areas.
- Development of eye care services and improvement in quality of eye care by training of personnel, supply of high tech equipments, strengthening follow up services and monitoring of services.
- Screening of school going children for identification and treatment of Refractive Errors; with special attention in under served areas.
- To make eye care comprehensive, besides cataract surgery other Intra Ocular surgical operations for treatment of Glaucoma, Diabetic Retinopathy etc. may also be provided free of cost to the poor patients through government as well as qualified non government organizations.

4. Targets set up by Govt. of India for Delhi (2008-09)

The programme would consolidate gains in controlling cataract blindness and also initiate activities to prevent & control blindness due to other causes particularly in children and the aged. This would be done by further increasing cataract surgery rates, increasing coverage, developing infrastructure and

human resources for other causes of blindness and involvement of community and voluntary organizations.

The targets of Delhi in 2008-09

Govt. of India has not set the targets for the year 2008-09 as yet but the targets set last year were as below

a. 90,000 cataract operation with more than 80% being IOL implantation.
b. Screening of 2,00,000 school children of class VI to VIII for detection of refractive errors & providing free spectacles to poor children.
c. Collection of 3000 donated eyes (after death) for transplantation in persons with corneal blindness.
d. Identification of one voluntary organization for strengthening / expanding eye care services for rural population. and providing non-recurring assistance of Rs. 25 lakhs to NGO

5. Activities & Pattern of Assistance

- **Strengthening of District Hospitals**

Non recurring commodity assistance/equipments procured centrally be supplied to Distt. Hospital as per their need / demand within an overall allocation of Rs. 150 lakhs.

- **Vision Centres at PHCs / in Voluntary Sector**

We will explore the possibility if some of the NGOs come forward to set up the vision centres, in case some of them come forward a Non recurring assistance of Rs. 25,000 for basic equipments, furniture and fixtures would be given from the overall GIA to DBCS. No separate money is being kept for this activity at the moment.

Assistance would be provided for following items

S.No.	Equipment/Furnishing
1.	Tonometers (Schiotz)
2.	Direct Ophthalmoscope
3.	Illuminated Vision Testing Drum
4.	Trial Lens Sets with Trial Frames
5.	Snellen & Near Vision Charts
6.	Battery Operated Torch (2)
7.	Furnishing & Fixtures
Maximum Assistance = Rs. 25,000	

- **Support to Eye Banks in Govt. / Voluntary Sector**

A) Non recurring assistance upto Rs. 10 lakh for equipments and furnishing towards strengthening/developing eye banks towards following items.

S.No.	Equipment/Furnishing
1.	Slit Lamp Microscope
2.	Operating Microscope with camera attachment
3.	Specular Microscope
4.	Laminar Flow
5.	Serology Equipment
6.	Instruments for corneal excision and enucleation including containers
7.	Autoclave
8.	Transport Facility (One 4 wheeler & One 2 wheeler)
9.	Refrigerator
10.	Computer & Accessories
11.	Telephone Line
12.	Air-Conditioner
13.	Renovation, Repair, Furniture & Fixtures
Maximum Assistance = Rs. 10 Lakh	

B) Recurring assistance : Rs. 500 per eye collected towards honorarium of eye bank staff, consumables including preservation material & media, transportation/ POL and contingencies. Recurring GIA would be paid through DSBCS.

- **Grant in aid to District Blindness Control Societies / Distt. Units under the Integrated Distt. Health Societies**

Recurring assistance in installments of Rs. 5 lakhs or more will be released to DBCSs through State Health Society, consequent upon submission of statement of expenditure and the available balance with the Distt. Society falling below Rs. 3 lakhs. The GIA will be utilised towards cost of consumables, minor equipments/instruments as per approved list (Annexure I), spectacles, POL and maintenance of vehicles and equipments, IEC activities, village blind registry, remuneration to District Programme Manager and support staff, grant-in-aid to NGOs for performing free cataract operations assistance to ASHAs for screening, motivation and transportation of cataract patients, recurring grant-in-aid to eye banks, School Eye Screening, eye donation activities, training within the district and other contingent expenditure as per guidelines. GIA can also be utilized for treatment of poor patients suffering from other eye problems like Glaucoma, retinopathy etc. at government or qualified NGOs. **In Delhi there are 9 distt units under the 9 Integrated Distt Health Societies and their projected requirements of fund is as enclosed at Annexure II.**

Commodity Assistance: Bulk consumables like sutures and IOLs will continue to be given as commodity assistance to DBCSs / Distt Hospitals and will be distributed to RIOs, Medical Colleges, District hospitals.

- **Grant-in-aid for free Cataract Operations by voluntary organizations in fixed facilities**

Recurring grant-in-aid to NGOs for performing free cataract operations & other Intra-ocular Surgeries is determined by following table.

	ICCE	***ECCE/IOL***	***Phaco***
a. Drugs and consumables	150	200	200
b. Sutures	50	50	0
c. Spectacles	125	125	125
d. Transport / POL	100	100	100
e. Organization & Publicity	75	75	75
f. IOL, Viscoelastics & addl consm.	0	200	250
Total	**500**	**750**	**750**

For identifying blind persons (blind registry), organizing & motivating identified persons and transporting them to Government/VO fixed facilities, ASHAs have been identified and would be involved by the District Blindness Control Societies. They would be eligible for support not exceeding Rs. 175 per operated case (d & e component in the table given above).

- **Non-recurring GIA for strengthening/expansion of Eye Care Units in Rural/underserved areas**

Non-recurring GIA upto Rs. 25 lakhs on a 1:1 sharing basis. Details of support are as below.

S.No.	Component
A	**Ophthalmic Equipments**
1	Operating Microscope with Assistantscope & Camera attachments
2	A-Scan Biometer
3	Keratometer
4	Slit Lamp
5	Yag Laser
6	Applanation Tonometer
7	Auto Refractometer
8	Vitrectomy Unit complete with endolaser photocoagulator
9	Flash Autoclave
10	Automated Perimeter with field analyzer
11	Phacoemulsifier
12	Double Frequency Yag Laser/Argon Green Laser
13	Fundus Fluorescein Angiography Camera
B	**Construction of eye ward/Operation Theaters**
C	**Furniture & Fixtures of Operation Theaters & Ward**

D	Vehicle for Transportation
Maximum Assistance = Rs. 25 Lakh	

But there are **no** proposals with the state society at the moment because these grants can only be given to an NGO who wishes to establish a facility when there is no facility in the nearby vicinity of 30-40 kms radius.

- **Training of Ophthalmic and support manpower**

  - Training of eye surgeons in Govt. of India identified institutes in following areas is arranged by Govt. of India, the job of State Health Society would be identify the trainees/eye specialists who can undergo this training.

    - ECCE/IOL Implantation Surgery
    - Small Incision Cataract Surgery
    - Phaco-emulsification
    - Low Vision Services
    - Glaucoma
    - Pediatric Ophthalmology
    - Indirect Ophthalmology
    - Laser Techniques etc.

  Support for training of eye surgeons would be provided by Govt. of India directly to training institution and TA/DA to the participant.

  - Training of District Programme Managers organized by Govt. of India, Central Cell.

  - Refresher training of MOs will be organized at State Health Society level.

INFORMATION, EDUCATION AND COMMUNICTION:

IEC is one of the most important component of the programme. The approach to IEC can be through mass media and inter personal approach. Mass media approach can arouse curiosity and some messages can be sent through mass media and this may ultimately result into cataract surgery and removal of blindness and control of some of the diseases. The inter personal approach can remove some of the doubts and misunderstandings of the people and ultimately result in cataract surgery and also some of the behavioral charges thereby preventing some of the blindness. The interpersonal approach is adopted by the eye specialists in the district hospitals and also by the health workers and ophthalmologists in the screening camps held by various district control societies. The State health Society proposes to strengthen the interpersonal approach through trainings of health workers through the involvement of District Blindness Control Societies. Whereas mass media is concerned, it is proposed to take up the following activities in 2008-2009.

(a) **Broadcast of Radio Jingles:**

Broadcast of Radio Jingles on AIR by purchasing time slots. Govt. of India has already developed the radio spots on National Programme for Control of Blindness and these spots are proposed to be relayed on FM channel of AIR and also on private channels.

(b) **Telecast of TV spots:**
Govt. of India has also developed the spots on blindness control activities and specially giving messages on the CATARACT & other eye diseases. It ia proposed to telecast the spot developed by Govt. of India in local language i.e. in HINDI on Regional Doordarshan Kendra / Cable Network / Private Satellite Channel so as to make the message reach across in Delhi.

(c) **Advertising in leading newspapers:**
Advertisements on the National Programme for Control of Blindness will be given in the leading newspapers and efforts will be made to reach the masses through this medium.

(d) **Hoardings at prominent places:**
Hoardings shall also be put up at prominent places and they shall be on Display for a period of 3-6 months.

(e) The services of District Blindness control Society shall also be utilized at the district level for inter personal communication, display of messages through posters, pamphlets etc.

Management Information System, monitoring & evaluation

State Level: Collection of the performance, expenditure data from the distt. units, NGOs, Private Sector etc. compilation forwarding same to Govt. of India at Central Level.

Distt. Level: Compilation of data from various performing units in standard records formats, reporting of performance & expenditure to States and Central Cell, monitoring of performance in various blocks.

State Blindness Central Society: Govt. of India has already released an assistance of Rs. 3 Lakhs as non-recurring grant in aid towards purchase of office equipments. Recurring grant in aid of Rs. 4 Lakhs is being requisitioned as grant in aid in the year 2008-09.

Additional ties under NRHM

a. Spectacles to GRCs – Department of Social Welfare has desired that the women visiting the gender resource centres be provided with spectacles. For this they have indicated 10000 spectacles per annum to be distributed through 45 GRCs located all over Delhi. An implication of Rs.1250000 would be there on this @ Rs.125 per spectacles

b. Salary of Grief Counselors – It is proposed that the salary of 20 grief counselors for the three eye banks i.e. GNEC, R.P.Centre & Safdarjung Hospital be kept under the additional ties under NRHM involving a total implication of Rs.24 lakhs calculated on the basis of Rs.10000 per month for a full year.

c. Strengthening of DSBCS – It is proposed that the following equipments may be supplied under this head for helping out in the training activities i.e. laptop, digital camera & a handicam which will involve an implication of Rs. 65000 for laptop, Rs.15000 for digital camera & Rs. 25000 for handicam.

d. The state ophthalmic cell was given a Govt. vehicle – A Gypsy in the year 1994-95 by GoI which has outlived its useful life and requires frequent repairing and maintenance costs are rising day by day. Technical officer of the Transport Deptt has also advised for its condemnation. It is proposed that a new vehicle be sanctioned against condemnation and funds to the tune of Rs 6 lakhs may be sanctioned to buy a new vehicle. The POL and salary of driver may continue to be drawn from State Fund. This vehicle is essential for supervision and monitoring of the programme and at the same time may also be utilized by the officers of programme division of GoI as when a team from other states or country visits Delhi.

Demand of Grant in aid to Delhi State Health Society under National Programme for Control of Blindness (Rs. in Lakhs) in the year 2008-09

1. Grant in aid for free catops and other activities by 9 Distt units as per their PIP including SESP	Rs. 96 Lakhs
2. Recurring grant in aid for eye donation	Against U/B
3. Training	Against U/B
4. Grant in aid for SES Project	Included in Distt PIP
5. Non recurring grant in aid to vision centers @ Rs. 25000 each	to be projected only once NGOs are identified
6. Non recurring grant in aid to NGOs @ Rs. 25 Lakhs	to be projected only once NGOs are identified
7. Non recurring grant in aid to eye banks @ Rs 10 lakhs	only once new banks are opened

8. IEC	Rs. 10 Lakhs
9. SBCS	Rs. 4 Lakhs
10. Purchase of ophthalmic equipments	Rs. 150 Lakhs
	Rs. 260 Lakhs

Additionalaties under NRHM

a.	Spectacles to GRCs	Rs 12.5 lakhs
b.	Salary to Grief Counselors	Rs 24 lakhs
c.	Strenghthening of DSBCS	Rs 1 lakh
d.	New vehicle against condemned vehicle	Rs 6 lakhs
	TOTALS :	**Rs 43.5 Lakhs**

Annexure 1

List of Items for Procurement at District Level by DBCS/SBCS

S.No.	Items
1.	Minor Equipment & Instruments
2.	Cataract set including ECCE/Intra Ocular Lens implantation and Small Incision Cataract Surgery
3.	Cryo Unit
4.	Distant Vision Charts
5.	Foreign Body Spud & Needle
6.	Lacrimal Cannula & Probes
7.	Lid retractors (Desmarres)
8.	Near Vision Charts
9.	Punctum Dialator
10.	Retinoscopic Mirror
11.	Rotating Visual Acuity Drum
12.	Torch
13.	Trial Frame Adult/Children
14.	Trial Lens Set
B	**Eye Ointments**
1.	Atropine (1%)
2.	Local antibiotic : Framycetin /Gentamicin etc.
3.	Local antibiotic Steroid ointment
C	**Ophthalmic Drops**
1.	Xylocaine 4% (30ml)

2.	Local antibiotic: Framycetin/Gentamicin etc.
3.	Local antibiotic steroid drops
4.	Pilocarpine Nitrate 2%
5.	Timolol 0.5%
6.	Homatropine 2%
7.	Tropicamide 1%
8.	Cyclomide 1%
D	**Injections**
1.	Inj. Xylocaine 2% (30ml)
2.	Inj. Hyalase (Hyaluronidase)
3.	Inj. Gentamycin
4.	Inj. Betamethasone/Dexamethasone
5.	Inj. Maracaine (0.5%) (For regional anesthesia)
6.	Inj. Adrenaline
7.	Inj. Ringer Lacate (540ml) from reputed firm
E	**Surgical Accessories**
1.	Gauze
2.	Green Shades
3.	Blades (Carbon Steel)
4.	Opsite surgical gauze (10X14 c.m)
5.	8-0 & 10-0 double needle Suture(commodity asst. from GOI)
6.	Visco-elastic from reputed firms
F	**Spectacles**
1.	For Operated Cataract Cases (after refraction)
2.	For poor school-age children with refractive errors

Monitoring & Evaluation Indicators

S.No.	Indicator	Numerator	Denominator	Source of Information	Expected Frequency
Performance indicator					
1	Performance of Cataract operations (No. & %age)	Cataract Operations performed during the month/quarter	Target of Cataract Operations	District Society	Quarterly
2	Cataract surgery rate	Cataract Operations Performed in the year	Population of District	District Society	Annual
3	Cataract operations by type of surgery (No. & %age)	IOL implantations	Total cataract operations	District Society	Quarterly
4	Children examined for refractive errors	Number of students	Target of students to be	District Society	Quarterly

	(No. & %age)	examined for refractive errors	examined		
5	Children with refractive errors (%)	Number of students detected with refractive errors	Number of students examined for refractive errors	District Society	Quarterly
6	Children with R.E. provided glasses	Number of students provided free glasses	Number of students detected with refractive errors	District Society	Quarterly
7	Eye Donations (No. & %age)	Donated eyes collected	Target for eye donations	District Society	Quarterly
8	Utilisation of donated eyes (No. & %age)	Donated eyes utilized for corneal transplantation	Donated eyes collected	District Society	Quarterly
HRD indicators					
9	Training of ophthalmic assistants & nurses (No. & %age)	Number of ophthalmic Assistants & Nurses trained	Target for training of ophthalmic assistants & nurses	District Society	Quarterly
10	Teachers trained in vision screening	Number of teachers trained in vision screening	Target of teachers to be trained	District Society	Quarterly
Financial indicators					
11	Utilisation of funds	Expenditure incurred on blindness control by societies	Funds released to societies for blindness control	State/ District Societies	Quarterly
12	Audited Statement Utilisation Certificate issue	Societies who have submitted audited accounts and UCs	All societies funded during the year	State/ District Societies	Annually

	ANNEXURE II										
	Item of expenditure	North	N-W	W	SW	S	E	NE	Central	ND	**Total**
1	Honorarium	42000	42000	42000	42000	42000	42000	42000	42000	42000	**378000**
2	Procurement of Goods	25000	25000	25000	25000	25000	25000	25000	25000	25000	**225000**
3	POL	25000	25000	25000	30000	30000	25000	30000	30000	30000	**250000**
4	Spectacles (a) School children	312500	437500	125000	500000	75000	656250	125000	62500	125000	**2418750**
	(b) Operated catops	9375	37500	62500	12500	75000	5000		62500	5000	**269375**
5	IEC	20000	20000	20000	20000	20000	20000	20000	20000	20000	**180000**
6	GIA to vol orgns										
	(a) Free Catops	562500	450000	375000	375000	375000	525000	750000	375000	300000	**4087500**
	(b) Motivations to ASHAs for catops	26250				35000	7000		35000	7000	**110250**
7	Training										
	(a) Teachers	60000	75000	19300	28400	30000	50000	45000	22800	30000	**360500**
	(b) ASHAs	10000	53000	118400	65000	41000	52500	40000	8900	17500	**406300**
8	Hon.for VBR & documentation	26000	65000		65000	65000	67750	65000	15000	15000	**383750**
9	Incumbents of Blind School	20000	20000	20000	20000	20000	20000	20000	20000	20000	**180000**
10	Treatment of other disease	10000	10000	10000	10000	10000	10000	10000	10000	10000	**90000**
11	Operational Expenditure	20000	20000	20000	20000	20000	20000	20000	20000	20000	**180000**
12	World Sight Day					20000			20000		**40000**
13	Eye Donation Fortnight					20000			20000		**40000**
14	**Additionalities under NRHM**										
	Specs to GRCs	125000	125000	125000	125000	125000	125000	125000	62500		**937500**

	TOTAL	**1293625**	**1405000**	**987200**	**1337900**	**1028000**	**1650500**	**1317000**	**851200**	**666500**	**10536925**

NIDDCP: National Iodine Deficiency Disorder Control Programme

NIDDCP: National Iodine Deficiency Disorder Control Programme is centrally sponsored national programme being implemented since 1962 with the objective of reducing & preventing iodine disorder control programme.

- ***Objectives :-***

1. Surveys to assess the magnitude of the iodine deficiency disorders.
2. supply of iodated salt in place of common salt
3. resurvey after every 5 years to assess the extent of iodine deficiency disorders and the impact of iodated salt
4. laboratory monitoring of iodated slat and urinary iodine excretion
5. Health education & publicity.

- ***Goal :-***

To decrease overall IDD prevalence (goiter) to <5% in the school children age 6-12 years.

- ***Strategy for implementation in NCT of Delhi***

The implementation of NIDDCP in NCT Of Delhi is being coordinated through the state IDD cell which has been established. The programme is being implemented as a vertical centralized activity from the state IDD cell located at GTB hospital. However, w.e.f. 2008-09 and as per discussions with Mission Director, the programme needs to be integrated under NRHM as a decentralized activity at the district level with coordination at the state level. The current PIP for NIDDCP is therefore being submitted as a plan to be implemented under NRHM in the horizontal mode instead of vertical programme mode. This would require district action plan (DHAP) of the state to incorporate and make provisions for implementation of this programme as per the following guidelines and overall scheme.
The components of NIDDCP implementation would include

1) To promote awareness of Iodine deficiency disorder(IDD)and benefits of iodized salt intake
2) To assess the IDD magnitude of various districts of Delhi
3) To monitor adequacy of iodization of salt and adequacy of iodine sufficiency

- *Activities planned:-*

A) **Goiter detection, Health education and awareness activities (IEC) and activities to determine adequacy of iodine in salt and urine will be undertaken under this program in different target populations**

a. **Women in child-bearing age (15-44 years) with special focus on pregnant women.**
b. **Children 6-12 years of age**

c. **Neonates**

B) **Resurveys of various school and health districts will be carried out to review prevalence of IDD and impact of iodated salt.**
C) **Monitoring of salt iodization at the level of retailers**
D) **IDD awareness programmes will be carried out in schools dispensaries and public places to create awareness about IDD and salt Iodization particularly during IDD week celebrations.**
E) **Neonatal screening using TSH for hypothyroidism in neonates**
F) **Organizing meetings with retailer groups/local area leaders/food inspectors regarding adequacy of iodization of salt.**

Details of the activities to be carried out are as follows:-

a) Goiter **detection activities :-**

Change in thyroid size as determined by palpation is used as a clinical indicator of goiter prevalence. Goiter will be looked for by clinical examination and classified as :-

- **Grade 0**
- **Grade 1**
- **Grade 2**

b) IEC activities :-

These will be carried out through lectures, group discussions, distribution of pamphlets, etc as well as one to one interaction with the patients regarding proper use and benefits of iodized salt and the harmful effects of iodine deficiency.

c) Iodine estimation in salt samples :-

Salt samples will be collected from the patients/ attendants/ school children/households/retailers for salt Iodine estimation by :-

- **Kit method (on the spot testing) in the field**
- **Titration method (in IDD monitoring lab at GTBH)**

d) Iodine Estimation In Urine Samples :-

Urine samples will be collected from the patients/ attendants for urine iodine estimation wherever it will be required. These will be analyzed later in the IDD monitoring lab at GTB hospital.

Further evaluation/ counseling will be done in those patients showing abnormalities viz, goiter, low salt iodine level & low urine iodine level.

e) Resurveys of IDD prevalence and impact of salt iodization will be carried out in school children aged 6-12 years as per standard techniques and guidelines prescribed for surveys under NIDDCP guidelines. These activities

will be coordinated with school health program of Govt of NCT of Delhi & NGOs . Surveys will include:

4) Goiter survey
2. Iodine estimation in salt samples
3. Iodine Estimation In Urine Samples
4. In addition to the above following parameters will also be assessed: -

a**) <u>Height/weight</u> :-**

Measuring the height/weight and other growth parameters of the children of age group 6-12 for checking proper physical growth because iodine deficiency mainly effect the development of the children.

b) **<u>School performance :-</u>**

For checking the proper mental development of school children their previous performance in the class will be analyzed by their marks or other co-curricular activities

C)Screening of school children surveyed with TSH to detect sub clinical hypothyroidism wherever possible

Counselling and specific follow up advice will be given to children detected to have IDD apart from education on IDD.

f) Neonatal screening using TSH for hypothyroidism in neonates

In the year 2008-09 it is proposed to establish neonatal screening programmes in GTBH as a pilot project and empower IDD monitoring Lab. NIDDCP Delhi with this expertise.

- **<u>Newer initiatives planned</u>**

1. <u>N</u>**<u>eonatal screening</u>**:- Screening of all neonates with blood spot TSH estimation on filter paper. This is a very useful impact indicator of IDD in a community. It is proposed to establish this process first as a <u>tertiary level measure</u> to cover live births at GTB hospital in the first year. Once established this can then be extended to all the health districts of NCT of Delhi by the end of 11th five year plan. This can form the basis for a universal neonatal TSH screening programme that is prevalent in several countries.
2. ANTI TPO estimations in a section of those individuals detected with goiter so as to determine the prevalence of autoimmune thyroid disease (AITD) in them. This would help in finding out the

contribution of AITD to goiter prevalence. It is proposed to do this estimation in about a 500-1000 individuals per year.

3. Formation of an effective steering committee which is multidisciplinary and involves relevant fields of nutrition, medicine, education, salt industry, media and consumers and coordinated by Ministry of Health, Govt of NCT of Delhi along with the state programme managers.
4. To organize /meetings of retailer groups/local area leaders/food inspectors for better coordination regarding adequacy of iodization of salt
5. It is proposed that a continuous supply of field kits to test iodine level in salt be made available with the state programme officer to be provided to the following for a wider and more meaningful coverage of salt iodine testing. This would effectively monitor the process of salt iodization. It is proposed to promote use of these kits more widely by distributing them to District Medical Officers, teachers, maternal and child health workers and voluntary agencies.

Restructuring of NIDDCP implementation w.e.f the year 2008-09 as a horizontal, decentralized, district level programme :

It is proposed that from this year onwards the NIDDCP implementation will be restructured as follows:

A. Activities at the district level will include

* All field level activities under the programme viz.
    a. Salt iodine estimations using field kit
    b. Collection of salt samples for iodine estimations by titration method in the districts from
        1. retailers
        2. households
    c. Collections of urine samples from households for urine iodine estimations
    d. Transportation of samples of salt and urine collected at the field level to the state IDD monitoring lab attached to IDD cell at GTB hospital.
        ii. About 10-20 percent of these samples can be passed on to the state IDD monitoring laboratory for salt iodine estimation by titration method.

    a. IEC activities and education of target populations as well as general public within the district about the harmful effects of iodine deficiency and the benefits of iodized salt intake. This can be done at dispensaries, schools, public places & camps.

IDD surveillance at community/household level - Role for ASHA workers – ASHA workers, who will be key resources persons for IDD surveillance activities, to be given the responsibility of all field activities of IDD surveillance at the community / household level as follows:

1. Salt estimations in the community by field test kit method during house to house visits in her assigned area.
    a. this may be done every month on health and nutrition day and report on adequately / inadequately iodized salt may be furnish to the district nodal officer for onward transmission to the state IDD cell.

2. Distribution of IEC material and basic education of the community at household level on benefits of iodized salt.
3. During ANC check-up specifically checking and ensuring adequacy of iodized salt consumption by pregnant women.

This would require basic training of ASHA in the following.

1. Salt iodine estimation by field test kit method
2. Basic knowledge of salt iodization and benefits of iodized salt used.
3. Methods of optimizing use of iodized salt including practices that can help prevent loss of iodine from the salt.
4. In addition ASHA worker should be imparted some basic knowledge of the following also.
    a. Why is iodine Important
    b. daily requirement of iodine and its natural source
    c. what is the cause of iodine deficiency
    d. principal manifestation of IDD
    e. target & high risk groups for iodine deficiency

The **districts CDMO/ Nodal Officer** can coordinate all the above mention activities on the one hand and with the state programme officer NIDDCP on the other.

It is proposed that **additional field staff** i.e. one attendant/NO on contract basis for each district may be sanctioned to carry out the activities outlined above. Alternately fixed honorarium to any existing personnel who may be identify for the job may be given.

B) Activities at the state level.

- b. Coordination of various activities under NIDDCP with all districts through CDMO's/Nodal Officer
- c. Laboratory estimations of urine and salt iodine at state level IDD monitoring lab of all samples received from various districts
- d. Resurveys in school to determine actual prevalence of IDD's
- e. Training and monitoring of personnel involved from different districts in the following
    - i. Goitre detection
    - ii. Salt iodine by field kit
    - iii. IEC activities
- f. Interaction with salt commissioner's office to devise effective ways of maintaining salt iodine quality at the retail level.

i. Enumeration of local units in Delhi which are manufacturing uniodized salt approximating about 300 or so.
ii. Planning and coordination of IEC activities under the programme for NCT of Delhi this would include planning and dissemination of IEC material
iii. Neonatal screening using TSH for hypothyroidism in neonates
iv. Organizing meetings with retailer groups/local area leaders/food inspectors regarding adequacy of iodization of salt
v. Coordination of different IDD awareness programme during IDD week and through out the year

Budget proposals

A) For the year 2008-09

- **Budget required for existing activities**

Budget Head	**Amount (per year)Rs**
A. IDD Cell and Monitoring lab	
1. Salaries of Existing Staff of IDD Cell & Lab	8, 80,000
2. Honorarium for Attendant/NO at district level @1500/- per month	1, 44,000
3. IDD Cell and Lab maintenance	1, 00,000
B. Transport Expenses	76,000
C. IEC Activities	2, 00,000
D. IDD Surveys	1, 00,000
Total	**15, 00,000**

Proposed budget at district level (per district)	per year (Rs)
Honorarium for Attendant/NO at district level @ Rs. 1500/- pm	18,000/-
Transport expenses	5,000/-
IEC activities	10,000/-
Total	**33,000 x 8 = Rs. 2,64,000/-**

Revised National Tuberculosis Control Programme
Annual Plan for the year2008-09

1st April 2008 to 31st March 2009

Objectives:
1. *To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases, and*
2. *To achieve and maintain detection of at least 70% of such cases in the population*
3. *To sustain the gain ands achievements made so far*

This action plan and budget have been approved by the STCS.

Signature of the STO
Name Dr. R.P. Vashist

Section-A – General Information about the State

1	State Population (in lakh) *please give projected population for next year*	175
2	Number of districts in the State	24
3	Urban population	89.92%
4	Tribal population	Nil
5	Hilly population	Nil
6	Any other known groups of special population for specific interventions Slum Population (e.g. nomadic, migrant, industrial workers, urban slums, etc.)	Slum,migrant, industrial workers etc. 70 lacs, shelter less 5lacs

(These population statistics may be obtained from Census data /State Statistical Dept/ District plans)

No. of districts that submitted annual action plans, which have been consolidated in this state plan: _24___

Organization of services in the state:

SN.	Name of the District	Projected Population (in Lakhs)	Please indicate number of TUs of each type		Please indicate no. of DMCs of each type in the district		
			Govt	NGO	Public Sector *	NGO	Private Sector^
1	R.K. Mission	6	1		6		
2	Moti Nagar	6	1		6		
3	DDUH	19	3	1	18	5	
4	RTRMH	10	1	1	7	5	
5	Gulabi Bagh	10	2		10		
6	Kingsway Camp	5	1		5		
7	BJRMH	5	1		5		
8	SGMH	6	1		6		
9	Narela	6	1		7		
10	Patparganj	7	2		8		
11	Shahdara	5	1		6		
12	GTBH	6	1		5	1	
13	Karawal Nagar	6	1		5		1
14	Hedgewar CC	5	1		5		
15	LRS Institute	10	2		10	2	3
16	Nehru Nagar	10	2		11	1	2
17	Jhandewalan	5	1		5		
18	NDMC	8	2		9		
19	LN Hospital	5	1		5		1
20	SPM Marg	5	1		5	1	
21	Malviya Nagar	10	2		10		0
22	Baba Saheb Ambedkar	5	1		5		
23	Ch. Desraj	5	1		5		
24	Shastri Park	5	1		5		
	Total	**170**	**32**	**2**	**169**	**15**	**7**

*Public Sector includes Medical Colleges, Govt. health department, other Govt. department and PSUs i.e. as defined in PMR report
^ Similarly, Private Sector includes Private Medical College, Private Practitioners, Private Clinics/Nursing Homes and Corporate sector

RNTCP performance indicators:

Important: Please give the performance for the last 4 quarters i.e. October 2006 to September2007

Name of the District (also indicate if it is notified hilly or tribal district	Total number of patients put on treatment *	Annualised total case detection rate (per lakh pop.)	No of new smear positive cases put on treatment *	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year	
						Annualized NSP case detection rate	Cure rate
R.K. Mission	2023	337	601	100	89%	Maintain 70% NSP Case Detection	Maintain 85% Cure rate
Moti Nagar	1883	378	472	94	84%	Maintain 70%	Achieve 85%
DDUH	5063	266	1247	66	86%	Maintain 70%	Maintain 85%
RTRMH	1714	171	540	54	88%	Achieve 70%	Maintain 85%
Gulabi Bagh	1861	186	573	57	85%	Achieve 70%	Maintain 85%
Kingsway Camp	1858	372	576	115	86%	Maintain 70%	Maintain 85%
BJRMH	1283	256	393	79	89%	Maintain 70%	Maintain 85%
SGMH	4206	440	1059	110	86%	Maintain 70%	Maintain 85%
Narela	1398	233	461	77	84%	Maintain 70%	Achieve 85%
Patparganj	2709	387	829	118	86%	Maintain 70%	Maintain 85%
Shahdara	2200	440	655	131	81%	Maintain 70%	Achieve 85%
GTBH	1912	319	602	100	84%	Maintain 70%	Achieve 85%
Karawal Nagar	2995	499	893	148	84%	Maintain 70%	Achieve 85%
Hedgewar CC	1700	340	457	91	82%	Maintain 70%	Achieve 85%
LRS Institute	3112	239	912	70	89%	Maintain 70%	Maintain 85%
Nehru Nagar	3885	320	1085	89	82%	Maintain	Achiev

						70%	e 85%
Jhandewalan	1488	298	419	84	82%	Maintain 70%	Achieve 85%
NDMC	1350	199	343	51	89%	Achieve 70%	Maintain 85%
LN Hospital	1052	210	288	58	90%	Achieve 70%	Maintain 85%
SPM Marg	1268	245	354	71	85%	Maintain 70%	Maintain 85%
BSA Hospital (From Qtr2,07)	626	250	138	55		Achieve 70%	
Ch. Desraj (From Qtr2,07)	518	207	118	47		Achieve 70%	
Shastri Park Hospital (From Qtr2,07)	1220	488	309	124		Maintain 70%	
Malviya Nagar Hospital (From Qtr2,07)	2063	413	518	104		Maintain 70%	

***** *Patients put on treatment under DOTS regimens only are to be included.*

Section B – List Priority areas at the State level for achieving the objectives planned:

S.No.	Priority areas	Activity planned under each priority area
1	Enhanced coverage in slums	1 a) Providing support to ASHA
		1 b)Providing support to NGOs for undertaking DOTS in slums
		1 c) Providing community DOT services
		1 d) Scaling up IEC activities in slums
2	Enhanced participation of private, NGOs and voluntary sectors	2 a) Increased CMEs for PPs with the target to enrol them for PPs schemes
		2 b) Increased IEC activities
		2 c) State level NGO workshop
3	Increased case detection rate	3 a) Increasing the reach of the RNTCP
		3 b)Involvement of more PPMs
		3 c)Increased IEC activities
4	Increased sputum conversion & cure rate	4 a)Making DOT more patient friendly

		4 b) Enhanced supervision and monitoring
		4 c) Increased IEC activities
5	Increased HIV-TB collaboration	5 a) Strengthening collaboration between TB Control Programme and AIDS Control Programme
		5 b)Training and retraining of the manpower
		5 c)Increased IEC activities

Priority Districts for Supervision and Monitoring by State during the next year

S No	District	Reason for inclusion in priority list
1	KarawalNagar	Very high case detection
2	*Patpargunj*	High case detection
3	Shahdara	High case detection
4	Hedgewar	High case detection
5	GTB Chest Clinic	High case detection
6	SGMH	High case detection
7	*Malviya Nagar*	New Chest clinic
8	BSA	New Chest clinic
9	Shastri Park Hospital	New Chest clinic
10	KCC	Low capacity
11	Des Raj Chest clinic	New Chest Clinic
12	Moti Nagar	Low capacity

13	**Gulabi Bagh**	**Low case detection**
14	**LRS**	**Low case detection**
15	**Lok Nayak Chest Clinic**	**Low case detection**
16	**RTRM Chest Clinic**	**Rural area low case detection**
17	**Narela Chest Clinic**	**Rural area low case detection**
18	**SPM**	**Low case detection minority community**
19	**Nehru Nagar**	**Low case detection large uncovered population**

Section C **– Consolidated Plan for Performance and Expenditure under each head, including estimates submitted by all districts, and the requirements at the State Level**

1. Civil Works

Activity	*No. required as per the norms in the state*	*No. already upgraded/ present in the state*	*No. planned to be upgraded during next financial year*	*Pl provide justification if an increase is planned in excess of norms (use separate sheet if required)*	*Estimated Expenditure on the activity*	*Quarter in which the planned activity expected to be completed*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
STDC/ IRL	*1/1*	*1*	*Nil*	*-*	*Nil*	
SDS	*1*	*1*	*Nil*	*-*	*Nil*	*-*
DTCs	*24*	*20*	*4*	*-*	*6,00,000*	*3rd Quarter*

TUs	*35*	*31*	*4*		*1,40,000*	
DMCs	*195*	*169*	*26*		*7,80,000*	
STO Office	*1*	*1*	*Nil*	*-*	*Nil*	
Maintenance for the existing units as per the norms					*3,09,300*	
				TOTAL	***18,29,300***	

2. Laboratory Materials

Activity	*Amount permissible as per the norms in the state*	*Amount actually spent in the last 4 quarters* (in Rupees)	*Procurement planned during the current financial year (in Rupees)*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Purchase of Lab Materials by Districts		*61,49,773*	*60,00,000*	*60,00,000*	*10 lac slides @ Rs.6 per slide(high case detection)*
Lab materials for EQA activity at STDC				*2,68,500*	*@Rs.0.15 per millionx175*
Total				***62,68,500***	

3. Honorarium

Activity	*Amount permissible as per the norms in the state*	*Amount actually spent in the last 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Honorarium	*35,00,000*	*5,97,540*	*10,00,000*	***10,00,000***	*25% of total patients x@Rs.250 per pt(12,000xRs.250)*

	No. presently involved in RNTCP	*Additional enrolment proposed for the next fin. year*
*Community volunteers in all the districts**	*100*	*300*

***** *These community volunteers are other than salaried employees of Central/State government and are involved in provision of DOT e.g. Anganwadi workers, trained dais, village health guides, ASHA, other volunteers, etc.*

4. IEC/Publicity:

Permissible budget for State and all Districts as per Norms:
Estimated IEC budget for all Districts, as per action plans (*please enclose consolidation summary)*: Rs. _____
Estimated IEC activities and Budget at the State level (excluding districts) for the next financial year proposed as per action plan detailed below: Rs. _____

Target Group / Objective	Activities Planned at State Level						Total activities proposed during next fin. year	Estimated Cost per activity unit	Total expenditure for the activity during the next fin. Year
	Activity (All activities to be planned as per local needs, catering to the target groups specified)	No. of activities held in last 4 quarters	No of activities proposed in the next financial year, quarterwise						
			Apr-Jun	**July-Sep**	**Oct-Dec**	**Jan-Mar**			

Patients and General public / for awareness generation and social mobilization	Hoardings for general population at rent free sites on DAVP rates in Hindi, Urdu & Punjabi	525	100	200	100	200	600	600xRs.6000	36,00,000
	Wall Paintings in schools and slums etc. (1500 schools & 1800 slums)	1000	350	350	400	400	1500	1500xRs.300	4,50,000
								15,00,000	15,00,000
	Observance of World TB Day main function (Newspaper Advertisement) etc.	100			50	50	100	100x4000	4,00,000
	Folk media Nukaad Natak on Ministry of Information & Broadcasting rate contract								
	Outreach activities: – Patient provider interaction meetings	800	200	200	200	200	800	800xRs.250	2,00,000
		200	50	50	50	50	200	200xRs1000	2,00,000
	– Community			5	5	10	20		2,00,000

	meetings – Public Meetings							20xRs.10,000	
								Total Budget	**65,50,000**

5 Equipment Maintenance:

Item	*No. actually present in the state*	*Amount actually spent in the last 4 quarters*	*Amount Proposed for Maintenance during current financial yr.*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Computer/Photocopier/fax/OHP *(Maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)*	*30*	*5,05,742*	*7,50,000*	*7,50,000*	*@ Rs. 0.30 lakh per year per 24 districts and one state*
Binocular Microscopes	*200*			*3,00,000*	*@ 1500/- per microscope per year*
STDC/ IRL Equipment					
Any Other (pl. specify) Air Conditioners	*30*			*1,00,000*	

			75,000	*@ Rs. 2500/- per AC AMC charges*
		TOTAL	***12,25,000***	

6. Training:

Activity	*No. in the state*	*No. already trained in RNTCP*	*No. planned to be trained in RNTCP during each quarter of next FY (c)*				*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*Q1*	*Q2*	*Q3*	*Q4*	*(d)*	*(e)*	*(f)*
Training of DTOs (at National level)	*24*	*24*	*1*	*1*	*1*	*1*		*50,000*	
Training of MO-TCs	*30*	*30*	*5*	*5*	*5*	*5*		*70,000*	
Training of MOs (Govt + Non-Govt)	*5000*	*2000*	*100*	*100*	*100*	*100*		*2,50,000*	
Training of LTs of DMCs- Govt + Non Govt	*-*	*160*	*10*	*10*	*10*	*10*		*80,000*	
Training of MPHS, pharmacists, nursing staff, BEO etc		*225*	*50*	*50*	*50*	*50*		*80,000*	
Training of Pvt Practitioners		*422*	*50*	*50*	*50*	*50*		*2,50,000*	
Other trainings #									

Re- Training of LTs of DMCs	*160*		*20*	*20*	*20*	*20*		*40,000*	
Re- Training of MPHS, pharmacists, nursing staff, BEO	*200*		*50*	*50*	*50*	*50*		*80,000*	
Re- Training of CVs	*50*		*10*	*10*	*10*	*10*		*20,000*	
Re-training of Pvt Practitioners	*200*		*50*	*50*	*50*	*50*		*1,20,000*	
TB/HIV Training of STLS, LTs , MPWs, MPHS, Nursing Staff, Community Volunteers etc	*400*		*100*	*100*	*100*	*100*		*2,00,000*	
Provision for Update Training at Various Levels #	10		3	3	3	3		1,00,000	
Review Meetings at State Level									
Any Other Training Activity									

 # Please specify

TOTAL 13,40,000

7. Vehicle Maintenance:

Type of Vehicle	*Number permissible as per the norms in the state*	*Number actually present*	*Amount spent on POL and Maintenance in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
Four Wheelers	*15*	*15*	*10,72,707*	*28,00,000*	*19,50,000*	*DTOs @Rs.1.25 las per vehiclex14 +* STO @ Rs.2 las per vehiclex1
Two Wheelers	*34*	*32*			*8,00,000*	*@ Rs. 25000/- per year per two wheeler*
				TOTAL	***27,50,000***	

8. Vehicle Hiring*:

Hiring of Four Wheeler	*Number permissible as per the norms in the state*	*Number actually requiring hired vehicles*	*Amount spent in the prev. 4 qtrs.*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
For STC/ STDC	*1*	*Nil*	*14,35,273*	*41,16,000*	*Nil*	
For DTO	*10*	*10*				

For MO-TC	*35*	*Nil*			*21,00,000*	*@ 700/- x 25 days x 12 months x 10 DTO*
					Nil	
					TOTAL	***21,00,000***	

** Vehicle Hiring permissible only where RNTCP vehicles have not been provided*

9. NGO/ PP Support:

Activity	*No. of currently involved in RNTCP in the state*	*Additional enrolment planned for this year*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
NGOs involvement scheme 1	*Nil*	*Nil*	*13,94,842*	*39,50,000*		
NGOs involvement scheme 2	*90*	*100*				
NGOs involvement scheme 3	*Nil*	*Nil*				
NGOs involvement scheme 4	*5*	*10*				
NGOs involvement scheme 5	*2*	*2*				

NGOs involvement unsigned	*6*	*50*				
Private practitioners scheme 1	*410*	*1000*				
Private practitioners scheme 2A	*38*	*50*				
Private practitioners scheme 2B	*1*	*10*				
Private practitioners scheme 3	*2*	*10*				
Private practitioners scheme 4	*4*	*10*				
					TOTAL	***17,50,000***	*@1lacx17.5million*

10. Miscellaneous:

*Activity** e.g. TA/DA, Stationary, etc	*Amount permissible as per the norms in the state*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
		32,89,897	*28,50,000*		
State level				*3,00,000*	
DTC level				*26,25,000*	*@0.15 per lac x175 lacs*

Extra exp. for TA , rent on hiring Microscopy Centers				*8,00,000*	*Extra amount for meeting TA /requirement to contractual/regular staff*
			TOTAL	***37,25,000***	

** Please mention the main activities proposed to be met out through this head*

11. Contractual Services:

Category of Staff	*No. permissible as per the norms in the state*	*No. actually present in the state*	*No. planned to be additionally hired during this year*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current fin. year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*		*(d)*	*(e)*	
TB/HIV Coord.	*1*	*1*	*0*	*3,23,19,806*	*422.86*	*3.36*	
Microbiologist	*1*	*1*	*0*			*3.60*	
Urban TB Coord.	*0*					*-*	
MO-STCS	*1*	*1*				*2.16*	
State Acctt	*1*	*1*				*1.80*	
State IEC Offr	*1*	*1*				*1.80*	
Pharmacist	*1*	*1*				*1.02*	
Secretarial Asst	*1*	*1*				*0.84*	
DEO- STCS	*1*	*1*				*0.84*	
MO-TC	*4*	*4*				*7.68*	
STS	*35*	*31*	*4*			*31.5*	

STLS	*35*	*29*	*6*			*31.5*	
TBHV	*170*	*170*				*122.4*	
DEO	*25*	*25*				*18.00*	
Accountant – part time	*24*	*24*				*5.76*	
Contractual LT	*187*	*178*				*145.86*	
Driver	*15*	*14*				*8.1*	
Any other contractual post approved under RNTCP							
					TOTAL	***386.22***	
Yearly estimated enhancement 15%(5+5+5)						***57.93***	
					TOTAL	***444.15***	

12. Printing:

Activity	*Amount permissible as per the norms in the state*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
*Printing-State level:** (stationery, treatment card, patient identity card, registers, training modules etc.)		*13,89,754*	***25,50,000***	***26,25,000***	*Rs. 1.50 lakh/million population, 17.5million x Rs. 1.5 = 26.25 lakh*

*Printing- Distt. Level:**					

** Please specify items to be printed in this column*

13. Research and Studies (excluding OR in Medical Colleges):

Any Operational Research projects planned (Yes/No) ____Yes,as per STF meeting_____
(If yes, enclose annexure providing details of the Topic of the Study, Investigators and Other details)

Whether submitted for approval/ already approved? (Yes/No)
_____
Estimated Total Budget _____Rs 15 lac_____

14. Medical Colleges

Activity	*Amount permissible as per norms*	*Estimated Expenditure for the next financial year(Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*
Contractual Staff: • *MO-Medical College (Total approved in state 6)* • *STLS/STS in Medical Colleges (Total no in state 5)* • *LT for Medical College (Total no in state 5)* • *TBHV for Medical College (Total no in state 5)* • DEO at NTF TOTAL 15%(5+5+5 enhancement)	*1.92x6* 0.9x5 0.78x5 0.72x5 0.72x5	*11.52* 4.5 3.9 3.6 3.6 27.12 4.06 **31.18**	*5 medical colleges 1 RML Hospital*

Research and Studies: • Thesis of PG Students	*20,000x5*	1.00	
Travel Expenses for attending STF/ZTF/NTF meetings		*0.50*	
IEC: Meetings and CME planned	*0.5x4+.05x5*	*2.25*	
Equipment Maintenance at Nodal Centres	*0.3*	*0.30*	
Total		***35.23 lacs***	

** Expenditure on OR can only be incurred after due approvals of STF/ STCS/ZTF/CTD (as applicable)*

15. Procurement of Vehicles:

Equipment	*No. actually present in the state*	*No. planned for procurement this year (only if permissible as per norms)*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
*4-wheeler ***				
2-wheeler	*25*	*9*	*4,50,000*	*@ 0.5 lakh per two wheeler*
Total			***4,50,000***	

*** Only if authorized in writing by the Central TB Division*

16. Procurement of Equipment:

Equipment	*No. actually present in the*	*No. planned for this year (only as*	*Estimated Expenditure for the next financial year for which plan is being*	*Justification/ remarks*

	state	*per norms)*	*submitted (Rs.)*	
	(a)	*(b)*	*(c)*	*(d)*
Computer			*Nil*	
Photocopier			*Nil*	
OHP				
Any Other				
Total			***Nil***	

Section D: Summary of proposed budget for the state

Category of Expenditure	**Budget estimate for the coming FY 2008-09** *(To be based on the planned activities and expenditure in Section C) (Rs.)*
1. Civil works	18,19,300
2. Laboratory materials	62,68,500
3. Honorarium	10,00,000
4. IEC/ Publicity	65,50,000
5. Equipment maintenance	12,25,000
6. Training	13,40,000
7. Vehicle maintenance	27,50,000
8. Vehicle hiring	21,00,000
9. NGO/PP support	17,50,000
10. Miscellaneous	37,25,000
11. Contractual services	4,44,15,000
12. Printing	26,25,000
13. Research and studies	15,00,000
14. Medical Colleges	35,23,000
15. Procurement –vehicles	4,50,000
16. Procurement – equipment	Nil
TOTAL	**8,10,40,800**

Integrated Disease Surveillance Programme.

The project development objective is *to improve the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors*. Specifically, the projects aims:

- To establish a decentralized system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in Delhi and also at the national level.

- To improve the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.

The IDSP project will assist the Government of Delhi to:

- survey a limited number of health conditions and risk factors;
- strengthen data quality, analysis and links to action;
- improve laboratory support;
- train stakeholders in disease surveillance and action;
- coordinate and decentralize surveillance activities;
  integrate disease surveillance at the state and district levels, and involve communities and other stakeholders, particularly the private sector.

PLAN OF ACTION FOR INITIATION OF THE IDSP in THREE MONTHS (JUNE – AUGUST)

1 Integrate and strengthen disease surveillance at the state and district levels

1 Creation of State Surveillance Unit:

The State Surveillance Unit (SSU) is headed by a public health specialist (SSO) from the state cadre. The state office will hire 2 technical consultants and 5 support staff as per the IDSP guidelines. The process will be completed within three months.

1.2 Creation of District Surveillance Units:. The nine District Surveillance Units (DSU) will be established under the project within three months. Each will be headed by Additional Chief District Medical Officer (DSO)of the respective district. Other contract staff as allowed under the IDSP will be recruited as per the guidelines.

2. Improve Laboratory Support.

2.1. The upgrading of laboratories at the state level The project provides for some minor internal modification of laboratories, equipment required for additional tests, reagents and kits, etc. for the State Public Health Labs. These will be assessed and deficiencies completed within three months in the following identified lab for specific disease conditions. Each lab. will have a nodal officer and will be coordinated through an integrated command system

	Conditions	Test	Confirmation	Objective	Id entified lab
1	Tuberculosis	AFB Culture and Sensitivity	Perform in 1% of positive cultures from district level	Identify magnitude of MDR TB	**New Delhi TB Centre**
2	Malaria		Confirm 1% from districts		**Microbiology MAMC**
3	Typhoid	Sensitivity testing in *S.typhi* isolates	Confirm 1% of bacterial isolates at district level	Pattern of AMR for *S.typhi* typing	**Microbiology MAMC**
4	Cholera	Cholera culture and Typing Cholera toxin test	1% of Cholera isolates from districts	Identify pattern of bacterial infection	**ID Hospital**
5	Water Quality	Colony count	Confirm 0.5% from district levels		**MCD PH lab**
6.	NCD surveillance	Blood sugar, HDL, LDL		Risk factor surveillance for NCD	**Bio –chemistry MAMC**
7.	Polio	Follow present procedures		Confirm Polio	**NICD/Microbiology MAMC**
8.	Measles	Kit for Measles IgM antibodies		Confirm Measles	**Microbiology MAMC**
9.	Leptospirae	MAT Test for Leptospira		Confirm Leptospirae	**Microbiology MAMC**
10	Dengue	IgM test for Dengue	Confirm 1% of samples from district	Quality control	**Microbiology MAMC**
11	Hepatitis	Serology for Hepatitis A, E, B, C	Confirm 1% of samples from district	Quality control Hepatitis work	**Microbiology MAMC**
12	Anthrax	Identification of Anthrax		Confirm Anthrax	**Microbiology MAMC**
13	Plague	Identification of plague		Confirm Plague	**Microbiology MAMC**

2.2. Strengthening of district labs. L2(district) laboratories will need to carry out tests for TB, malaria, typhoid, cholera and water quality, primarily to confirm results from the peripheral levels and for quality control. Some will require minor internal modification and additional equipment, reagents and kits. The district laboratories are situated attached to hospitals and primarily performing the functions of a curative laboratory. Each lab. Will have a nodal officer. The activities of the district laboratories will be coordinated by the district surveillance officer . These laboratories will be staffed by a qualified person who can undertake microbiological cultures.

At the district level integration of equipment and trained staff will be improved by bringing the DTC laboratory staff and Malaria laboratory staff within the

district public health laboratory. Integration of DTC and Malaria program at the district level is crucial for effective functioning of the district level laboratory, since trained laboratory technicians are already available with these programs.

Staff will be as already assigned, reassigned from other laboratories or, in the case of microbiologists, hired on contract in the following district labs.

Name of the district	**District lab**
New Delhi	Smt. Sucheta Kirplani Hospital
Central	LN Hospital
North	Aruna Asaf Ali Hospital
North-West	BSA Hospital
East	LBS Hospital
South-West	RTRM Hospital
South	M M M Hospital
North-East	GTB Hospital
West	DDU Hospital

2.3.Strengthening of L1 laboratories 172 in numbers will provide information for the diagnosis of malaria, TB, typhoid, chlorination levels in water and fecal contamination of water. Whilst these laboratories already handle examination of sputum and blood smears, some need minor internal modification as well as the provision of kits for typhoid diagnosis and assessment of fecal contamination of water. A survey will be conducted to find out the modifications needed within three months. Modifications needed will start simultaneously.

3.Initiating and establishment of the disease surveillance mechanism

3.1. Notification of State Surveillance Committee and State Rapid Response Team will be done in the first month.

3.2. Notification of Districts Surveillance Committees and District Rapid Response Teams will be done in the first month.

3.3 Training for Disease Surveillance and Action

.Eight separate short-term training programs for various categories of staff will start simultaneously within three months.

S.N	**Trainees**	**Number to be trained**
I	Training of state and district surveillance teams	50
II	Medical Officers of the HCs, and Urban Health centres. MOs of local Medical colleges. MOs of NGOs/ Nursing Homes etc.	1000
III	Medical Officers of the Hospitals,	1000

IV	ANMs, Health Supervisors, NGO volunteers,	1000
V	State and District level microbiologists / lab technicians. . Also Microbiologists from local Medical Colleges	150
VI	Training for lab assistants at HC s	180
VII	Training for data management at district and states level	29

4. Assessment of the bio-safety issues in the IDSP will be completed in three months and short gaps will be rectified.

5. Procurements of the goods: the process will start in the first month and will be completed in the three months.

6. Launching of the IDSP will be announced at the end of three months and an advocacy workshop for the beurocrats/HODs will be held.

As no funds were spent in year 2007-08, the allocation by Govt. of India in 2007-08 may be treated as budget proposed in 2008-09.

Proposed Budget in 2008-09:- Rs. 302 Lac.

National Vector Borne Disease Control Programme

LONG TERM ACTION PLAN FOR THE PREVENTION AND CONTROL OF DENGUE AND CHIKUNGUNYA IN DELHI

B. PREVENTION AND CONTROL PLAN OF ACTION

NO VACCINE is available yet for the prevention of dengue infection and there are no specific drugs for its treatment. Hence DF/DHF control is primarily dependent on the control of *Ae. aegypti.* **The basic elements of the strategy to control (11) are** :

- Establish effective disease and vector surveillance systems based on reliable laboratory and health information systems.
- Undertake disease prevention through selective, stratified and integrated vector control with community and intersectoral participation.
- Establish emergency preparedness capacity to prevent and control outbreaks with appropriate contingency plans for vector control, hospitalization, education and adequate logistics.
- Ensure prompt case management of DHF/DSS, including early recognition of the signs and symptoms, to prevent case mortality.
- Strengthen capacity and promote training, health education, and research on surveillance, vector control, and laboratory diagnosis and case management.

Environmental Management

Environmental management involves any change that prevents or minimizes vector breeding and hence reduces human-vector contact. The World Health Organization (12) (1982) has defined three kinds of environmental management. These environmental methods are source reduction, solid waste management, modification of man-made breeding sites, and improved house design.

B.1.1.SOURCE REDUCTION

B.1.1.1. ENVIRONMENT MODIFICATIONS

B.1.1.1.1 Improved water supply

B.1.1.1.2.Mosquito-proofing of overhead tanks/cisterns or underground reservoirs

B.1.1.2.Environmental manipulation

B.1.1.2.1.Draining of water supply installations

B.1.1.2.2.Domestic storage

B.1.1.2.3.*Flower pots/vases and ant traps*

B.1.1.2.4.Aedes breeding in incidental water collections

B.1.1.2.5.Building exteriors
B.1.1.2.6.Mandatory water storage for firefighting
B.1.1.2.7.Solid waste disposal

B.1.1.2.8.Tyre management
B.1.1.2.9.Filling of cavities of fences
B.1.1.2.10.Glass/plastic bottles and cans

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B.2. Personal Protection at household level : Community will be advised to

- Kill adult mosquitoes by making use of commercially available safe aerosols (pyrethroid-based). Spray bedrooms including closets, bathrooms and kitchens for a few seconds and close the rooms for 15-20 minutes. The timing of spray should coincide with the peak biting times of early morning or late afternoon.
- Intensify efforts to reduce actual or potential larva habitats.
- Cover water containers in the house to prevent fresh egg-laying.
- Have infants sleep under bed nets during the day.
- Wear protective clothing, preferably sprayed with a repellent.
- Use commonly-available repellents during the day time and also make liberal use of mats and coils, etc. during night and day (including all family members – whether they stay at home or go to work).

B.2.4.Insecticide-treated mosquito nets and curtains

B.3. Biological Control

B.3.1.Fish

Larvivorus fish (*Gambusia affinis* and *Poecilia reticulata*) have been extensively used for the control of *An. stephensi* and/or *Ae. aegypti* in large water bodies or large water containers in many countries in South-East Asia. The programme has been using successfully. It will be further encouraged (**annexure XII**) .

B.3.2.Bacteria

Two species of endotoxin-producing bacteria, *Bacillus thuringiensis* serotype H-14 *(Bt.H-14)* and *Bacillus sphaericus (Bs)* are effective mosquito control agents. They do not affect non-target species. *Bt.H-14* has been found to be most effective against *An. stephensi* and *Ae. aegypti*, while *Bs* is the most effective against C*ulex quinquefasciatus* which breeds in polluted waters. There is a whole range of formulated *Bti* products produced by several major companies for control of vector mosquitoes. Such products include wettable powders and various slow-release formulations including briquettes, tablets and pellets. These will be used appropriately .

B.3.3.Autocidal ovitraps

These will be used appropriately in identified places like airports, large campuses etc.

B.4. Chemical Control

B.4.1.Chemical larviciding

. Chemical larvicides will be best used in situations where the disease and vector surveillance indicate the existence of certain periods of high risk and in localities where outbreaks might occur. The Programme would always encourage house occupants to control larvae by environmental sanitation.

There are three insecticides that will be used for treating containers that hold drinking water.

B.4.1.1Temephos 1% sand granules

.Application of these will be considered appropriately in consultation with NVBCDP/MRC .

B.4.1.3.Bacillus thuringiensis H-14 (Bt.H-14)

.The application will be used appropriately in consultation with NVBDCP/MRC.

B.4.2. Adult mosquitocidals

B.4.2.1.Space sprays

These will be followed. Generally, there are two forms of space-spray that have been used for *Ae. aegypti* control, namely “thermal fogs” and “cold fogs”. Both can be dispensed by vehicle-mounted or handoperated machines.

B.4.2.1.1.Thermal fogs

B.4.2.1.2.Ultra-low volume (ULV), aerosols (cold fogs) and mists

The droplet size would be monitored by exposure on Teflon or silocone-coated slides and examined under a microscope. Aerosols, mists and fogs are being applied by portable machines, vehiclemounted generators (**annexure IV,V)**

B.4.3.Integrated control approach

Insecticide susceptibility monitoring

These will be used.NICD/NVBDCP/ Malaria Research Centre (ICMR) would be requested to do the needful before deciding the procurement of the insecticides.

Safety precautions for chemical control

B.5.EpidemiologicalSurveillance

EPIDEMIOLOGICAL surveillance of DF/DHF will cover both disease (case) and entomological (vector) surveillance.

B.5.1.Case Surveillance

Effective surveillance of DF/DHF infection is essential for monitoring endemic transmission and for early recognition of impending epidemics. There would be close collaboration between the epidemiologic, clinical and laboratory components .

B.5.1.1. Early Case reporting

B.5.1.1.1.Fever alert surveillance

B.5.1.1.1.2 For early capture of any incipient outbreak of a suspected vector borne disease, it is envisaged that the health workers and grassroots level functionaries such as ASHA (NRHM), Anganwadi worker (AWW),Basti Sevikas and Fever Treatment Depots (FTD) etc.shall be trained in

identification and reporting of *fever syndrome* to district vector borne disease control officer/municipal zone officer directly under intimation to respective health institution.

B.5.1.1.1.3.To supplement the activity, an interactive voice response systeming (IVRS) will be set up where any person can lodge the information. The system would be able to alert the concerned health facility for verification of any reported cases of unusual increase in the epidemic-prone diseases.

B.5.1.1.1.4.Health and Sanitation Committee (HSC) under NRHM would also provide exceptional reporting in the event of emerging outbreak of fever cases.This mechanism would facilitate immediate investigation of cause of the fever followed by remedial measures.

B.5.1.1.2.Sentinel surveillance sites with laboratory support

B.5.1.1.2.1.Presently, the epidemics are near peak transmission before they are recognized and confirmed as dengue. By then it is generally too late to implement effective preventive measures that could have an effective impact on transmission/ the course of the epidemic.

B.5.1.1.2.2. It is therefore proposed that the surveillance for dengue would be proactive. The most important component of this proactive system will be serological/ virological surveillance, which will monitor the dengue virus transmission especially during inter-epidemic periods. It will also continually provide information on where transmission is occurring, what virus serotype or serotypes are involved and the type of complications associated with dengue infection. It will also permit to differentiate whether the illness is dengue or chikungunya, as the initial symptoms are similar in both the disease. It is proposed that a network of thirty sentinel surveillance hospitals will be monitoring dengue virus activity during the inter-epidemic period and alert the programme managers for effective remedial measures in areas with viral activity. A contingency grant of Rs 50,000/- shall be made available to each of these hospitals to meet out the expenditures towards laboratory reagents, internet, stationery, data management and travel cost for attending meetings by the In-charge of sentinel laboratory.

B.5.1.1.2.3. The sentinel surveillance hospitals will carry out various activities like taking blood samples from the suspected patients with viral syndrome, maintaining line-listing of positive cases of dengue and chikungunya and capacity building of health institutions within their allotted jurisdiction etc.

B.5.1.1.2.4.As soon as a dengue case is confirmed by serological test (IgM Capture ELISA Test), the district vector borne disease control officer/ chief district medical officer/ dy. municipal health officer would be intimated by telephone, e-mail or speed post so that he/she can immediately initiate remedial measures in respect of vector control in the affected area(s). The time lag between intimation received and actions initiated by the district/municipal authorities would not be more than 24 hrs in order to effectively interrupt dengue transmission.

B.5.1.1.2.4.Each sentinel surveillance hospital will have ELISA reader, ELISA washer and other necessary equipment for conducting dengue serology. In case, the equipment is not available with the hospital, the State Programme Officer will immediately arrange the equipment in consultation with the Dte of NVBDCP to ensure that the facility is made available. The IgM MAC ELISA capture test kits will be supplied by NIV, Pune under the instructions/guidance

of Dte of NVBDCP GoI. The technical requirements of the kits based on the previous epidemiological data will be prepared and sent directly to NIV Pune under intimation to Dte. Of NVBDCP. The payment for these kits will be made by the Dte. Of NVBDCP out of the funds available under the commodity grant.

Sentinel Hospitals

AIIMS, Safdarjung Hospital, DDUH, RML Hospital, GTB Hospital, Lok Nayak Hospital, Hindu Rao Hospital, Aruna Asaf Ali Hospital, Babu Jagjivan Ram Hospital, Kastruba Hospital, ABG Hospital Moti Nagar, Patel Hospital Patel Nagar, Lal Bahadur Shastri Hospital, Shastri Park Hospital, SDN Hospital, Lady Hardinge Hospital, Chacha Nehru Children Hospital, Kalawati Saran Children Hospital, Dr. Hedgewar Arogya Sansthan, NC Joshi Hospital, Sanjay Gandhi Memorial Hospital, Rao Tula Ram Hospital, SRHC Narela, Bhagwan Mahavir Hospital, Charak Palika Hospital, Malviya Nagar Hospital, Guru Gobind Singh Hospital, Maharishi Balmiki Hospital, Attar Sen Jain Hospital,

Activities to be undertaken by Sentinel Surveillance Hospitals:

(i) Blood samples will be taken from the representative cases of the viral syndrome(3-15days after the onset of symptoms) referred by the Sentinel Clinic/Physician/Fever Alert processed on a weekly basis to detect the presence of dengue/Chikungunya specific IgM antibody. The second set of samples will be sent to the identified laboratory for virus isolation/PCR test.

(ii) These hospitals will also **maintain line-listing of dengue and Chikungunya positive cases.**

(iii) Sentinel surveillance hospitals will also help in the capacity building of health care institutions in their allotted areas.

Each such centre shall have a trained microbiologist and laboratory technician. The training of the microbiologists/technicians of the sentinel surveillance hospitals will be conducted at identified apex referral labs.

B.5.1.2.Strengthening of referral services For advanced diagnostic facilities such as PCR, virus isolation in Dengue and other viral vector borne diseases, 2 apex laboratories in Delhi have been identified at AIIMS and NICD.These

laboratories will also be helping capacity building of the sentinel surveillance hospitals as well as quality control of laboratory services.

B.5.1.3.involvement of clinics/dispensaries/health centres in sentinel surveillance

In addition to sentinel surveillance hospitals, the private clinics/dispensaries/health centres/nursing homes in endemic areas/municipal zones/districts will be identified for establishing sentinel surveillance sites. However, they will avail the laboratory facilities of the sentinel hospitals for confirmation of dengue cases. These sites shall also maintain line listing of cases. The district vector borne disease control officer/zonal municipal health officer shall be in contact with the sentinel surveillance clinics/hospitals to update his database for rapid response. The MOs/Physicians from these centres shall also be included in the training programme organized for sentinel hospitals.

B.5.1.2.Passive surveillance

DF/DHF is a reportable disease in Delhi. The existing reporting system based on standardized case definitions will be merged into Integrated Disease Surveillance Programme (IDSP). Although passive systems are not sensitive and have low specificity since cases are not laboratory confirmed, they are most useful in monitoring long-term trends in dengue transmission. The clinical spectrum of illnesses associated with dengue infection ranges from non-specific viral syndrome to severe haemorrhagic disease or fatal shock. It may sometimes be difficult to differentiate the illnesses from those caused by other viruses, bacteria and parasites. Therefore, surveillance would be supported by laboratory diagnosis. However, the reporting of dengue disease generally has to rely on clinical diagnosis combined with simple clinical laboratory tests and available epidemiological information. Passive surveillance would require case reports from every clinic, private physician and health centre or hospital that provides medical attention to the population at risk. However, even when mandated by law, passive surveillance is insensitive because not all clinical cases are correctly diagnosed during periods of low transmission, when the level of suspicion among medical professionals is low. Moreover, many patients with mild, non-specific viral syndrome self-medicate at home and do not seek medical treatment. By the time dengue cases are detected and reported by physicians under a passive surveillance system, substantial transmission has already occured and may even have peaked. In this case, it is often too late to control the epidemic. Therefore sentinel surveillance system will be supplemented by the above mechanism.

B.5.1.3. *Reporting system*

Peripheral health units would report to the Municipal Zonal Health Officer(IDSP). These will be reported to the Chief District Medical Officer (IDSP) and ultimately at the Municipal Health Officer(IDSP), the State IDSP and the National IDSP.

B.5.2.1.Case management

B.5.2.1.1.Standard case management guidelines developed by National Vector Borne Diseases Control Programme Government of India; will be followed www.nvbdcp.gov.in (annexure)

B.5.2.1.2. Similarly, treatment of Chikungunya is also symptomatic and patients would be monitored until they become afebrile and get relief of the joint pains.

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B.5.2.2.Epidemic preparedness and rapid response

B.5.2.2.1.A contingency plan dealing with emergency hospitalization shall be prepared by each endemic district and municipal zone for making the most effective use of hospitals and treatment facilities in case of DHF/DSS or Chikungunya outbreak occurs. Emergency action committee(EAC) will be constituted .

5.2.2.2.Based on the previous year's epidemiological data on DF/DHF, the district/municipal zone should estimate requirements for inpatient hospital facilities. Generally, in the worst scenario, the incidence of seriously ill patients requiring hospitalization may be one case per 100 dengue infections.

B.5.2.2.3. The endemic districts/municipal zones shall estimate the number of beds required during the period of three months of high transmission of DF/DHF. If adequate number of beds are not available in the endemic districts, plans for additional temporary beds shall be made in advance. Contingency plans should also be developed to convert schools or public buildings if necessary to handle the excess of indoor patients. Rapid response teams (RRT) will be constituted immediately.

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B.5.3.Entomological (vector) surveillance.

Surveillance for *Ae. aegypti* is important in determining its distribution, population density, major larval habitats, spatial and temporal risk factors related to dengue transmission, and levels of insecticide susceptibility or resistance(26), in order to prioritize areas and seasons for vector control. These data will enable the selection and use of the most appropriate vector control tools, and can be used to monitor their effectiveness.These will include the followings :

B.5.3.1. Larval surveys

For practical reasons, larval sampling procedures rather than egg or adult collections will be done. The basic sampling unit will be the house or premise, which is systematically searched for water-holding containers. Three indices will be used to monitor *Ae. Aegypti* infestation levels(25, 26) The house index has been most widely used for monitoring infestation levels, but it does not

take into account the number of positive containers nor the productivity of those containers. Similarly, the container index only provides information on the proportion of water-holding containers that are positive. The Breteau index establishes a relationship between positive containers and houses, and is considered to be the most informative, but again there is no reflection of container productivity. Nevertheless, in the course of gathering basic information for calculating the Breteau index, a profile of the larval habitat characteristics will be obtained by simultaneously recording the relative abundance of the various container types, either as potential or actual sites of mosquito production (e.g. number of positive drums per 100 houses, number of positive tyres per 100 houses, etc.). These data will be used for focusing control efforts on the management or elimination of the most common habitats and for the orientation of educational messages for community based initiatives (**annexure IX**)

Indices to be used to assess the levels of *Ae. aegypti* infestations

House index (HI): percentage of houses infested with larvae and/or pupae.

$$HI = \frac{\text{Number of houses infested}}{\text{Number of houses inspected}} \times 100$$

Container index(CI): percentage of water-holding containers infested with larvae or pupae.

$$CI = \frac{\text{Number of positive containers}}{\text{Number of containers inspected}} \times 100$$

Breteau index (BI): number of positive containers per 100 houses inspected.

$$BI = \frac{\text{Number of positive containers}}{\text{Number of houses inspected}} \times 100$$

Pupal index: **number of pupae per 100 houses**

$$PI = \frac{\text{Number of pupae}}{\text{Number of houses inspected}} X\ 100$$

In order to compare the relative importance of larval habitats, the pupal index will be broken down to “useful”, “non-essential” and “natural” containers, or by specific habitat types, such as tyres, flower vases, drums, clay pots, etc. Given the practical difficulties and labour-intensive efforts entailed in obtaining pupal counts, especially from large containers, this method will not be used in every survey, but will be reserved for special studies or used once in each locality during the wet season and once

during the dry season, to determine the most productive container types.

B.5.3.2.Adult surveys

The collection methods also tend to be labour intensive and heavily dependent on the collector's proficiency and skill.Therefore these will be restricted for research only.

B.5.3.3. Landing/biting collections

Feasibility of incorporating the landing/biting collections in the routine operations will be determined in consultatation with Malaria Research Centre (MRC) ICMR.

B.5.3.4.Resting collections

B.5.3.5.Oviposition traps

"Ovitraps" will be used to detect the presence of *Ae. Aegypti etc.* where the population density is low and larval surveys are largely unproductive (e.g. when the Breteau Index is less than 5), as well as under normal conditions. They are particularly useful for the early detection of new infestations in areas from which the mosquitoes have been previously eliminated.

B.5.3.6.Tyre section larvitraps

Sampling strategies The sample size for routine larval surveys would be calculated using statistical methods based on the expected level of infestation and the desired level of confidence in the results.

Systematic sampling

Every nth house is examined throughout a community or along linear transects through the community. For example, if a sample of 5% of the houses is to be inspected, every 20th house would be inspected. This is a practical option for rapid assessment of vector population levels, especially in areas where there is no house numbering system.

Simple random sampling

The houses to be examined are obtained from a table of random numbers (found in statistical text books or from a calculator or computer generated list). This is a more laborious process, as detailed house maps or lists of street addresses are a prerequisite for identifying the selected houses.

Stratified random sampling

This approach minimizes the problem of underand over-representation by subdividing the localities into sectors or "strata". Strata are usually based on identified risk factors, such as areas without piped water supply, areas not served by sanitation services, and densely populated areas. A simple random sample is taken from each stratum, with the number of houses inspected being in proportion to the number of houses in that sector.

Frequency of sampling

Control programmes using integrated strategies do not require sampling at frequent intervals to assess the impact of the applied control measures. This is especially true where the effect of the alternative strategies outlasts residual insecticides (for example, larvivorous fish in large potable water storage containers, source reduction or mosquito-proofing of containers) or when larval indices are high (HI greater than 10%). On the other hand, feedback on

at least a monthly basis may be desirable to monitor and guide community activities and to identify the issues that need more scrutiny, especially when the HI is 10% or lower. For specific research studies, it may be necessary to sample on a weekly, daily or even hourly basis (e.g. to determine the diurnal pattern of biting activity).

Insecticide susceptibility testing

Information on the susceptibility of *Ae. Aegypti* to insecticides for the planning and evaluation of control is of fundamental importance. The status of resistance in the population will be carefully monitored to ensure that timely and appropriate decisions are made to use alternative insecticides or to change control strategies. Standard WHO susceptibility test procedures and kits will be used to determine the susceptibility or level of resistance of mosquito larvae and adults to insecticides (WHO, 1981)(29). Test kits can be ordered and purchased through WHO Representatives (WRs) at country level and WHO regional offices.The susceptibility will be tested under a protocol to be developed in consultation with NICD/NVBDCP/MRC.

Additional information for entomological surveillance

In addition to the evaluation of aspects directly pertaining to vector density and distribution, community-oriented, integrated pest management strategies require that other parameters be measured or periodically monitored. These include the distribution and density of the human population, settlement characteristics, and conditions of land tenure, housing styles and education. The monitoring of these parameters is relevant and of importance to planning purposes and for assessing the dengue risk. The knowledge of changes over time in the distribution of water supply services, their quality and reliability, as well as in domestic water storage and solid waste disposal practices is also particularly relevant. Meteorological data are also important. Such information aids in planning targeted source reduction and management activities, as well as in organizing epidemic intervention measures. Some of these data sets are generated by the health sector, but other sources of data will be necessary. In most cases, annual or even less frequent updates will suffice for programme management purposes. In the case of meteorologic data, especially rainfall patterns, humidity and temperature, a more frequent weekly analysis is warranted if it is to be of predictive value in determining the seasonal trends and short-term fluctuations of vector populations.

B.5.4.Sustainable Prevention and Control Measures

B.5.4.1.Community Participation

Objectives of community participation in dengue prevention and control

- To extend the coverage of the programme to the whole community by creating community awareness. This however often requires intensive inputs.

- To make the programme more efficient and cost-effective, with greater coordination of resources, activities and efforts pooled by the community.
- To make the programme more effective through joint community efforts to set goals, objectives and strategies for action.
- To promote equity through sharing of responsibility, and through solidarity in serving those in greatest need and at greatest risk.
- To promote self-reliance among community members and increase their sense of control over their own health and destiny.

How to invoke community participation

By showing concern

Initiating dialogue

Community organizers and opinion leaders or other key personnel in the power structure of
the community, namely women's groups, youth groups and civic organizations etc. would be identified. Dialogue would be undertaken through personal contacts, group discussions, meetings and workshops. Interaction should generate mutual understanding, trust and confidence, enthusiasm and motivation. The interaction would not be a one-time affair, but would be a continuing dialogue to achieve sustainability through the Bhagidari.

Creating community ownership

The programme would use (a) community ideas and participation to initiate the programme process,(b) community leaders to assist the programme, and (c)community resources to fund the programme. Mosquito control, abatement agency and community partnerships would be strong.

Health education (HE)

Health education would not be based on telling people the do's and don'ts through a vertical, top-down communication process. Instead, health education would be based on formative research to identify what is important to the community and would be implemented at three levels, i.e. the community level, systems level and political level.

Community level

People would not only be provided with knowledge and skills on vector control, but education materials should empower them with the knowledge that allows them to make positive health choices and gives them the ability to act individually and collectively.

Systems level

To enable people to mobilize local actions and societal forces beyond a single community, i.e. health, development and social services.

Political level

Mechanisms must be made available to allow people to articulate their health priorities to political authorities. This will facilitate placing vector control high on the priority agenda and effectively lobby for policies and actions.

Defining community actions

For sustaining DF/DHF prevention and control programmes, the following community actions are essential(56):

- At the individual level, encourage each household to adopt routine health measures that will help in the control of DF and DHF, including source reduction and implementation of proper personal protection measures.
- At the community level, organize “cleanup” campaigns two times a year (June-july and Oct-Nov) to control the larval habitats of the vectors in public and private areas of the community. Some key factors for the success of such campaigns include extensive publicity via mass media, posters and pamphlets etc., proper planning, pre-campaign evaluation of foci, execution in the community as promised, and follow-up evaluations. Participation by local resident welfare associations , market committees, individual s,municipal sanitation services would be promoted.
- Where community-wide participation is difficult to arrange for geographical, occupational or demographic reasons, participation will be arranged through voluntary associations and organizations. The people in these organizations may interact daily in work or institutional settings, or come together for special purposes, i.e. religious activities, civic clubs, women’s groups and schools etc.
- Emphasis will be on school-based programmes targeting children and parents to eliminate vector breeding at home and at school.
- The private sector will be encouraged to participate in the beautification and sanitary improvement of the community as sponsors with emphasis on source reduction of dengue vectors.
- Community participation in DHF prevention and control with other priorities of community development will be combined. Where municipal services (such as refuse collection, wastewater disposal, provision of potable water, etc.) are either lacking or inadequate, the community and their partners will be mobilized to improve such services, and at the same time reduce the larval habitats of *Aedes* vectors as part of an overall effort at community development.
- Dengue vector control will be combined with the control of all species of disease-bearing and nuisance mosquitoes as well as water borne diseases control and fly control, cockroach control, rodent control etc. to ensure greater benefits for the community and consequently greater participation in neighbourhood campaigns under the Bagidari.
- Novel incentives will be provided for those who participate in community programmes for dengue control. For example, a competition can be promoted to identify the cleanest localities/housing societies/markets/villages/institutions/ communities etc. or those with the lowest larval indices .

Community actions during the epidemics will be guided by Annex **VIII.**

Activities during anti-dengue/Chikungunya months (June-July and Oct-Nov):

Month of June has already been declared as anti-malaria month all over the country. Messages on Dengue and Chikungunya would also be added up in the campaign. In addition, the month of July shall also be observed as cleanliness month in all cities/towns/Panchayats, following activities should be undertaken.

- Messages from Chief Minister and Lt Governor
- 1st week of July could be observed as cleanliness week by all institutions both in public-private sector. Wide publicity of such campaigns would be disseminated through local newspapers, radio and cable TV on each day.
- Maintenance divisions of CPPWD,PWD,Local self government etc. shall ensure checking of all over head tanks, undergrounds tasks cisterns, etc. to ensure that lids in the water containers are tightly closed and there are no holes for the entry of the mosquitoes.
- Besides routine checking of breeding of mosquitoes by municipal bodies, a random check of all water containers/potential breeding places would be conducted to assess the impact of cleanliness week in the 2nd week of July. Civil defence volunteers ,school volunteers, NSS, Girl guides and Scouts etc. will be involved
- All construction sites in citiy shall be identified by the local bodies and regular check up for mosquitoes shall be organized. The contractors and owners of the building shall be motivated to maintain cleanliness at the sites of construction and ensuring mosquito free premises.
- Residents Welfare Associations shall organize week long cleanliness campaigns in respect of their premises and ensure that all coolers and water storage tanks are free of mosquito breeding. They shall organize house to house check of mosquitoes breeding in co-ordination with the functionaries of local bodies.
- Discarded tyres (cycle, scooter and motor vehicles) are potential source of Aedes mosquito breeding. The local bodies shall identify such places or repair shops and educate the owners for proper storage of all such tyres.
- Schools/colleges/university campuses shall organize cleanliness drive by involving school children/students. The volunteers of the National Service Scheme (NSS) should be involved in organizing cleanliness drive in every school and college premises. Some of the volunteers shall be trained to check the breeding of mosquitoes. The insect collectors of

the local bodies shall make a random check of schools in each ward of cities and towns to assess whether breeding of mosquitoes exist. The outcome of such survey shall be disseminated through newspapers, Cable TV and Radio so that others schools are motivated to ensure proper cleanliness and mosquito free environment in their school premises.

- In rural areas, the volunteers of NYKS shall be involved in dissemination of information and organizing cleanliness drive in co-ordination with Panchayats and functionaries of Rural Development Departments.
- Under the National Rural Health Mission, untied funds have been made available to each village/colony etc for environmental sanitation and hygiene which will be spent through village health and hygiene committee constituted under the leadership of Gram Pradhan. At the village level, ASHA, AWW and other members of village health and hygiene committee should be sensitized by the area Health Worker (ANM/MPW) on prevention and control of Dengue.
- All the perennial water bodies in wards/zones should be identified and mapped for seeding with larvivorous fish. Hatcheries for supply of larvivorous fish will be maintained. The local committee should monitor percentage of water bodies seeded with larvivorous fish. During the month of June, a drive should be organized to ensure coverage of all water bodies with larvivorous fish.
- On pilot basis, impregnation of curtains with deltamethrin liquid will be carried out in Delhi. Requirement should be calculated @ 15ml and requirement should be estimated accordingly. Government of India will be requested to forward approved rates for deltamethrin liquid to MCD & NDMC and Railway, Cantonment area for procurement of SP liquid. Expenditure towards procurement of SP liquid will be reimbursed to NCT and NCR of Delhi by Governmment of India. Health authorities of the respective organization shall make an action plan for impregnation of curtains in the month of May and June. For monitoring of the coverage, ward-wise and household-wise number of curtains should be estimated in order to ensure more than 60% coverage.
- Print and electronic media shall be informed on day to day activities for control of Dengue and Chikungunya. Besides these meetings, information on dengue and Chikungunya will also be posed on websites at the above mentioned frequently.

- A detailed calendar of health alerts will be worked out. Mass media like newspapers, TV and Radio would also be used to display alerts on Dengue/Chikungunya. A long term action plan for Dengue/Chikungunya is being finalized.

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B.5.4.2. Capacity Building:

B.5.4.2.1.**Trainings;** s. Training would also be imparted to dengue treatment clinics and hospitals in private sector. The following reorientation training programmes shall be organized and completed in a time bound manner:All Medical Colleges, major hospitals will be encouraged to act as training institutes.

- Training of National Trainers for tertiary level Dengue/ Chikungunya Treatment Teams: All India Institute of Medical Sciences, New Delhi shall be identified as a Nodal Institute for organizing National level trainers' training for Dengue Treatment Teams.
- State level training for Dengue Treatment Teams:National Dengue Training Teams trained at AIIMS shall be responsible to train state level dengue treatment teams.
- District Level Trainers for Dengue Treatment Teams:The state level trainers' teams for dengue treatment would train teams from each of endemic districts on the same line as recommended for state level trainers' teams.
- Training of teams at Primary Health care Institutions: Each district shall organize this training .

B.5.4.2.2. All participating units will have **quality assurance** programmes . Standard operating procedures(SOP), guidelines etc. will be prepared. External quality assurance programme protocols will be developed

B.5.4.2.3. Appropriate capacity with matching infrastructure will be provided at all levels for the Programme Management Units, Epidemiological and Entomological units.An exercise will be undertaken to identify the gaps.

B.5.4.3.Intersectoral Coordination

The prevention and control of dengue requires close collaboration and partnerships between the health and non-health sectors (both government and private), nongovernmental organizations (NGOs) and local communities. During epidemics such cooperation becomes even more critical, since it requires pooling of resources from all groups to check the spread of the disease. Intersectoral cooperation involves at least two components: (i) resource-sharing, and (ii) policy adjustments among the various ministries and nongovernmental sectors.

B.5.4.3.1.Resource sharing

Resource sharing would be sought wherever the dengue control coordinator can make use of underutilized human resources, e.g. community, religious, social and youth groups etc. to check mosquito breeding, spreading awareness and clean up discarded tyres and containers in neighbourhoods.The corporates etc will be encouraged to adopt localities/public parks/places etc for the clean up operations.

B.5.4.3.2 Policy adjustment

The dengue control programme would seek the accommodation or adjustment of existing policies and practices of other ministries, sectors, and municipal governments to include public health as a central focus for their goals. For instance, the urban development sector would be encouraged to adjust its policies to give first priority to water supply improvements for the communities in slums at highest risk of dengue, education department can be encouraged to take up setting up a positive health club in each school with emphasis on various preventable diseases control activities etc.

Role of non-health sectors in dengue control

The following examples show how several government ministries may contribute to dengue vector control efforts.

Role of the Urban Development, DDA, CPPWD, PWD, building and land departments of Delhi Govt,MCD and NDMC, Jal Board

The above departments and their municipal counterparts should play a key role in dengue control. They can contribute to source reduction by providing a safe, dependable water supply, proper drainage system, adequate sanitation, and effective solid waste management. In addition, through the adoption and enforcement of housing and building codes, proper maintainance of the buildings under their control etc. Delhi Jal Board may mandate the provision of utilities such as individual household piped water supplies or sewerage connections and proper maintainance etc., and rainwater (storm water) runoff control for new housing developments, or forbid open surface wells.

Role of the deparment of education

The Ministry of Health would work closely with the Ministry of Education to develop a health education (health communication) component targeted at school children, and devise and communicate appropriate health messages. Health education models can be jointly developed, tested, implemented and evaluated for various age groups. Research programmes in universities and colleges can be encouraged to include components that produce information of direct importance (e.g. vector biology and control, case management) or indirect importance (e.g. improved water supply, educational interventions to promote community sanitation, waste characterization studies) to dengue control programmes.

Role of the department for the environment

The Ministry of Environment can help the Ministry of Health collect data and information on ecosystems and habitats in or around cities at high risk of dengue. Data and information on local geology and climate, land usages, forest cover, surface waters, and human populations are useful in planning control measures for specific ecosystems and habitats. The Ministry of Environment may also be helpful in determining the beneficial and adverse impacts of various *Ae. Aegypti* control tactics (chemical, environmental and biological).

Role of the Irrigation and Flood Control Department
Maintainance of the flood control drains properly. Remove silt and water hyacinth. Prevent sewerage discharge in the strom water drains

Role of Railways, Airport authority, Army, Universities etc.
The agencies are the land owners for a vast tract of land and buildings in Delhi.

Role of Department of Horticulture CPPWD, Delhi Govt.,MCD and NDMC
As owners of vast area under the horticulture cover with water management

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B.5.4.4.N*ongovernmental organizations (NGOs), community based organizations(CBOs), resident welfare associations(RWAs),market committees etc. participation*
These organisations can play an important role in promoting community participation and implementing environmental management for dengue vector control. This will most often involve health education, source reduction, and housing improvement related to vector control. Community NGOs may be informal neighbourhood groups or formal private voluntary organizations, service clubs, or other religious groups, or environmental and social action groups. After proper training by the Ministry of Health staff in source reduction methods, NGOs can collect discarded containers (tyres, bottles, tins, etc.), clean drains and culverts, fill depressions, remove abandoned cars and roadside junk, and distribute sand or cement to fill treeholes. NGOs etc. may also play a key role in the development of recycling activities to remove discarded containers from yards and streets. Such activities must be coordinated with the environmental sanitation service. NGOs may also be able to play a specific, but as yet unexplored, role in environmental management during epidemic control. Under guidance from the Ministry of Health, NGOs etc. could concentrate on the physical control of locally identified, key breeding sites such as water drums, waste tyre piles etc. Service clubs such as Rotary International etc. have supported DF/DHF prevention and control programmes in the American Region for over 15 years(57). In Asia and the Pacific, programmes have been initiated in Sri Lanka, Philippines, Indonesia and Australia to provide economic and political support for successful community-based campaigns. Women's clubs have contributed to *Ae. aegypti* control by conducting household inspections for foci and carrying out source reduction. There are many opportunities, mostly untapped, for environmental organizations and religious service groups to play similar roles in each *Ae. aegypti*-infested community. NGOs etc. will be supported with financial grants to carry out dengue control activities particularly in the epidemic prone hot spots as a part of Bhagidari.

B.5.4.5 Model Development

Model development for dengue control through a community participation approach would be initiated in order to define potential prime movers in the communities and to study ways to persuade them to participate in vector control activities. Social, economic and cultural factors that promote or discourage the participation of these groups would be intensively studied in order to gain more participation from the community.

B.5.4.6.Social Mobilization

Advocacy meetings would be conducted at all levels from policy makers to opinion leaders for attaining commitment for mass clean-up campaigns and environmental sanitation. Intersectoral coordination meetings with possible parteners including media, would be conducted to explore possible donors for mass antilarval control campaigns and measures and to help finance the programme. Reorientation training of health workers would be conducted to improve their technical capability and ability to supervise prevention and control activities. A “DHF month” would be identified twice a year, during the pre-transmission season(May-June) and during the peak transmission period (Sept-Oct)

B.5.4.7.Health Education

Health education is very important in achieving community participation. It is a long-term process to achieve human behavioural change, and thus would be carried out on a continuous basis. Health education would be given priority in endemic areas and in areas at high risk for DHF. Health education will be conducted through the different channels of personal communication (IPC), group educational activities,and mass media. Health education will be implemented by women’s groups, school teachers, formal and informal community leaders, and health workers. Health education efforts would be intensified before the period of dengue transmission as one of the components of social mobilization.

B.5.5.Legislative Support

Legislative support is essential for the success of dengue control programmes. All states have legislation addressing control of epidemic diseases which authorize health officers to take necessary action within the community for the control of epidemics. On a continuous and sustainable basis, various municipalities have adapted legislation for the prevention of “nuisance mosquitoes”, however they lack specific provision related to dengue and/or *Ae. aegypti* control. At the national level, all countries are signatories to the International Health Regulations which have a specific provision for the control of *Ae. aegypti* and other disease vectors around international sea/airports.Existing byelaws of some local bodies like Mumbai Municipal Corporation, New Mumbai Municipal Corporation, Municipal Corporation of Chandigarh and Goa would be studied and adopted ,if needed.

The formulation of legislation on dengue/ *Ae.aegypti* control should, therefore, take into consideration the following points:

(a) All existing decrees and resolutions on dengue/*Ae.aegypti* prevention and control will be reviewed, and their effectiveness evaluated in terms of structural, institutional and administrative changes.

(b) Regulations should be formulated on the basis of existing sanitary codes, a strategy that is most needed . Sanitary regulations are primarily the responsibility of agencies other than the Department of Health GNCTD (e.g. municipal governments), a coordinated and cooperative line of action with the health department needs to be developed.
(c) Legislation should incorporate municipal authorities as the central element for implementation and enforcement. Municipal governments may consider the adoption of local ordinances for *Ae. Aegypti* control.
(d) Legislation should contemplate intersectoral coordination among the ministries involved in order to prevent isolated implementation of individual programmes and harmful environmental changes that could create potentially hazardous public health conditions. Ministries would be advised on the best ways to encourage disease prevention.
(e) Legislation should cover all aspects of environmental sanitation in order to effectively contribute to the prevention of all transmissible diseases.
(f) Laws should contemplate the existing judicial administrative framework . Importance should also be placed on norms aimed at developing human resources within the institutional framework.
(g) In developing legislation, the social component must be considered. Legislation should seek support based on justice and justification: individuals and the community must be persuaded that the law is good and that it is intended to protect them and their families, and that compliance with it is one of the most important components for dengue control .

Examples of other enforcement methods that may be considered

- Ordinances that require mosquitoproofing of cisterns, water-storage tanks, wells and septic tanks.
- Ordinances that authorize the removal of junk cars and other scrap, after proper notification.
- Ordinances that authorize the posting of “No Dumping” and “No Littering” signs and civil penalties for violators.
- Ordinances that require houseowners to keep their yards free of junk, litter, and potential foci, under threat of civil penalty.
- Orinances requiring mandatory household collection of solid wastes for all neighbourhoods.

B.5.6 Co-ordination committees:

A coordination committee will be constituted under the Chairpersonship of Pr. Sec(H)GNCTD.The various stake holders will be requested to nominate one senior person as their representative as member. The committee will meet every first Wednesday. Agenda of the meeting will be drawn by the Central Cross Checking Organisation(CCO) NVBDCP and will be circulated before the meeting. A quarterly meeting will be held under the chairmanship of Chief Secretary GNCTD to review the progress and also to resolve any inter agency conflict points. The committee would also ensure that emergency

hospitalization plan, including availability of diagnostics and therapeutics and oversee usage of supplies and outcome of the clinical care programme. The committee would advise the community during the outbreak situation and provide them necessary information on the availability of diagnostic and treatment services for DF/DHF and chikungunya.

B.5.7.Evaluation of DF/DHF Prevention and Control Programmes

It is essential to monitor and evaluate the progress of DF/DHF prevention and control programmes. They enable the programme manager to assess the effectiveness of control initiatives and must be continuous operational processes. The specific objectives of programme evaluation are:

- to measure progress and programme achievements,
- to detect and solve problems,
- to assess programme effectiveness and efficiency,
- to guide the allocation of programme resources,
- to collect information needed for revising policy and replanning interventions, and
- to assess the sustainability of the programme.

NICD and its field units and ICMR institutes, including National Institute of Malaria Research (NIMR), involve in vector borne diseases research shall be involved in monitoring and evaluation of dengue control programme.In addition,community medicine departments of all the five medical colleges and JNU etc.will be involved for monitoring and evaluation of Dengue Control Programme. The plan for monitoring and evaluation would include:

a. Periodic operational assessments to determine the progress of work and actual inputs received by the programme in terms of materials and manpower and
b. Periodic entomological assessments to determine the success or failure of the control measures applied to the vector population and/or epidemiological analyses.

A protocol for monitoring and evaluation of dengue control programme is under preparation by GoI which will be adopted/ used.

Geographical Information System (GIS) based maps of dengue would be prepared for effective monitoring of the prevention and control measures.

B.5.8 Retrospective study of epidemic – lessons learned

A retrospective study would be conducted to cover all aspects of hospital care and case management, any variation in clinical signs and symptoms from the known management successes, and all administrative aspects relative to the adequacy of hospital management to meet such emergencies. The evaluation study should cover all aspects of the agent-host vector interaction and all morbidity and mortality data including prevalence of the infection by age, sex, occupation and sociocultural factors which may have promoted outbreaks, vector prevalence, types of containers promoting breeding, evaluation of all *Ae.aegypti* control measures, factors related to cost-effectiveness and sustainability, degree of community participation, degree of governmental preparedness to respond to and control such epidemics, and all other factors

which will enhance the future capabilities of all those involved in epidemic control.

BUDGETARY PROVISIONS:

Since NVBDCP provides funds to the state government for various activities & interventions to prevent & control diseases. The same amount as proposed in year 2007-08 i.e. Rs 170 lac is proposed for 2008-09. Additionally the State Government considers its responsibility & will commit additional funds for the program in 2008-09 as GIA to the local bodies, as done in previous year, which are primarily engaged in vector control in the state.

Since the existing arrangements for the NVBDC programmes are being done through the local bodies, & since the funds released for Chikenguniyya control are to be meant for logistical arrangements, it is considered appropriate to to use the earlier existing arrangement this year also of disbursing the funds directly from the Sub account of the NVBDCP to the MCD/NDMC instead of routing it through the IDHS mode .

National Polio Eradication Program

Delhi state has a very systematically organized structure to implement the program. Many state specific innovations have been done in the implementation & planning resulting in a near total control on the spread of the wild virus despite a very high inflow & transportation from adjoining high circulation states which are also grappling with the problem.
Funds released by GOI are optimally utilized & State plans to adhere to the same. Since SCOVA now gets amalgamated with the State Health Society Delhi, the funds will be flowing through the RCH / Immunization funds.
State also makes a provision of some funds every year for supporting some of the key activities of the program & the same will be provisioned in year 2008-09 also.

Chapter 12

NRHM DSHM ADDITIONALITIES

I. STATE & DISTRICT PROGRAMME MANAGEMENT UNITS:

Strengthening of SPMU

Manpower STATUS:

Category of Manpower / Item	Total Sanctioned	In place	Remarks
State Program Manager	1	yes	
State Finance Manager	1	yes	
State Accounts Manager	1	Yes	
State MIS Expert	1	No	
Maternal Health Consultant	1	Yes	
Child Health Consultant	1	No	
Training Coordinator	1	Yes	
IEC Consultant	1	Yes	
NGO Coordinator	1	Yes	
Logistics Consultant	1	No	
Accounts Assistant	3	Yes	
Civil Engineer	1	No	
Steno cum Computer Assistant	2	Yes	
Data Assistant	3		
Peon	3	Yes	

Financial Implications for SPMU

Category of Manpower/ Item	Total required	Unit Cost x Numbers	Total (Rs.)	***Remarks***
State Program Manager	1	(27,500 x 4)+ (25,000x8)	3.10 lac	Post already approved and recruited in 2007 -08
State Finance manager	1	(27,500 x 4)+ (25,000x8)	3.10 lac	Post already approved and recruited in 2007 -08
State Accts. Manager	1	(13,200 x 4)+ (12,000x8)	1.49 lac	Post already approved and recruited in 2007 -08 Remuneration kept in

				2007-08 was very less
State MIS Expert	1	(27,500 x 4)+ (25,000x8)	3.10 lac	Post already approved and will be recruited in 2008 -09
Maternal Health Consultant	1	(27,500 x 4)+ (25,000x8)	3.10 lac	Post already approved and recruited in 2007 -08
Child health consultant	1	(27,500 x 4)+ (25,000x8)	3.10 lac	Post already approved and will be recruited in 2007 -08
Training Coordinator	1	(33,000 x 4)+ (30,000x8)	3.72 lac	Post already approved and recruited in 2007 -08
IEC Consultant	1	(27,500 x 4)+ (25,000x8)	3.10 lac	Post already approved and recruited in 2007 -08
NGO Coordinator	1	(27,500 x 4)+ (25,000x8)	3.10 lac	Post already approved and recruited in 2007 -08
Logistics Consultant	1	(27,500 x 4)+ (25,000x8)	3.10 lac	Post kept as stores Pharmacist in 2007 -08, however could not be filled due to less remuneration as well as due to the different needs of the SPMU
Accounts Assistants	3	(9,680 x 4)+ (8,800x8)	3.27 lac	Posts already approved and 4 recruited in 2007 -08 and rest will be in place in 2008-09. remuneration same as proposed in 2007-08 PIP
Civil Engineer	1	27,000 x1 x12	3.24 lac	Post already approved but could not be recruited in 2007 -08 due to low remunerations kept
Steno cum computer assistants	2	(11,000 x 4)+ (10,000x8)	2.48 lac	Posts already approved and recruited in 2007 -08
Data Assistants	3	(8,800 x 4)+ (8,000x8)	2.98 lac	Post already approved and recruited in 2007 -08
Peon	3	(5,500 x 4)+ (5,000x8)	1.86 lac	Post already approved and recruited in 2007 -08
Mobility support to SPMU	5 vehicle	20,000 x 5 x 12	12 lac	For Field monitoring & other office works.

	s			
Laptop computers	2	80,000 x 2	1.6 lac	5 were approved in 2007 -08, procured 3 and rest may be procured in 2008 -09
Office equipment including furniture, computers & printers & other computer accessories	As per require ment	As per requirement	12 lac	In year 2007 – 08, no desktops purchased as no funds were kept in 2007 -08 PIP. Now SPMU is functioning and computers and peripherals are essential requirements for office work. Similarly furniture may be required, which will be procured on need basis only
Communication support – telephone lines, mobile phones, fax & internet connectivity including residential internet connectivity to program officers/ consultants on functional requirement basis & AV equipments	As per require ment	As per requirement	3.5 lac	SPMU requires telephone lines and broadband connectivity to take care of the communications within the state and as well as to the national level. Therefore, essential.
Office contingencies to support electricity, water telephone, AMC stationary & other miscellaneous bills		75,000/- PM	9 lac	
Renovation of SPMU	-	-	5 lac	In the year 2008-09, a sum of Rs. 20 lac was provisioned and approved under the PIP, expenditure of around 16 lac (approx.)

				has been incurred and rest of the sum may be needed to finish the unfinished related works.
Legal Officer	1	25000x12	3 lac	
Printer, scanner and fax facility at residence office of Mission Director and 2 SPOs (SPMU HQ) including recurring expenditure	3 units		1 lac	Due to the nature and amount of work these facilities are needed at the residence of the officers who are directly involved in the working of SPMU
Security & Sanitation expenditure		30,000/- PM	3.6 lac	
Power back up	Inverters	1,00,000/-	1 lac	
TA / DA of staff & Program officers	-	-	3 lac	
Expenditure on recruitments	-	-	20 lac	Many vacant posts of SPMU/DPMU are to be filled up. Moreover, a central advt. May also go for the posts to be filled up by various IDHS
		Total	**118.54 lac**	

Strengthening of DPMU

Status: Manpower in position**:**

District	District Program Manager	District Accounts Manager	MIS Expert	Accounts Assistant	Data Assistant
West	Yes	X	Yes	X	Yes
North West	Yes	Yes	X	Yes	Yes
South West	X	Yes	X	Yes	Yes
South	Yes	Yes	Yes	Yes	Yes

North	X	Yes	X	X	Yes
North East	Yes	Yes	Yes	X	Yes
East	Yes	Yes	X	X	Yes
Central	X	Yes	Yes	Yes	Yes
New Delhi	X	Yes	X	X	Yes

Financial Implications for DPMUs

Category of Manpower/ Item	Total required	Unit Cost x Numbers	Total (Rs.)	***Remarks***
District Program Managers	9	(27,500 x 4) + (25,000x8)	27.9 Lac	Posts already approved and 5 recruited in 2007 -08 and rest will be in place in 2008-09
District Accts. Manager	9	(13,200 x 4) + (12,000x8)	13.40 lac	Posts already approved and 8 recruited in 2007 -08 and rest will be in place in 2008-09.
District MIS Expert	9	(27,500 x 4) + (25,000x8)	27.90 Lac	Posts already approved and 4 recruited in 2007 -08 and rest will be in place in 2008-09
Accounts Assistant	9	(9,680 x 4)+ (8,800x8)	9.82 Lac	Posts already approved and 4 recruited in 2007 -08 and rest will be in place in 2008-09. remuneration same as proposed in 2007-08 PIP
Civil Engineer	9	25,000x9x12	27 Lac	In every district there is requirement of

				Civil works/ Electric works, therefore proposed for the first time
Peon	1	5000x9x12	5.4 lac	To be out sourced
Space hiring for DPMU	Shortage of space for functionalizing DPMU	@ Rs 120 per Sq feet per month for maximum of 1200 Sq feet at each district 1.44 Lac x 6 x 12+10,00,000 as one time requirement of South west district for construction of building	103.68Lac + 10 lacs	In Delhi as per Master Plan, no offices can be established in either residential or mixed land used areas and rates in commercial areas are very high, thus in 2007-08 space could not be hired, therefore it is proposed to hire the DPMU space in commercial areas and rates proposed are realistic commercial rates. However, the proposed rates are upper limit at which the space may be hired and in actual the hiring cost may be less. The proposal is only for 6 districts out of 9 as Northwest, Southwest and northeast districts have managed the space in existing

				building or other Govt. building
Mobility support to DPMU Office	3	3x12x9x16,000	51.84 Lac	For Field monitoring & other office works.
Laptop computers	1	@ Rs 80,000 x9 with Software & Accessories	7.2 Lac	Essential for monitoring & dissemination during field advocacy.
Office equipment including furniture, computers & printers	As per requirement	As per requirement	(2.5x8)+(1x1) Total = 21lac	Requirement of NW district is only 1 lac
Communication support – telephone lines, mobile phones, fax & internet connectivity	As per requirement	As per requirement	1 Lac x 9 = 9 lac	No. of telephone lines not to exceed two in DPMU. Mobile phone reimbursement restricted to Rs. 800 per month for program officer & Rs 500 per month for others in DPMU if needed.
Office contingencies to support electricity, water telephone, AMC stationary & other miscellaneous bills	As per requirement	@ Rs. 40,000/- Per month x9x12	43.2 Lac	
Security & Sanitation expenditure on DPMU	As per requirement	@ Rs. 20,000/- Per monthx9x12	21.6 Lac	
Power back up	____	1 Generator /	0.7 x 9 = 6.3	

		Inverter @ Rs. 0.5 Lac + Rs. 0.2 Lac running cost	Lac	
TA / DA of DPMU staff & Program officers	As per requirement	As per financial guidelines	1 Lac x9 = 9 Lac	
		Total	**394.24Lac**	

Requirement of each (East, West, South, Central, New Delhi, North) district: 48.62 lacs
Requirement of South West: 41.34 lacs
Requirement of NW : 29.84 lacs
Requirement of NE : 31.34 lacs

II. ASHA SCHEME

ASHS Scheme is a **totally incentive based scheme** wherein **women who volunteer from local community are being selected** and trained to reinforce community action for universal immunization , safe delivery , newborn care , prevention of waterborne and communicable diseases , improved nutrition and promotion of household / community toilets.
Under ASHA Scheme 5450 ASHAs were to be selected and trained over a period of two years. 2725 in 2007-08 and another 2725 in 2008-09. The Scheme is being implemented in all nine districts of the State.
In 2007-08 , areas for ASHA intervention were identified and prioritized to be covered over a period of next two years in a phased manner. In Delhi one ASHA is envisaged for 2000 population.

A. SELECTION OF ASHAs:

Once the scheme had been cleared in the Cabinet , orientation of the district officials followed by their thorough familiarization with the scheme was undertaken. Guidelines were disseminated. Against a target of 2725 , 2260 ASHAs have been selected across the nine districts.

S No.	District	Target	ASHAs selected	Remarks
1.	Northwest	528	525	One of the largest districts with large pockets of vulnerable population .
2.	North	100	102	Smaller district with relatively better population profile and healthcare availability.
3.	West	479	405	Large district with its share of

				vulnerable population .
4.	Southwest	400	260	Another large district with its share of vulnerable population and rural villages.
5.	South	499	423	Contrary to the popular belief , this large district has a significant share of slums / resettlement colonies.
6.	East	250	262	Both these districts have a very high population density and large vulnerable population segment . Will be needing more ASHAs in the second phase.
7.	Northeast	250	205	
8.	Central	50	39	Small district with a smaller defined population needing ASHA intervention.
9.	New Delhi	50	45	Small district with few defined clusters needing ASHA intervention.
	TOTAL	2725	2266	

B. TRAINING OF ASHAs:

After selection ASHA needed to be trained.The whole training process was decentralized.

Training of Master Trainers : In all districts batches of Master trainers were identified drawing from the Health department of Delhi Govt and MCD, an Epidemiologist from each district , an NGO , an ICDS functionary and an AYUSH representative. Seventy Master trainers from the districts and the state level were trained at NIHFW in two batches of three day training each.

Training of Trainers : 222 Unit level Trainers (Block level) were trained by these Master Trainers in the districts. Each Unit has 50 ASHAs and five trainers. The training was of seven days duration and covered all the modules.

Training of ASHAs : TOTs were followed by the Training of ASHAs which are still in progress and likely to be completed by March end 08. All the 2266 selected ASHAs will be completing the first modular training by 31st March.

Adaptation of Modules and development of ASHA IEC Material:

In Delhi the four ASHA Modules were condensed to three modules 1 to 3 . They were adapted to Delhi specifics. In order to ensure quality and uniformity in the trainings THE Master trainers and Trainers were provided with these adapted modules in English along with CDs carrying presentations prepared at NIHFW and the State Programme officers. They were also provided with the facilitators guide provided by GOI.

The ASHA Modules were translated in Hindi . Module one has already been published and is being used to train the current ASHAs. A set of 35 IEC Cards in a folder has also been prepared for ASHAs, to be used in the field by

ASHA when she gives her health related messages. She will carry this set in her bag along with her drug kit.
In addition to the modules and flip cards , ASHA is also being provided with an ASHA Diary to plan out her work and maintain record of the work being done by her. All this material has been provided to her within the budget kept for her training Material.

Training of ASHA s

S No.	Districts	Master Trainers		Trainers		ASHAs		Remarks:
		Target	Completed	Target	Completed	Target	Completed	
1.	Northwest	8	8	50	42	525	525* in process	*To be completed by March end 08.
2.	North	5	5	10	10	102	102	*To be completed by March end 08.
3.	West	7	7	40	40	405	405* in process	*To be completed by March end 08.
4.	Southwest	7	7	30	29	400	260* in process	*To be completed by March end 08.
5.	South	8	8	50	50	423	423* in process	*To be completed by March end 08.
6.	East	7	7	20	21	262	262* in process	*To be completed by March end 08.
7.	Northeast	6	6	20	20	205	205*	
8.	Central	5	5	5	5	50	50*	*To be completed by March end 08.
9.	New Delhi	5	5	5	5	45	45*	*To be completed by March end 08.
	State Level	11	11	x	x	x	x	
	Total	70	69	230	222			

C. Provision of Drug Kits
ASHA is being provided with a sturdy bag to carry the basic drug kit and her IEC kit and her Diary . The bag is carrying the ASHA logo.
Certain modifications have been in the drug kit as per Delhi scenario. Tablet Chloroquin has been omitted , Bandage and Antiseptic lotion has been added. Chlorine tablets have been added. It will contain paracetamol tablets, Iron Tablets , Oral rehydration solution packets, Oral Contraceptives (only to be replenished after their initiation under medical supervision) , Condoms.

The AYUSH drugs will be added after her modular training dealing with AYUSH is completed. ASHA will receive the drug kit upon completion of her training.

	District	Drug Kits required	To be provided by
1)	Northwest	525	March end 2008
2)	North	102	
3)	West	405	
4)	Southwest	400	
5)	South	423	
6)	East	262	
7)	Northeast	205	
8)	Central	50	
9)	New Delhi	45	

D. Work and Incentives :

ASHA will carry out a survey of her 400 assigned houses in the first two months . For this the GOI Form has been translated and modified and will be used .

The information she collects by filling these forms will help her in understanding the nature and quantum of activities that she can facilitate in her area. Together with her area ANM , local health plan will be prepared and executed. The local health activities carried out will be recorded in her diary and accordingly the work done evaluated and incentives calculated.

It is felt that the incentive package being offered to this voluntary worker is less and is therefore proposed to increase the incentives for different activities and add new activities for incentivisation in the year 2008-09 to sustain the ASHA in the system.

S N0.	Activity	Remarks
1.	**Roles of ASHA & Incentive Information disseminated to ASHAs.**	To all selected ASHAs
2.	**ASHA Work Diary**	Provided To all selected ASHAs
3.	**Training on how to fill the Diary provided to ASHAs**	To all trained ASHAs.
4.	**Training to ANMs on working with ASHAs / calculation of Incentives**	Done

E. Formation of Mentor groups :

Formation of Unit level mentor / support groups is to be taken up during 2008-09. Also a District level Mentor / support group along with a grievance redressal mechanism will be set up.

ASHA Support Mechanism:				
State Level				Expenditure
1.	State ASHA Resource Centre & Grievance redressal	One	Formationof the necessary expert group / development of ASHA study material / monitoring & facilitation mechanisms / conduct of meetings / visits to other states/ documenting best practices / Computer with printer / CDEO / Stationary	5 lacs
District Level				
2.	District Level Mentor groups	No. of Districts	District level Support groups	Expenditure
		9	9	9 x 50000
Unit (Block) level				
	Districts	No. of Units	No. of Mentor Groups	
1.	Northwest	10	10	10 x 0.25 lacs
2.	North	2	2	2 x 0.25 lacs
3.	West	8	8	8 x 0.25 lacs
4.	Southwest	6	6	6 x 0.25 lacs
5.	South	10	10	10 x 0.25 lacs
6.	East	5	5	5 x 0.25 lacs
7.	Northeast	4	4	4 x 0.25 lacs
8.	Central	2	2	2 x 0.25 lacs
9.	New Delhi	2	2	2 x 0.25 lacs
		39	39	21.75 Lacs

Work Plan for second phase (2008-09) of ASHA

SNo.	Activity	Number	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
1.	Identification of second phase areas and formation of unit Nodal Committees					
2.	Setting up of District mentor groups	**9**				
3.	Setting up of Unit mentor groups	**39**				
4.	Setting up of State ASHA Resource Centre	**1**				

5.	Selection of 2nd phase ASHAs	**3184**				
6.	Training of Trainers					
7.	Training of ASHAs					

Financial Implications :

Funding from State Funds.

Budget for the year 2008-09 for the selected ASHAs:

S No.	Activity	Expenditure per unit(batch)	Budget for the year 2008-09
1.	Selection of ASHAs	182	4000* x 182 = 7.28 lac
2.	**Trainings		
A.	Training of 2500 ASHAs recruited in 2007-08		
a.	Module 2 (6 days) (Batch of 25)	0.414	X100 = 41.4 lacs
b.	Module 3 (6 days) (Batch of 25)	0.414	X100 = 41.4 lacs
c.	Refresher Trainings 1day / mth x 8 / year (Batch of 25)	0.552	X 100 = 55.2 lacs
	Total expenditure on Training of 2500 ASHAs , modules 2&3, refresher trainings.		138 lacs
B.	Training of 3000 ASHAs to be recruited in 2008-09		
a.	Training of Master Trainers (State + District level) (5 days)(Batch of 37)	0.85	X2 =1.70 lacs
b.	Training of Trainers (Batch of 25)	0.68 lac	X12= 8.11 lacs
c.	Induction Training		
i.	Module 1(11 day) (Batch of 25)	0.85 lac	X 120=101.58 lacs

ii.	Module 2 (6 days) (Batch of 25)	0.414	X120 = 49.68 lacs
iii.	Module 3 (6 days) (Batch of 25)	0.414	X120 = 49.68 lacs
	Total expenditure on Training of 3000 ASHAs , all modules.		**200.94 lacs**
	Total Training Expenditure		348.75 lacs
3.	**Incentives**		
a.	For 2500 ASHAs recruited in 2007-08.	2000/-	2500 x 2000 x 12 = 600 lacs
b.	For 3000 ASHAs recruited in 2008-09.		3000 x 2000 x 4 = 240 lacs
	TOTAL Incentives		840 lacs
4.	Drug Kits	600/-	X 5500 = 33.0 lac
5.	Printing of Household Survey forms and other proformas.		25 lacs
6.	CDMO cum assistant for Units.	Reflected in strengthening	
7.	Setting up of ASHA Mentor Groups – Unit level(39 mentor groups for ASHAs recruited in 2007-08 + 60 for ASHAs to be recruited in 2008-09)	25000/-	100 X 25000/- = 25 lacs
8.	District level Mentor Group and Grievance redressal Mechanism	50,000/-	9 x 50,000/- = 4.5 lac
9.	State Level ASHA Resource Centre	5 lacs	5 lacs
10.	IEC	50 lacs	50 lacs
	TOTAL Expenditure		1338.53 lacs
10.	Contingency (10 %)		133 lac

	TOTAL:		**1471.53 lac**

*Although new number of ASHAS are 3184 but due to possible dropouts and deletion during the year, we have budgeted it for selection of 4000 ASHAS

**Training details given in Table below.

Training details :				
Training of Master Trainers.				
Duration of training : 5 days. Sessions per day: 5 Number of trainees:5-7 per districts and 10 to 11 from the State Batches : 2 (of 35 to 37 each)				
S. No.	Activity	Expenditure per unit	Number of units	Expenditure
1.	Honorarium to the Trainer of Master trainers	500	X 5 x 5	12500
2.	Per diem for Trainees	200	X 37 x 5	37000
3.	Training Material for trainees	350	X 37	12950
4.	Lunch & tea for trainees, Trainers , support staff. (37 + 5+ 4)	100	X 45 x 5	22500
	Total Expenditure per batch			84950
Training of Trainers :				
Duration of Training : 7 days Sessions per day : 5 Number of trainees per batch : 25				
1.	Honorarium to the Trainer of Trainers	250	X 5 X 7	8750
2.	Per diem for Trainees	150	X 25 X 7	26250
3.	Training Material for trainees	350	X 25	8750
4.	Lunch & tea for trainees, Trainers , support staff. (37 + 5+ 4)	100	X 34 X 7	23800
	Total Expenditure per batch			67550
Training of ASHAs:				
Induction Training : 23 days (Three modules) Module 1 (11 days) Module 2 (6 days) Module 3 (6 days) (6 – 8 wks apart). Number of ASHAs per batch: 25 .				
Refresher Training : One day per month. Max sessions per day : 5. Number of ASHAs per batch: 25 .				
Induction Training				
Module 1				
1.	Honorarium to the Trainer of Trainers	200	X 5 x 11	11000
	Per diem for Trainees	100	X 25 x 11	27500
	Training Material for trainees	350	X 25	8750
	Lunch & tea for	100	X 34 x 11	37400

	trainees, Trainers , support staff. (37 + 5+ 4)			
	Total Expenditure per batch			84650

Module 2				
1.	Honorarium to the Trainer of Trainers	200	X 5 x 6	20400
2.	Per diem for Trainees	100	X 25 x 6	15000
3.	Training Material already budgeted under module 1	---	-----	-----
4.	Lunch & tea for trainees, Trainers , support staff. (37 + 5+ 4)	100	X 34 x 6	37400
	Total Expenditure per batch			41400
Module 3				
1.	Honorarium to the Trainer of Trainers	200	X 5 x 6	20400
2.	Per diem for Trainees	100	X 25 x 6	15000
3.	Training Material already budgeted under module 1	---	-----	-----
4.	Lunch & tea for trainees, Trainers , support staff. (37 + 5+ 4)	100	X 34 x 6	37400
	Total Expenditure per batch			41400
Refresher Training (1 day)				
1.	Honorarium to the Trainer of Trainers	200	X 5	1000
2.	Per diem for Trainees	100	X 25	2500
3.	Training Material already budgeted under module 1	---	-----	-----
4.	Lunch & tea for trainees, Trainers , support staff. (37 + 5+ 4)	100	X 34	3400
	Total Expenditure per batch			6900

III. Strengthening of Existing Health Infrastructure

1. Primary Healthcare

Delhi has a peculiar problem of multiplicity of agencies . There are multiple agencies with no structural / functional standardisation with multiple authorities and a total lack of coordination.

Standardization of Primary Healthcare Facilities and upgradation of existing health facilities to these standards. This will take care of the multiplicity of agencies and bring uniformity and quality assurance in the primary healthcare tier. This would have following components.

a). Laying down the Standards for a Primary Urban Health Centre (PUHC). .Recognition of the basic primary healthcare facility as a Primary

Urban Health Centre. and standardizing this PUHC in terms of the population to be catered to, assured services to be provided at the centre, the infrastructure -- both physical and in terms of human resource and system reforms required to deliver the mandated services optimally.

Indian Public Health Standards (IPHS) for PHCs have been recommended by GOI , but the PUHC of Delhi is radically different from a PHC of the rural states, The existing Indian Public Health Standards for PHCs will have to be revised / modified to become applicable to a PUHC.

A Committee had been formed and is already working on laying down the Standards for a PUHC. The report will be available by Feb 08 .

b). Facility survey of the Primary Health care units belonging to different agencies . This survey will help in identification of the existing better equipped facilities which can be upgraded to PUHCs for the 50,000 population around them . A preliminary facility survey has already been done and more detailed facility surveys are ongoing in all the districts. They are to be completed by Feb 08.

c). Upgradation of the identified units to the Standards laid down. Once a PUHC has been identified it will be upgraded to the standards laid down and will be recognized by a common insignia / board recognizing it as a PUHC for the linked 50,000 population. The unit will retain its parental identity and be under the same administrative control. The performance will be monitored by Integrated District Health Society to assess if the objective of strengthening the unit has been achieved or not. This activity will entail strengthening all the identified units in terms of infrastructure / manpower and will be phased over next three years.

d).**Facility wise population linkages**. The upgraded unit will be assigned 50,000 population around it. Facility and population mapping is already underway. Over time the households of the attached population will be linked to the facility by family health cards. Formalization of linkages with Family Health Cards will be staggered and synchronized with upgradation .

Standardization and upgradation is being taken up on a priority basis as the vision of accessible, affordable and accountable healthcare for all is directly linked to it.

Once a facility is identified as a potential PUHC it will be upgraded to the standards laid down and will be recognized by a common insignia / board recognizing it as a PUHC for the linked 50,000 population. The unit will retain its parental identity and be under the same administrative control. The performance will be monitored by Integrated District Health Society to assess if the objective of strengthening the unit has been achieved or not. This activity will entail strengthening all the identified units in terms of infrastructure / manpower and will be phased over next three years.

Facility Survey was undertaken by the Districts for Primary Healthcare facilities belonging to the main service providers(Delhi Govt , MCD , NDMC).

SNo.	Districts	Allo Disp (DGD)	Allo Disp (MCD)	IPPVIII (MCD)	M&CW Centre (MCD)	Ayush Disp DGD	Ayush Disp MCD	Allo NDMC/ CGHS/SBI/ RBI/RLY/ DJB/ESI/DVB/BSES
1.	Northwest(77)	44		7	26			
2.	North (33)	15	7		11			
3.	West (45)	27		5	13			
4.	Southwest (42)	28	5		9			
5.	South (64)	18	3	8	20	10	5	
6.	East (53)	23	2	2	9	14	3	
7.	Northeast (47)	19	1		10	**4**	**13**	
8.	Central (33)	12	6		15		nk	
9.	New Delhi (8)				8 (NDMC)			

Total number of facilities identified for strengthening:

SNo.	District	Population	PUHCs required	Pr. Health Facilities available (all kinds)*	Centres identified for any strength-Ening (including potential PUHCs) (Total)	Agency wise break up		
						DGD	MCD	NDMC
1.	Northwest	38.6(2008)	78	98	31	20	11	
2.	North	7.8lac(2001)	16	39	11	10	1	
3.	West	27 lacs	54	56	11	8	3	
4.	Southwest	22 lacs	44	42	13	8	4	
5.	South	30 lacs(2008)	60	68	29	18	11	
6.	East	19 lacs (2008)	38	53	16	11	5	
7.	Northeast	25 lacs (2008)	50	54	14	12	2	
8.	Central	6.5 lacs (2001)	13	51	5	2	3	
9.	New Delhi	5 lacs (2008)	10	36	5	x	x	5
					134			

- The total facilities available may be misleading as this includes even the most rudimentary facilities and distribution may be inequitable ie. Two or three of them clustered together.

The centres selected for strengthening in 2008-09 include :

1. Potential PUHCs.(DG / MCD/NDMC)
2. ASHA Units .
3. Health Centres attatched to Maternity Homes.

ASHA units must have two MOs and a CDEO .
For centres attatched to Maternity Homes already the Committee has given the norms.

Total Pr. Healthcare facilities selected for strengthening in the Year 2008-09..are 154 which includes Delhi Govt , MCD , NDMC Units .

As a result of facility surveys done certain gaps have been identified and projected for the selected units .These are mainly in terms of staff.

S No.	Districts	Potential PUHCs						Not potential PUHCs						Total Units identified for Strengthening
		DG		MCD (Including IPPVIII)		Health centres attatched to Maternity Homes		DG		MCD (Including IPPVIII)		Health centres attatched to Maternity Homes		
		N o n ASHA	ASHA Units	ASHA Units	Non ASHA	ASHA Units	Non ASHA	ASH A Units	Non ASHA uNITS	ASHA Units	Non ASHA uNITS	ASHA Units	Non ASHA uNITS	
1.	Northwest	17	3	4	5	2	0	2	0	1	0	2	0	36
2.	North	9	1	1	0	0	0	0	0	0	0	0	3	14
3.	West	0	3	1	0	0	0	0	5	0	2	0	0	11
4.	Southwest	4	5	3	1	0	0	0	0	0	0	0	0	13
5.	South	12	6	7	2	1	0	0	0	0	0	0	1	29
6.	East	9	5	0	0	0	0	0	0	2	0	0	0	16
7.	Northeast	7	4	0	3	0	0	0	0	0	0	1	1	16
8.	Central	1	1	0	1	0	1	0	0	0	1	0	0	5
9.	New Delhi	4	1	0	0	0	0	0	0	0	0	0	0	5

Strengthening of Primary Health Infrastructure

S. No.	Category of Staff		District									Total	Expenditure	Source
			NW	South	SW	East*	North	West*	North East	Central	New Delhi (NDMC)			
1.	**Medical Officer (Salary component to be budgeted from RCH Flexipool)**													
a)	Already working	DGD & M & CW Centre	150 MOs already recruited under RCH, details available with RCH.											RCH Flexipool
b)	More required	DGD	9	13	8	11	4	17	16	2	5	97	25000 x 97 x 12	RCH Flexipool
		M & CW Centre	5				4			3				
2.	**ANMs (Salary Component to be budgeted from RCH Flexipool)**													
a)	Already working	DGD & M & CW Centre	650 ANMs already recruited under RCH , details available with RCH.											RCH Flexipool
b)	ANMs Required	DGD	46	33	20	52	23	1	35	4	15	280	8500 x 400 x 12	RCH Flexipool
		M & CW Centre	7				37			7				
		Seed PUHC Component	8	41	24	14	2	9	22	0	0	120		
3.	**Pharmacist (RCH)**													

b)	Pharmacist Required	M & CW Centre	1	0	3	2	4	5	0	2	0	17	15,000 x 17 x 12 = 30.60	**From NRHM Flexipool**
4.	**LT * Lab requirements being taken care of NRHM Flexipool**													
5.	**Dresser (RCH)**													
b)	Dresser Required	DGD			0		5	3			0	12	6,000 x 12 x 12 =8.64 lacs	From Parent agency – DGD , MCD,NDMC etc.
		M & CW Centre		0	4									
6.	**NO**													
b)	NO Required	DGD	1	1			3	3			0	14	5,000 x 14 x 12 = 8.4 lacs	From parent agency
		M & CW Centre	1	1	4									
7.	**SCC**													
b)	SCC Required	DGD	10	Nil			23	5		0	0	53	4,000 x53 x 12 = 25.44 lacs	From parent agency
		M & CW Centre	3		12									
8.	**CDEO**													To be budgeted from NRHM (MIS)
b)	CDEO Required	DGD	20	29	9	14	11	32	10	2	5	140		
		M & CW Centre	2		4					2				
9.	**Equipment**													

a)	ROs		84	18	-	14	-	11	26		-	153	30,000 x 153 = 45.9	49 lacs from RCH Flexipool
b)	Water Dispenser			10	13	4				4		31	10,000 x 31 = 3.1	

2. Laboratory Strengthening :

1. Strengthening of existing labs.
2. Setting up of basic labs.
3. PPP for diagnostics (See details in innovations).

District wise detail of the Lab Strengthening activity:

SNo.	**Districts**	Pathologists	LTs (Mother lab)	Basic lab			Expenditure for 2008-09	Source	Remarks: STATUS.
				equipment + LT		Only LT			
				Approved in 2007-08	Added requirement projected in 2008-09	Added requirement projected in 2008-09			

1.	Northwest	1 x 3.6 lacs	6 x 1.08= 6.48 lacs	8 x 3.0 lacs	X		34.08	NRHM	**a).**Units identified for Basic labs . **b).**Rate contracts for Laboratory items disseminated to the districts. **c).** Staff approved in 2007-08 in the process of being recruited.
2.	North	1 x 3.6 lacs	3 x1.08 = 3.24 lacs	4 x 3.0 lacs	X		18.84	188 lacs available as unutilized	
3.	West	1 x 3.6 lacs	6 x1.08 = 6.48 lacs	8 x 3.0 lac.	X		34.08		
4.	Southwest	1 x3.6 lacs	4 x 1.08= 4.32 lacs	6 x 3.0 lacs	2 x 3.0		31.92		
5.	South	1 x 3.6 lacs	5 x 1.08= 5.4 lacs	7 x 3.0 lacs	1 x 3.0		33.00		
6.	East	1 x 3.6 lacs	6 x 1.08 = 6.48	3 x 3.0 lacs	X		19.08		
7.	Northeast	1 x 3.6 lacs	5 x 1.08= 5.40lacs	4 x 3.0 lacs	3 x 3.0 lacs	*5 for DGDs	30.00		
8.	Central	1 x 3.6 lacs	2 x 1.08= 2.16 lacs	5 x 3.0 lacs	X		20.76		
9.	New Delhi	1 x 3.6 lacs	0	0	5 x 3.0		18.6		
	Expenditure	32.4 lac	39.96 lacs	3.0 x 50 = 150 lacs	6 x 3.0 = 18 lac				
	TOTAL						240.36 lacs		

Pathologist : Salary 30000/- x 12 = 3.6 lac per year.
LT : Salary 9000 /- x 12 = 1.08 lac per year.
Basic Lab equipment : Cost 3 lac per year.(One time + recurrent, includes salary of LT)

4. Telephone connection for M&CW Centres:

SNo.	Activity	District									Funds from
	Telephone Connection	NW	South	South west	East	North	West	North east	New Delhi	Central	

1.	One time installation	8 x 2000	19 x 2000	0	15 x 2000	3 x2000	7 x2000	10 x2000	5x 2000		
2.	Recurrent	16 x1000 x12	19 x 1000 x 12	8 x 1000 x12	15 x 1000 12	11x1000 x12	15 x1000 x 12	10 x 1000 x12	5 x 1000 x 12	5x1000 x12	
	Expenditure	208000	266000	96000	210000	138000	194000	140000	70000	60000	
Total Expenditure		**13.82 LAC**									**N R H M Flexipool**

III. Strengthening of Existing Health Infrastructure

1`. Strengthening of Maternity Homes:

Increasing the Institutional Delivery rate in Delhi is one of the primary objectives envisaged in State PIP (DSHM). In order to achieve this, the existing health facilities capable of providing basic and comprehensive Obstetric services have to be optimally functionalized. There are 32 (10 to 15 bedded Maternity Homes). Six under IPPVIII and remaining with the MCW wing of MCD.

Strengthening of these Maternity homes is an important step in this direction. A Committee was set up to facilitate this activity.

The Committee has developed draft standards on the basis of available IPHS standards for CHCs (Community Health Centres) and 30 to 50 bedded hospitals .

Finalisation of these standards is likely to take some one more month. Meanwhile the Committee has given interim guidelines regarding manpower / equipment requirements for the two categories of Maternity homes – For comprehensive Obs (which will provide elective LSCS, MTP / sterilization services also) and Basic Obs .. After developing a format , a facility survey of the existing maternity homes has been carried out by the Maternity home functionaries.

Based on the facility survey and the interim guidelines the Committee has selected 20 maternity homes for upgradation and submitted a proposal for this upgradation with facility specific requirements. These are givrn below districtwise.

Maternity Home Strengthening – Staff Requirements

SNo.	Category of staff	Staff required	Northwest	South	South west	East	North	West	North East	Total Expenditure
1.	Medical Officers	46	13 x 25000 x 12 = 39 lacs	7 x 25000 x 12 = 21 lacs	2 x25000 x 12 = 6.0 lacs	4 x 25000 x 12 = 12 lac	4 x 25000 x12 = 12 lac	6 x 25000 x 12 = 18 lac	10 x 25000 x 12 = 30 lac	46 x 25000 x12 = 138 lacs
2.	Gynecologists	7	2 x 30000 x 12 = 7.2 lacs	3 x 30000 x 12 = 10.8 lacs	0	0	0	1 x 30000 x 12 = 3.6 lac	1 x 30000 x 12 = 3.6 lac	7 x 30000 x 12 = 25.20 lacs
3.	Pediatrician	10	4 x 30000 x 12 =14.40 lacs	3 x 30000 x 12 = 10.8 lacs	0	0	0	2 x 30000 x 12 = 7.2 lac	1 x 30000 x 12= 3.6 lac	10 x 30000 x 12 = 36.00 lacs
4.	Anaesthetist	3	1 x 30000 x 12 = 3.6 lacs	1 x 30000 x 12 = 3.6 lacs	0	0	0	1 x 30000 x 12 = 3.6 lac	0	3 x 30000 x 12 = 10.8 lacs
5.	Lab Technician	24	7 x 9000 x 12= 7.56 lacs	2 x 9000 x 12 = 2.16 lacs	1 x 9000 x 12 = 1.08 lacs	2 x 9000 x 12 =2.16 lac	3 x 9000 x 12 3.24 lac	3 x 9000 x 12 = 3.24 lac	6 x 9000 x 12 = 6.48 lac	24 x 9000 x 12 = 25.92 lacs
6.	OT Technician	2	0	1 x 10000 x 12 = 1.2 lacs	0	0	0	0	1 x 10000 x 12 = 1.2 lac	2 x 10000 x 12 = 2.4 lacs
7.	OT Assistent	8	4 x 6000 x 12=2.88 lacs	2 x 6000 x 12= 1.44 lacs	0	0	0	1 x 6000 x 12 = 0.72 lac	1 x 6000 x 12 = 0.72 lac	8 x 6000 x12 = 5.76 lacs
8.	Staff Nurse	73	20 x 12000 x 12 = 28.8 lacs	5 x 12000 x 12 = 7.2 lacs	4 x12000 x 12 = 5.76 lacs	8 x 12000 x 12 = 11.52 lac	12 x 12000 x 12 = 17.28 lac	8 x 12000 x 12 = 11.52 lac	16 x 12000 x 12 = 23.04 lac	73 x 12000 x 12 = 105.12 lacs
9.	CDEO cum assist	20	5 x 8000 x 12 = 4.8 lacs	2 x 8000 x 12 = 1.92 lacs	1 x 8000 x 12 = 0.96 lacs	2 x 8000 x 12 =1.92 lac	3 x 8000 x 12 2.88 lac	3 x 8000 x 12 = 2.88 lac	4 x 8000 x 12 = 3.84 lac	20 x 8000 x 12 = 19.20 lacs
	Total Expenditure		108.24 lacs	60.12 lacs	13.8 lac	27.6 lac	41.4 lac	50.76 lac	72.48 lac	**368.4 lacs**

Maternity Home Strengthening – Staff Requirements (Probable modality – outsourcing)

La	Category of Staff	Staff Required	Districtwise requirement							Total Expenditure
			NW	South	Southwest*	East	North	West	Northeast	
1.	Ward Ayah	70	16 x 4000 x 12	6 x 4000 x 12	3 x 4000 x 12	8 x 4000 x 12	12 x 4000 x 12	14 x 4000 x 12	11 x 4000 x 12	70 x 4000 x 12 = 33.60 lacs
2.	Nursing Orderly	12	4 x 5000 x 12	4 x 5000 x 12	0	0	0	2 x 5000 x 12	2 x 5000 x 12	12 x 5000 x 12 = 7.2 lacs
3.	Safai Worker	21	6 x 4000 x 12	5 x 4000 x 12	1 x 4000 x 12	1 x 4000 x 12	4 x 4000 x 12	1 x 4000 x 12	3 x 4000 x 12	21 x 4000 x 12 = 10.08 lacs
4.	Chowkidar	75	15 x 4000 x 12	8 x 4000 x 12	4 x 4000 x 12	8 x 4000 x 12	12 x 4000 x 12	12 x 4000 x 12	16 x 4000 x 12	75 x 4000 x 12 = 36 lacs
5.	District specific	Repair/ construction			15lacs					15 lac
		Total expenditur	20.16 lac	11.52 lacs	18.84 lac	8.16 lacs	13.44 lacs	14.16 lacs	15.6 lacs	**101.88 lacs**

		e								

Expenditure on strengthening of Maternity Homes :

S No.		District Wise Expenditure							Source
		NW	South	Southwest	East	North	West	Northeast	
	Centres to be strengthened	3 basic Obs + 2 compre Obs	2 basic + 2 compre Obs	1 basic Obs	2 basic Obs	3 basic Obs	2 basic + 1 compre Obs	4 basic Obs	
Expenditure									
1.	Contractual Staff	108.24 lac	60.12 lacs	13.8 lacs	27.6 lacs	41.4 lac	50.76 lac	72.48 lac	NRHM
2.	Staff to be outsourced	20.16 lacs	11.52 lac	18.84 lac	8.16 lac	13.44 lac	14.16 lac	15.6 lac	NRHM
3.	Equipment	7.70 lacs	5.6 lacs	2.4 lac	5.75 lac	7.8 lac	6.6 lacs	10 lacs	NRHM
4.	For Calling the Empanelled Specialist	20 lacs to be released to the districts							
5.	Referral	Rs 20000 x 5	Rs 20000 x 4 =	Rs 20000 x	Rs.20000/- x 2 = 0.40	Rs 20000 x 3 = 0.60	Rs 20000 X 3= 0. 60	Rs 20000 x	NRHM

	Transport	= 1 lac	0.8 lac	1= 20000	lac	lac	Lac	4 = 0.8 lacs	
	T o t a l Expenditure	137.1 lac	78.04 lac	35.24 lac	41.91 lac	63.24 lac	72.12 lac	98.88 lac	**546.53 lac (NRHM)**

While strengthening of these maternity homes Referral linkages above and below for each facility will form a part of the facility specific plan and will be worked out in consultation with the involved incharges.

For implementation , district level committees will be constituted for each unit which will include Incharge of the facility, District NRHM Officer, Finance / Managerial official from DPMU, referral linkage unit representative.

In addition Central District has proposed Strengthening of Raiger pura Maternity Home which is not included in the List .

Financial Implications: 28.72 lacs

New Delhi District has proposed strengthening of Charak Palika Maternity Home , NDMC .

Financial Implications :39.36 lacs

Northeast District has proposed strengthening of Shastri Park Hospital . Funds (20 lakhs available with them under RCH).

IV . Coverage of unserved and underserved areas.

1). Setting up of PUHCs for pockets of 50000 population . Ultimate aim is to provide quality healthcare through a Primary Urban Health Centre at every 50000 population..

2).Setting up seed PUHCs in unserved areas.
For unserved areas it was decided to provide some immediate relief by setting up seed PUHCs (RCH centres) for around 50000 population pockets till more permanent and comprehensive structures are put in place. As they will also be providing basic curative care and are being provided with a Lab also they are to be called Seed PUHCs with the intent that they will be subsumed into comprehensive PUHCs subsequently.These will be linked to the nearest Primary urban health centres..
In this regard a proposal was submitted as a part of State PIP, 2007-08 and was approved for 25 such centres.

Bottlenecks faced while implementation of this activity.

- These centres are primarily required for slums , JJ Clusters , resettlement colonies , unauthorized colonies which are not likely to have a PWD standardized rental structure available . In order to overcome this hurdle special provision was allowed – to form district level committees , explore the sites and rents attatched in the area where a seed PUHC is to be started. Suitable sites along with rents are

to be placed before the Integrated District Health Society and approved by it within the cap of 10,000/-per mth as approved IN State PIP.

- The one time expenditure kept for furniture and equipment for the centre was less and it was not possible to accommodate the basic equipment and furniture in this.
- The salary projected for pharmacist is less.
- The recurring monthly expenditure approved to cover security and sanitation staff / water / electricity / contingency / telephone was approved at 10000/- mth which is less.
- Although ANMs have been recruited under RCH , still there is an overall shortage of ANMs. And at the rate of 2 per seed PUHCs they are being projected.
- As these centres will be providing all the basic healthcare activities , a basic lab with a LT is proposed .

STATUS of implementation :

- Areas where these seed PUHCs are to be set up have been identified and by the Districts and many have surveyed the areas and found possible venues for opening the same and will be soon entering into rental agreements.
- The MOs and Pharmacists approved for 25 centres in PIP 2007-08 are in the process of being recruited.
- Districts are also in the process of procuring furniture / equipments.

Certain changes have been proposed to address the bottlenecks and the estimated expenditure per one such unit is :

Details of expenditure per unit:

1).The rental component (upto 10,000 per month)(same as in PIP 2007-08).
2).The one time furniture & Equipment cost raised to 100,000(50000 proposed in PIP 2007-08) *.
3).The recurring cost – Sanitation and secutiry , electricity, water , telephone , contingency raised to 15000 per month from 10,000 per month which had earlier been approved by GOI .
4).Equipment (for Basic Lab) 1.5lacs.
5).Staff Component**:**
a) MO @ 25000 per mth.
b).Pharmacists @15000 per mth.
c).LT @ 9000 per mth.
d).2 ANMs @ 8500 per mth. From RCH Flexipool
6) . Medicines / Logistics to come from DFW / DHS.

Recurring cost 74000 x 12 = 8.88 lacs
One time cost 100,000+ 150,000 = 250, 000
Total expenditure per unit 11.38 lacs per year.

25 centres already approved in the PIP 2007-08.

Districts have sought approval for starting 14 more centres in addition to these 25 leading to a total of 39 centres.

Total funds approved for the activity in year in 2007-08 187.64 lac. Practically the entire fund is available unutilized.

Total projected budget for the year 2008-09 for 39 seed PUHCs with the revisions proposed as above is 464.74 lac.

District wise details SEED PUHCs

S No.	Districts	No. of Units Proposed in 2007-08	Additional Units Proposed in 2007-08	One time cost	Recurring cost	Expen Diture for 2008 - 09	Remarks.
1.	NW	2	2	2.5 x 4=10	2 x 74000 X 12=17.76 2X74000X6 =8.88	36.64	Activity approved for 25 centres last year. 157.5 lacs available unutilized.
2.	North	1	0	2.5 x1=2.5	1x74000X12 = 11.38	11.38	
3.	West * (1 ASHA Unit)	2	1	2.5 x3=7.5	2 x 74000 X 12= 17.76 1x74000x6 = 4.44	32.2	
4.	SW* (4 ASHA Units)	4	2	2.5 x 6=15.0	4x74000X12 =35.52 2X74000X6 =8.88	59.4	
5.	South* (5 ASHA Units)	8	5*	2.5 x13=32.5	8X74000X12 =71.04 5X74000X6 =22.20	125.74	
6.	East * (2 ASHA Units)	4	0	2.5 x4=10	4x74000X12 =35.52	45.52	
7.	NE* (2 ASHA Units)	4	4	2.5 x 8=20	4x74000X12 =35.52 4x74000X6 =17.76	73.28	
8.	Central	NIL	0	NIL	NIL	XX	
9.	N e w Delhi	nil	0	nil	NIL	XX	
	TOTAL	25	14	97.50 lacs	286.66 lac	**384.16**	

*Seed PUHCs to function as ASHA Units in next phase will have 5 ANMs.

3). Mobile Health Units for population pockets less than 10000 .

For unserved population pockets of less than 10000 , Mobile health clinics are proposed. State is already having a mobile Health Scheme wherein 70 mobile health clinics are covering slums and JJ Clusters. This activity is reserved for areas where the state MHS is unable to provide services and it is not feasible to start a seed PUHC . In PIP 2007-08 25 such mobile health clinics were approved but were functionalized as it was decided by to try and relocate the existing State run MHC s to cover these unserved areas instead of starting new mobile clinics.

In the current plan with rapidly expanding population and also realizing the constraints of a mobile clinic most of the districts have proposed seed PUHCs than relying on mobile clinics to cater to these vulnerable populations . Only three mobile health clinics have been sought in the current PIP.It was decided that this requirement be taken up by the Mobile health Scheme of DHS, State Govt.

4). Public NGO / Pvt Partnership

a).Public – NGO Partnership In Northeast District a Primary urban health facility is being operationalised to cater to a hitherto underserved population of approximately 1.5 lacs in Snia Vihar slums in partnership with HOPE Foundation. MOU has been signed between the two partners .The centre will cater to the core 50000 population around the centre and in addition also cover the one lakh population beyond this with its outreach activities.See details ion Innovation.

b). Partnership for increasing available centres for Family Planning Services

	PPP for Tubectomy / Vasectomy Services	**Exp per unit**	**Number of units**	**Expenditure 2008-09**	**Source**
1.	South	10 lacs	1	10 lacs	NRHM Flexipool
2.	East	10 lacs	1	10 lacs	NRHM Flexipool
3.	South (for PPP to cover the underserved / unserved)	20 lacs	1	20 lacs	NRHM Flexipool
4.	To start FP Centre (SW District)		1	35 lacs	**NRHM FLEXI**
	TOTAL			**75 lacs**	

Details in Innovations.

d).MAMTA Scheme . See details under Innovations

e).PPP for Diagnostics. See details under Innovations

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V. Capacity Building

Capacity Building :

Institutional and individual capacity building is an important activity in the State PIP.

In addition to Setting up of State and District Programme Managewment Units, this includes equipping the State and Districts with:

a).Establishing District Training Centres.
b).Establishing District BCC Units.
c).Setting up of district level stores.
d). Strengthening the CDMO/ Society offices / programme management support for other programmes where it has not been given by their programme.
e). Telemedicine network.

a.Training Infrastructure

S.No	Activity	North	South	East	West	NE	NW	SW	Central	New Delhi
1	**a) Rent** (if no space available)	1,20,000 x12	1,20,000 x12	1,20,000x12	1,20,000x12	1,20,000x12	0	0	1,20,000x12	1,20,000x12
2	**b) Minor Repairs**/Civil works/Maintenance if Govt. Space is available							0		
	i) Air Conditioner							25000x4		
3	**c) Furniture and Sound System**	200000	200000	200000	200000	200000	200000	0	200000	200000
4	**d) Equipment**				+40000					
	i)Overhead Projector									
	ii)LCD Player with Screen									
	iii)TV									
	iv)Computer with printer and Fax	60000	60000	60000	60,000	60,000	60000		60000	60000
	v)Handy cam							25000x1		
5	**e)Staff**									
	i) District Training Officer	20000x12	20000x12	20000x12	20000x12	20000x12	20000x12	20000x12	20000x12	20000x12

	ii) Data Entry Operator	8000x12	8000x12	8000x12	8000x12	8000x12	8000x12	8000x12	8000x12	8000x12
	iii) Class IV & NO to look after the venue(4 per District)	4000x4 x12	4000x 12x4	4000x4x12	4000x4x12	4000x12x4	4000x4x12	4000x4x12	4000x4x12	4000x4x12
6.	Contingency / Stationary	2000x 12	2000x 12	2000x12	2000x12	2000x12	2000x 12	2000 x 12	2000x12	2000x12
	TOTAL	**225200 0**	**2252000**	**2252000**	**2292000**	**2252000**	**812000**	**677000**	**2252000**	**2252000**

Total Financial Implications : 172.93 (District Training Venues) + 50 lacs (for State Infrastructure) = 222.93

b. Setting up of BCC Infrastructure:

ACTIVITY	Expenditure per unit	Units	Expenditure 2008-09	Expenditure 2009-10	Funds from	Remarks
State Bureau		1	30.28 (One time and recurrent)+ 6.28 (recurrent)	6.28	NRHM Flexi	36.7 lacs was approved for 2007-08 and is available
Districts BCC Units						
Staff : District BCC Officer . Data entry	25000/- per month.x12 8000/- per month x 12	9 9	24.30 8.64	24.30 8.64	NRHM Flexi	Approved in 2007-08 and is available .
Equipment Computer with printer with fax	60000/-	9	5.40	xxxxxxx	NRHM Flexi	
Mobillty	600 /- per day x 10 days per month x 12	9	6.48	6.48	NRHM Flexi	
	Total		**75.22**	45.7	NRHM Flexi	

c. Setting up of District Stores.

S.no.	Activity	East	West	North	South	NE	NW	SW	Central	New Delhi
1	Hiring of Space	1,20,000x12	1,20,000x12	1,20,000x12	1,20,000x12	1,20,000x12	1,20,000x12	X	1,20,000 x12	1,20,000x12
	Renovations/Misc							2,00,000		
2	Furniture/ Computer with Printer	310000	310000	310000	310000	310000	310000	310000	310000	310000
3	Stationary/ Misc	2000x12	2000x12	2000x12	2000x12	2000x12	2000x12	2000x12	2000x12	2000x12
4	Staff									
	i)Pharmacists	15000x2x12	15000x2x12	15000x2x12	15000x2x12	15000x2x12	15000x2 x12	15000x2 x12	15000x12 x2	15000x2x12
	ii) CDEO	8000x12	8000x12	8000x12	8000x12	8000x12	8000x12	8000x12	8000x12	8000x12
	iii) Security+NO	6000x5x12	6000x5x12	6000x5x12	6000x5x12	6000x5x12	6000x5x12	6000x5 x12	6000x5 x12	6000x5x12
5	Running Cost:	20000x12	20000x12	20000x12	20000x12	20000x12	20000x12	20000x12	20000 x12	20000x12
	Generator							90000		
6	Mobility	800x22x12	800x22x12	800x22x12	800x22x12	800x22x12	800x22x12	800x22x12	800x22 x12	800x22x12
	TOTAL	3041200	3041200	3041200	3041200	3041200	3041200	1891200	3041200	3041200
								Total of 9 districts		26220800

d..**For addressing the critical gaps in CDMO Offices / Other National Programme Management Units** where funds are not available from their programmes , (after required approvals – SHS , IDHS.) : 50 LACS .

e- Budget for year 2008-09

For year 2008-09, Delhi State Plans to initiate Telemedicine network in the form of connection between a super specialty hospital and few district hospitals. This is going to reduce the patient load of tertiary care hospitals and provide specialty healthcare advice where it is needed; also it will bridge the public-private facility gap in the state. Budget required for the purpose comes to around 2.5 crores

. Initially only feasibility study and evaluation of existing set up may be taken up requiring around 10 lacs

VI .Maintainance of existing Infrastructure:

SNo.	Unit	Cost per Unit	NW	N	SW	S	W	NE	E	ND	Central	Total Number	Expenditure for 2007-08	Funds from
1.	Mat Homes (can be equated to CHC)	1 lac	5(5 lacs)	1(1 lac)	0	2(2 lacs)	3(3 lacs)	1(1 lac)	2(2 lacs)	1(1 lac)	2(2 lacs)	17	17	NRHM Flexipool
2.	PUHCs	50000	7(3.5 lacs)	5(2.5 lacs)	7(3.5 lacs)	12(6 lacs)	11(5.5 lacs)	10(5 lacs)	2(1 lac)	5(2.5 lac)	4(2 lacs)	63	31.5	"
3.	Subcentres	25000	4(1 lac)	0	0	3(0.75 lacs)	0	0	0	0	0	7	1.75	"
	TOTAL		**(9.5 lacs)**	**(3.5 lacs)**	**(3.5 lacs)**	(8.75 lacs)	**(8.5 lacs)**	(6 lacs)	(3 lacs)	(3.5)	(4 lacs)	87	50.25 lacs	

VII. Untied Funds for the :

SNo.	Unit	Cost per Unit	NW	N	SW	S	W	NE	E	ND	Central	Total Number	Expenditure for 2007-08	Funds from
1.	Mat Homes (can be equated to CHC)	50000	5(2.5 lacs)	0	0	4(2 lac)	3(1.5 lacs)	0	2(1 lac)	1(0.5 lacs)	1(0.5 lacs)	16	8.0 lacs	NRHM Flexi pool
2.	PUHCs	25000	4(1 lac)	12(3 lacs)	19(4.75 lacs)	16(4 lacs)	11(2.75 lacs)	0	0	5(1.25 lacs)	4(1 lac)	71	17.75 lacs	"
3.	Subcentres	10000	5(0.5 lac)	0	0	0	0	0	0	0	1(0.1 lacs)	6	0.6	"
	TOTAL		**(4 lacs)**	**(3 lacs)**	**(4.75 lacs)**	**(6 lacs)**	**(4.25 lacs)**		(1 lac)	(1.75 lacs)	(1.6 lacs)		26.35 lacs	

Funds for major construction : 50 lacs . To be released as per approved proposals to the districts.

VIII. Mainstreaming of AYUSH is an important activity to be taken up in a phased manner.

All districts have presence of Delhi Govt and MCD Homeopathy , Ayurveda and Yunani health facilities. A facility survey has to be done to identify units where AYUSH components are required to be integrated with allopathy facilities .In PIP 2007-08 only one district had proposed additional AYUSH Units . They had not been able to carry this out .

As is evident from the Infrastructure database , Delhi has a sizable AYUSH infrastructure available with it. The need seems to be more towards:

(i).Clearly defining the role of the AYUSH system in Delhi context ,

(ii).Making the stakeholders – other system practitioners and the population aware of what AYUSH has to offer and where and how the services are easiliy available.

For this a budget of 2 lacs per district and 2 lac at the State level is proposed to initiate a ground level hand holding and exploring methods of bringing the systems together in a synergistic mode.

Already this integration has begun through ASHA .

Total Financial Implications : 20 lacs

VIII. Innovations ::

A).PUBLIC PRIVATE / NGO PARTNERSHIPS

a). PPP – With HOPE Foundation in Northeast District by setting up a PUHC.

b). **Mamta Freindly Hospital Scheme** planned as a Pilot Project in Southwest District . The scheme is aimed at providing complete antenatal / natal and postnatal care with essential care for the new born by entering into partnership with local nursing homes in the unserved and underserved areas.

c). PPP for diagnostics.

Details are given in Innovation section and the activities are to be budgeted from NRHM Flexipool.

**d).Dental Mobile Clinics : **

Oral hygiene and dental care are the especially neglected areas in vulnerable populations . As the problem is not life threatening , it is often unattended with much pain and suffering as public health facilities with dental care are far and few . It is proposed to set up four Mobile Dental Clinics which will initially serve the districts with rotating predetermined destinations.

Each Clinic will have two chairs and an X-ray Machine.

Total Financial implications for four such Mobile Clinics along with recurrent expenditure per year : 200 lacs

IX.Intersectoral Convergence

Realising the importance of the activity a seperate section has been devoted to convergence with other agencies / other programmes / other sectors – Social Welfare through ICDS / Education / Water and sanitation (Dept of Urban Development.

Proposed activities will be budgeted through the NRHM Flexipool.

X. Setting up of State Health Resource Center:

Financial Implications

Activity	Expenditure for 2008-09	Funds from	Remarks
Setting up of State Health Resourcs Centre	50.00 lacs	N R H M Flexipool	Approved last year.

XI. Taking up of Research Activities relevant to optimising Mission Implementation.

To be funded from NRHM Flexipool. Detailed activity will be proposed for 2008-9 when the State Health Resource Centre is in place.

XII. Preparation of annual district and state report.

Activity	Unit	Unit Cost	Expenditure in 2007-08	Remarks
Preparation of annual report	**State 1**	**2 lacs**	**2 lacs**	Funds already approved . NRHM Flexipool
	District 9	**0.5 lacs**	**4.5 lacs**	
Total			**6.5 lacs**	

XIII. Upgrading to IPHS

From 2008-09 onwards all the identified PUHCs and Maternity Homes (will be upgraded to laid down Public Health Standards over two years . This activity has already entered its first phase of implementation with identification of certain centres to be strengthened in 2008-09 and subsequently upgraded . The exercise of upgradation of all identified facilities will be completed in next three years

Chapter 13

Intersectoral Convergence

In keeping with the tenets of National Rural Health Mission, **CONVERGENCE** has been one of the main strategies adopted by State Health Mission to achieve the optimum healthcare delivery using the existing resources.

In context of our State this convergence will take place at various levels:

A). Interagency Convergence.
B). Inter Programmatic Convergence.
C). Inter Sectoral Convergence.

A).Inter Agency Convergence

Presence of underserved / unserved population and far from optimum health indicators in presence of over 900 peripheral health facilities points to a systemic error. In case of our State it is the existence of multiple health facilities under different administrative controls with wide ranging structural and functional heterogeneity. This is further compounded by the lack of co-ordination and synergy between various health provider agencies..

In Delhi there is Delhi Government , Municipal Corporation of Delhi , New Delhi Municipal Committee , Central Government Health Services , DGHS, ESI, Railways , DJB , DVB , Defence and many other agencies providing public sector healthcare . Since due to age-old reasons they cannot merge, a sincere and effective convergence is the only answer. Delhi Govt and the MCD have been involved together in preparation of this document. MCD has appointed District and State Level Co-coordinators for representing MCD while planning of Mission activities. In addition to the groundlevel handholding ,ownership and commitment to make this effort at convergence work has to come from the highest level .

Mission is seen as the amalgamating force which can tie these agencies through synergistic functional linkages by making them stakeholders at a common platform without infringing upon their individual identities. Expectations from the individual agencies is that they come forward with enthusiasm and utilize the resources provisioned under the Mission through the mechanisms laid down ie. through the District and State Health Societies. At the same time they own up the mandate of the Mission to provide Accessible , Affordable and accountable health for all and make themselves amenable to monitoring mechanisms set up under the Mission.

To revive the MCW and IPPVIII Maternity Homes a Committee was constituted under convenership of Director IPPVIII , MCD to provide the Public Health Standards for these Maternity Homes. As per Committee's recommendations 20 out of 32 Maternity Homes surveyedare to be strengthened in the 2008-09.

Identification and strengthening of the most appropriate health units irrespective of the agency they belong to is envisioned in a phased manner in the current plan. The agencies will also pool in their resources in terms of technical resource and training portals to provide trainings for all categories of staff.

B).Inter Programme Convergence

a). National AIDS Control Programme (NACP)

Although NACP has not directly been brought under the umbrella of NRHM , for the effective implementation of the Programme and its monitoring, the areas for ground level convergence were identified .At the request of Mission , DSACs has designated an officer to co-ordinate these activities.

The three action points identified were :

1).**Training** of ASHAs , ANMs , PHNs , MOs and paramedical staff in RTIs and STDs .The ground level implementation of any health programme is in the hands of these health functionaries and empowering them with the knowledge of what to do and how to do along with provision of relevant logistics is vital to success of any programme. The training component has already been included in the capacity building section. The trainings will be funded by DSACS .
The training budget and the structure has been redefined. Now with a training co-ordinator in place at state level and a DSACS coordinator identified to co-ordinate the trainings scheduled for the current year will be completed as scheduled.

2). Setting up of **Blood Storage facilities** for the FRUs in the districts . For an FRU (Maternity home , subdistrict and District hospital) to provide optimal service delivery as mandated in its function , round the clock blood availability has to be ensured . Depending upon the availability of the other resources , functional status and the workload , the Units have been identified and prioritized to be equipped with Blood storage facilities.

The district will have to provide fund for the:
a). One time equipment cost of 75000/-.
b). Salary component of the doctors(3) / LTs (3)/ Class IV worker (3).
(MO =25000 X 3 x12), (LTs = 9000 X 3 X 12) (Class IV = 4500 X 3X12)

(Total of 13.86 lac / yr)

c). Petrol / Diesel running cost for the vehicle . (4000/mth)
(48000 per year).
TOTAL Rs. 15.09 LACS

NACO will provide :

a). A mobile Van to carry the blood from the connected Blood Bank .
b). Salary Component of the driver and attendant for the vehicle .
c). Annual Contingency funds for the Units which will cover the cost of reagents needed for Blood grouping and Cross matching .
d). Training for the MO / LT / Paramedical staff.

Status :

S No.	District	Bld Storage Units Visualised for 2007-08	Bld Storage Facilities Visualized for 2008-09	Remarks : None could be functionalised
1.	Northwest	1(Staff only+ Petrol / diesel)	1	**Process Indicator :** 1). Number of FRUs with Equipment, Staff , Van . 2). % of recruited staff trained. **Output Indicators**:Number of Fully functional Blood Storage Units with Blood BankLinkages. **Outcome Indicators :** Number of Surgeries performed in each upgraded FRU. Indicator
2.	North	1	1	
3.	West	1	1	
4.	Southwest	1(only staff + Petrol / diesel))	1	
5.	South	1	0	
6.	East	1(ONLY Staff + Petrol / diesel))	1	
7.	Northeast	1	1	
8.	Central	0	0	
9.	New Delhi	0	0	

TOTAL 85.41 LAC

It was observed that secondary care units identified for this activity had selective needs and the entire package was not required .

Financial Implications :

	Name of the District	Number of units Set up / proposed	Budget for the year 2008-09	Unutilised Funds

1)	Northwest	1	14.34lacs	15.09 lacs
2)	North	1	15.09 lacs	15.09 lacs
3)	West	1	15.09 lacs	15.09 lacs
4)	Southwest	1	14.34lacs	15.09 lacs
5)	South	Nil	Nil	15.09 lacs(to be surrendered)
6)	East	1	14.34 lacs	15.09 lacs
7)	Northeast	1	15.09 lacs	15.09 lacs
8)	Central	Nil	Nil	Nil
9)	New Delhi	Nil	Nil	Nil

Cost of upgrading 7 FRUs by setting up Blood Storage Facilities for the year 2008-09 is 88.29 lacs..

3). Opening of Integrated Counseling and Testing Centres (ICTCs).
As of today, only 13% of the people who are HIV Positive in the country are aware of their HIV Status. The NACP takes it as a challenge to make all HIV infected people in the country aware of their status so that they adopt healthy life styles and prevent the transmission of HIV to others .

There are 59 Integrated Councelling and Testing Centres (ICTCs)* in Delhi . Recommended norms are atleast one ICTC per one lac population . The target of DSACs for the year is 37 new centres , and 15 of these were planned as an activity under the State Health Mission under NRHM for 2007-08. Only seven could be functionalised

Contribution from NACO / DSACS:
a). Manpower – LT and the Councelor for the ICTC.
b). Equipment and Rapid testing kits .
c). Consumables.
d). IEC Material.
e). Required trainings.

Contribution from the district authorities :
a). Provide space for the ICTC in the identified centre.
b). The MO I/C will be incharge of the centre.
c). Outreach workers and ASHAs will be actively involved in the Programme.

* Voluntary Councelling and Testing Centres (27), PPTCs (16), and Mitwas (Mobile ICTCs) are all called ICTCs now.

S No.	District	ICTC Centres visualized for 2007-08	ICTC Centres Opened in 2007-08	ICTCs to be opened in 2008-09.	Monitoring Indicators
1.	Northwest	2	2		**Process Indicators :** 1). Number of ICTCs set up with equipment / staff . 2). % of attached Staff trained. **Output Indicators:** 1). Number of fully functional ICTCs performing councelling / tests / referrals. **Outcome Indicators:** 1).Number of individuals screened for HIV . 2). Number of STIs treated at the centre.
2.	North	2	1		
3.	West	2			
4.	Southwest	2			
5.	South	2	2		
6.	East	2			
7.	Northeast	2			
8.	Central	2			
9.	New Delhi	2			

No financial implications.

TOTAL Financial Implications : 88.29 from NRHM Flexipool.

III. INTERSECTORAL CONVERGENCE

1). With Department of Social Welfare .
2). With Department of Urban Development.
3.).With Department of Education.

1).INTERSECTORAL CONVERGENCE WITH DEPARTMENT OF SOCIAL WELFARE (thru INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS).

Integrated Child Development Services (ICDS) under aegis of Social Welfare Department is the only major National Programme that addresses the needs of children under the age of six years. Providing an integrated package of services – Supplementary Nutrition , Healthcare , Preschool education.

Integrated Child Development Scheme has large infrastructure comprising of 34 ICDS Projects , 168 Supervisors with 4428 Anganwadis (the figure has crossed 6000 now)with 4428 workers (AWWs) and 4428 helpers and the main objective of improving infant , child and maternal health and nutrition.

Nutrition Scenario in Delhi : Situational Analysis.

Major nutrition-related public health problems

1. Chronic energy deficiency and undernutrition
2. Micro-nutrient deficiencies
- **a).** Anaemia due to iron and folate deficiency
- **b).** Vitamin A deficiency
- **c).** Iodine Deficiency Disorders

3.Chronic energy excess and obesity

Chronic Energy Deficiency – (CED) Protein Energy Malnutrition

As can be seen by comparing the NFHS Surveys (below) , there has been no significant decline in prevalence of Protein Energy Malnutrition (Chronic Energy Deficiency) in our children. The number of wasted children has in fact gone up from 13 to 16 % and decline in % of stunted and underweight children is only marginal over last 14 years.

Trends in Children's Nutritional Status --Delhi			
	Stunted	Wasted	Underweight
NFHS1 1992-93	40	13	41
NFHS 2 1998-99	37	13	35
NFHS-3 2006-07	35	16	33

Anemia

Similarly it is distressing to see that 63% of our children in 6–35 months age group and 43% of women aged 15 – 49 years are anemic despite the fact that remedy is cheap and universally available being provided free at Government health facilities.

Anaemia among Children and Adults --Delhi	NFHS III 2005-06	NFHS II 1999-99	NFHS 1992-93
Children age 6-35 months who are anaemic (%)	63.2	69.0	na
Ever-married women age 15-49 who are anaemic (%)	43.4	40.5	na
Pregnant women age 15-49 who are anaemic (%)	29.9	34.7	na
Ever-marrried men age 15-49 who are anaemic (%)	18.9	na	na

Vitamin A Deficiency:

Children age 12-35 months who received a vitamin A dose in last 6 months (%)	21.0	22.6	20.4

As per the Tenth Plan elimination of Vitamin A deficiency as a public health problem was a goal to be achieved by 2007. Around 50000 children still go blind annually due to severe Vitamin A deficiency . The malnourished children are extremely prone especially after an attack of measles

Child Feeding Practices:

We also seem to have made no significant headway in changing the infant and child feeding practices .In fact NFHS III has shown a decline in prevalence of early initiation breast feeds. Despite so much talk about importance of breast feeding only 34.5 % infants are being exclusively breast fed and weaning at right age seems to be taking place in only 60% children.

Child Feeding Practices	NFHS III 2005-06	NFHS II 1999-99	NFHS I 1992-93
Children under 3 years breastfed within one hour of birth (%)	19.3	23.8	6.3
Children age 0-5 months exclusively breastfed (%)	34.5	na	na
Children age 6-9 months receiving solid or semi-solid food and breastmilk (%)	59.8	na	na

As can be seen from the data revealed by NFHS 2005-06 we have not been able to tackle our nutritional problems to any significant extent and serious ground level work has to be put in.

The DLHS Data 2002-04 gives a districtwise data for Delhi .

For a long time now the country has adopted a multi-sectoral, multipronged strategy to combat these problems and to improve the nutritional status of the population. So far various sectors which can / are contributing in raising the nutritional status of our population have been working in isolation and with a

blurred focus. The key stakeholders / sectors have to converge and operationalise meaningful linkages out in the field.

Other important resources are **Food and Nutrition Board** which in addition to its other duties is engaged in promoting healthy feeding practices , and in training of grass root in disseminating the skill of making nutritious food from easily available , affordable , homebased ingredients. **National Nutrition Foundation ,** the apex institutions which can serve as resource for devising our field friendly nutritional interventions , their implementation, monitoring and evaluation. **Nongovernmental organisations can play a vital role in supplementing the local gaps and IEC.**

Close co-ordination and synergistic action is needed between :

1. Ministry of women and Child development (ICDS).
2. Department of Health and Family Welfare.
3. Department of Urban/Rural Development.
4. Food and Nutrition Board .
5. National Nutrition Foundation.
6. NGOs / Development Partners.

Why we have not achieved our nutritional goals?

1). Suboptimal utilization of existing resources under ICDS due to poor targeting , monitoring and supervision.

2). Healthcare providers are not sensitized to the need for providing appropriate health and nutrition education for prevention of under nutrition and ill health ; do not take steps to prevent infections, detect them early and treat them so that the nutrition toll of infection is reduced ; mechanism for universal screening children at least four times a year for early detection of under nutrition is not operationalised; they are not aware of the enormity of problem and the role they can play in combating it . They do not watch out for mild to mod anemia , mild to moderate malnutrition , IDDs**.** Any nutritional problem needs a sustained multipronged intervention with a change in nutrition behaviour / hygiene/ sanitation**.**

3). Nutritional rehabilitation is a weak area. There are no efforts to screen all children and detect those with moderate and severe undernutrition and to provide them with double rations and health care along with nutrition and health education to the mothers so that to the extent possible rehabilitation is done at home settings. There is no system of referral to hospital children who have infections or any life threatening complication

4).Ineffective IEC/ BCC. The ANM , AWW do not have orientation to the current concept on prevention, detection and management fo undernutrition and micronutrient deficiencies and seldom spend enough time with the familes providing them the knowledge on how they can prevent and correct under nutrition in their home settings.ASHA can be an important vehicle for this.

5). Need for more resources.

PLAN OF ACTION

Vision :

- To make each anganwadi a place of some light , air and cheer with each child accounted for.
- To ensure that the AW plays the critical role in providing nutrition education, ensuring that women practice universal exclusive breast feeding for six months , appropriate adequate complementary feeding at six months, know how to feed children during illness and convalescence.
- Ensure that the anganwadi worker weighs and detects all children with undernutrition; advise the family how to correct the mild undernutrition with the family food.
- To make each anganwadi a place of supplementary nutrition for those with moderate and severe undernutrition and monitoring implementation and improvement in nutritional status for those who get supplementary feeding , basic preventive services and monitoring for those who need it – children < 6yrs, pregnant women .
- To make each anganwadi a place where a woman can get advice and some help on her basic health , nutrition and fertility related issues.
- To equip each anganwadi with weighing machines / acrds / trained personnel.

Understanding the urgent need for this convergence several meetings were held with the functionaries of Deptt of Social Welfare looking after the ICDS .

To begin with a proposal was made wherein **one anganwadi would be identified for every 5-6 anganwadis and designated as mother anganwadi and to begin with the health activities can flow out of this unit. :**

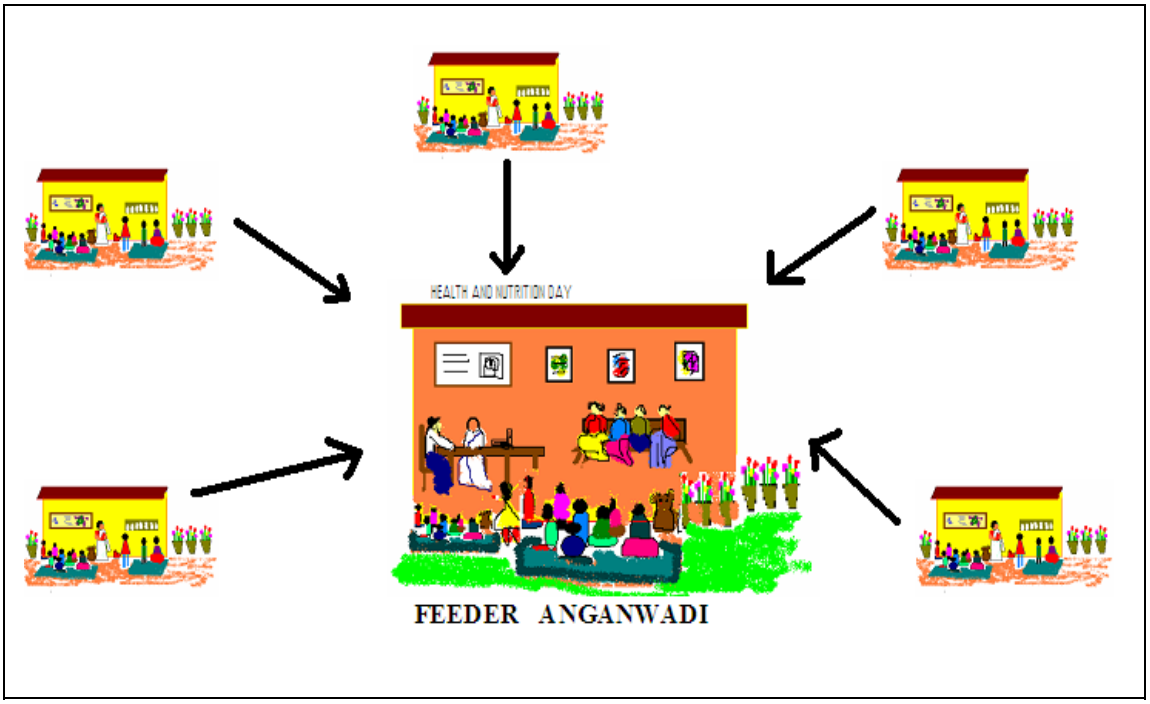
1. Nutritional assessment : Assessment of nutritional status of all of all new entrants and formulation of their nutritional POA with filling of Road to health cards. Screening for micronutrient deficiencies clinically/ Hb% estimation/ on Health and nutrition days .

2.Health activities : Through the regular monthly health and nutrition day.

Antenatal and postnatal check up.
Delivery preparedness**.**
High risk identification and referral.
Immunisation of pregnant ladies / children.
Treatment of Minor ailments.

3. **Family Planning advice** : Advice and availability on Condoms / Oral Pills. Advice and Referral for IUCD / Tubectomy / vasectomy.

4. Health Education



Health & Nutrition Day

This Mother anganwadi:

- Wherever possible will provide the venue for the Village Health and Nutrition Day.
- Will be strengthened to carry out the nutritional surveillance and supplementation.
- Will be provided with stock of Iron/folic acid supplements / Vit A / Oral Pills / Condoms / ORS etc.
- Have Relevant Health education material displayed in the anganwadi which can be periodically updated.

This mother anganwadi will be institutionalized by the ANM of the area who will be in regular touch she will be a part of the three member team (Doctor / ANM) who will visit this feeder anganwadi once every month on the designated Health and Nutrition Day. In addition now ASHA will also be working in close association with her.

Prevalence of Malnutrition and Anemia. DLHS –RCH (2002-04).

District	Weight for age		Anemia among children			Anemia among adolescents			Anemia among pregnant women		
	- 3SD	-2SD	Mild	Moderate	Severe	Mild	Moderate	Severe	Mild	Moderate	Severe
DELHI	10.8	35.3	45.6	48	3.8	18.8	51.6	28.7	46.5	47.3	1.3
Central	14.2	31.5	47.7	39.1	3.3	30.3	41.8	24.0	57.7	34.6	3.8
East	6.5	28.1	42.5	51.4	3.9	11.2	48	40.1	37.5	50.0	0.0
NewDelhi	9.0	28.7	43.6	49.2	6.7	10.2	55.9	33.9	57.1	42.9	0.0
North	7.4	33.6	51.2	31.8	4.1	35.2	37.7	22.6	60.0	25.0	0.0
Northeast	14.4	39.8	49.6	47.8	1.6	19.9	56.3	23.4	47.5	47.5	3.4
Northwest	10.2	38.7	61.4	35.1	1.8	26.2	59.3	14.5	54.5	40.9	0.0
South	9.1	34.8	42.0	52.4	5.1	14.8	51.2	33.6	39.5	53.5	2.3
Southwest	8.1	24.9	33.8	55.4	6.4	9.3	51.7	38.1	38.1	61.9	0.0
West	15.4	42.6	40.7	54.4	3.7	18.4	51.3	30.3	50.9	43.6	1.8

ACTIVITIES REQUIRED TO ACHIEVE THE ABOVEMENTIONED OBJECTIVE.

SNo.	Activity	Unit	Cost Per unit	Fund Flow from	Budget 2008-09	Remarks
1.	Identifying mother anganwadis	800	xxxx	No funds needed	xxxxxx	The task done by the ICDS Functioaries.
2.	Equipping the 4000 anganwadis with weighing scales-	4000	1500	NRHM Flexipool To strengthen the ICDS activities.	60 Lacs	**NRHM Flexi** (Unutilised fund 40 lacs)
3.	Providing IFA / Deworming agents / ORS/ OCs / Condoms for all anganwadis	845	5000	NRHM Flexipool To strengthen the ICDS activities.	----	RCH
4.	Hoardings for Mother anganwadi centres.	845	400	NRHM Flexipool To strengthen the ICDS activities.	3.38 lacs	NRHM Flexi (Unutilised funds 3.1 lacs)
5.	Training of AWWs in Nutritional monitoring(batch of 20 for one day). 2000 AWW in one year.	100	6000	NRHM Flexipool To strengthen the ICDS activities.	6 lacs	NRHM Flexi (Unutilised funds 6 lacs)
6.	Identifying linked centres to provide logistics and visiting health teams .	xxxxx	xxxxx	No Funds Required	.	The visiting health Teams will come from nearest DHS / MCD Centres
5.	Institutionalising Monthly health and Nutrition Day at mother anganwadis.	Rs 900/- Per Health And Nutrition Day day provided as mobility support / local incentives / contingency.	900/-	RCH	-----	RCH
6.	Orientation and Training of Doctors/ANMs/	Details in Capacity	Details in Capacity Building	ICDS / RCH	ICDS / STCDFW to carry out sensitization /	

	AWWs / Helpers	Building		Flexipool	Trainings
8.	Monitoring and evaluation: a).Field viable System to be developed . b).Monitoring in the field.	Apex Nutrition agency -- Nutrition Foundation of India. External agency	5.0 lacs	NRHM Flexipool	National Nutrition Foundation of India/ Development partners can contribute to be approached for developing the mechanisms.
9.	Strengthening of food component	ICDS		Deptt of Women and Child Dev Enhancement of salary component of functionaries	
10.	Giving more space for anganwadi / increasing rent component	Deptt of Rural / Urban Development		Deptt of Rural / Urban Development	
11.	Additional				
12.	Dari for each AW sought by West district	222 x 1000 =2.2 lacs			

Total Financial Implications : 77.4lacs

2.CONVERGENCE WITH DEPARTMENT OF EDUCATION

School is an ideal place for inculcating healthy habits especially with regard to sanitation, hygiene and personal care in our children. Many vital issues relating to physical, mental and psychological changes of adolescence can be dealt with in school. The teachers will have to be sensitized and trained in the required counseling skills. The high prevalence of anemia in our children and adolescent girls, refractive errors in school going children are problems that can be addressed effectively through the school health scheme.

Convergence with the Department of education is envisioned through two instruments available to us. One is the **School Health Scheme** and the other through the **adolescent health component of RCH II Programme** .

School Health Scheme has been operational in Delhi since 1979 to cover the Govt and Govt-Aided Schools with the following objectives :

- Promotion of positive Health (Health Education).
- Prevention of Disease (Including immunization).
- Early diagnosis and treatment .
- Referral Services to higher centres.

There is a School Health Scheme run by the MCD for primary schools under MCD and a separate School Health Scheme run by the Directorate of Health Services, Govt of Delhi for the Primary and secondary schools

The services to be provided to the students include :

- Routine complete physical check up of each student .
- Curative services through OPD Services.
- Immunization against tetanus at the age of 10 and 16 years.
- Referral of students who require attention of a specialist, to referral centers / Hospitals and subsequent follow up of these cases.
- Health education and counseling.
- Advising the school authorities for maintenance of healthy and safe environment.

NRHM is committed to providing support for School Health Programmes in each and every district of the country based on specific proposals prepared as part of the of District Health Action Plans

Delhi Govt School Health Scheme

The existing Scheme is able to cover only one third of the schools (Total number of schools is 1134, with 910 Govt and 224 Govt aided). The revamped school health scheme was launched on 2nd Oct 2006 .The Govt has involved NGOs and allotted schools to them after signing a MOU with them.

At present the scheme is operational through 15 Govt centres , each one to look after around 10000 students . Out of the remaining schools some are being covered through NGOs for which they are reimbursed on a per child basis. The health education / councelling and follow up component of the programme is weak . There is at best one or two contacts per child per year at the time of screening in the current scheme whether it is implemented through the Govt / NGO functionaries .

Meanwhile monitoring of the activities under the school health was entrusted to the CDMOs and this is one activity which has been provisioned for under the Mission.

Developing a Monitoring mechanism for the school health component with the objective of assessing extent / methodology / adequacy of existing school health services in delivering the mandated components of school health services.

Activities:
a). Each district to have two member teams (preferably of a retired teacher / and a doctor) to assist the inspection of the schools for the activities of the school health scheme .
b). The mechanism / format to be provided to the inspecting teams .
c). At least 50 schools with operational school health scheme will be monitored in each district in the current year.

Activity : Inspection of schools for monitoring school health services

S No.	Activity	Number of inspections in current year.	Expenditure per inspection	Expenditure in 2007-08	Funds from
1.	Inspection of schools for school health scheme activities.	450	*1600/-	7.20 lacs	NRHM Flexipool
2.	Development and printing of formats.	For 900 inspections.	xxxx	0.25 lacs	NRHM Flexipool

*(Honorarium for two team members = 500/- x 2 = 1000/-.
Hiring of a vehicle per school = 600/-
Total cost of monitoring one school per year =1600/-)

Total Cost of monitoring 450 schools per year : 7.45 Lacs.

School Health Melas

	Actvity	Expenditure per unit	Number	Expenditure	
1.	School Health Melas(South District)	20000	5	1 lacs	NRHM Flexipool

Strengthening the adolescent Health component of the school health Role of Department of Health and Family Welfare in Social Welfare in YUVA.

The role of the health personnel in this holistic and ambitious programme with tremendous sensitivity to the needs of the growing children is to provide answers to their queries / guide them in dealing with their changing physiological needs on a need based pattern. The existing scheme is not able to provide this.
There is need to have an Adolescent health clinic or " YUVA Swasthya Kendra " in every school . To begin with , a doctor will look after five such clinics ie. Will be available for fixed one day / week in the school . The room and support staff (cleaning) will be provided in the school . IEC material will be provided by the health department. Help in training for these doctors will be sought from MOHFW / WHO who have done excellent work in development of relevant modules .

Initially it may be taken up as a pilot project in two districts covering 200 schools in each (100 schools) .Two districts have been identified for this activity – Northwest and South Districts as they are larger districts with a significant number of schools still uncovered by school health services.

Expenditure	Number of units	Expenditure per unit	Expenditure in 2007-08	Funds from

Doctors	40 x 12	25000	112 lacs	NRHM
PHN	40 x 10	16000/-	64 Lacs	NRHM
Trainings	4 (a batch of 10 for five days)	50,000	2.00 lacs	NRHM Flexipool
Development of IEC Material			1 lac	NRHM Flexipool
IEC Material	200	4000/Year	8.00 lacs	NRHM Flexi
Basic drug kit	200	5000/ year	10.00 lacs	NRHM Flexi
Monitoring and evaluation	200	1600/ yr	3.20 lacs	NRHM Flexi
Total Expenditure			200.2 lacs	NRHM Flex

The project will be monitored by the mechanism outlined above with the help of predesigned formats / inspections / interviews with students and teachers / clinic records.

3. CONVERGENCE WITH THE WATER AND SANITATION DEPARTMENT

The National Rural Health Mission relates good health to nutrition, sanitation , hygiene and safe drinking water . The Indian census provides an opportunity to understand accessibility of safe drinking water at district level . The information presented was gathered at household level on eight types of drinking water sources . These were : tap , Handpump , Tubewell , , Tank / Pond / Lake / River / Canal , Spring and Any other water sources. In the study , Tap , Handpump , and Tubewell are taken as safe drinking water sources. A household using water for drinking purposes from any of the three sources is defined as one using safe drinking or improved drinking water. Similarly the Indian Census has categorized the households as having pit latrines/water closet latrine , other latrine as households having any type of toilet facility vis a vis those having no facility.

For Delhi :

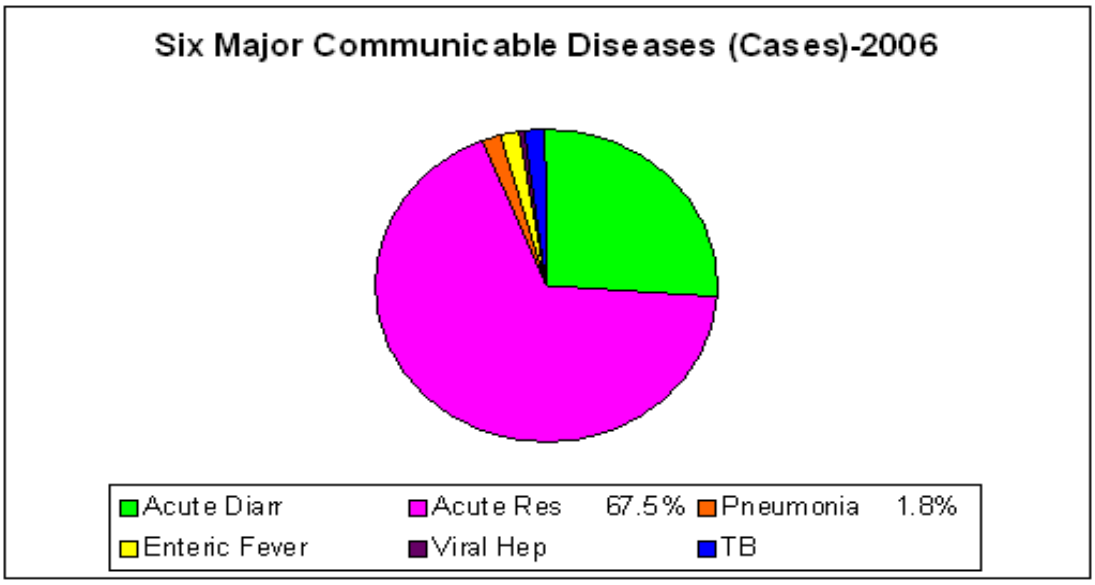
State / District	**% of households using safe drinking water**	**% of households having any kind of toilet.**

Delhi	**97.20**	**78%**
New Delhi	**99.8**	**68.0**
Central	**99.3**	**80.0**
Northeast	**98.8**	**83.1**
East	**98.8**	**81.8**
West	**98.2**	**81.9**
South	**97.1**	**78.9**
Southwest	**96.4**	**81.0**
Northwest	**95.8**	**68.2**
North	**93.5**	**75.8**

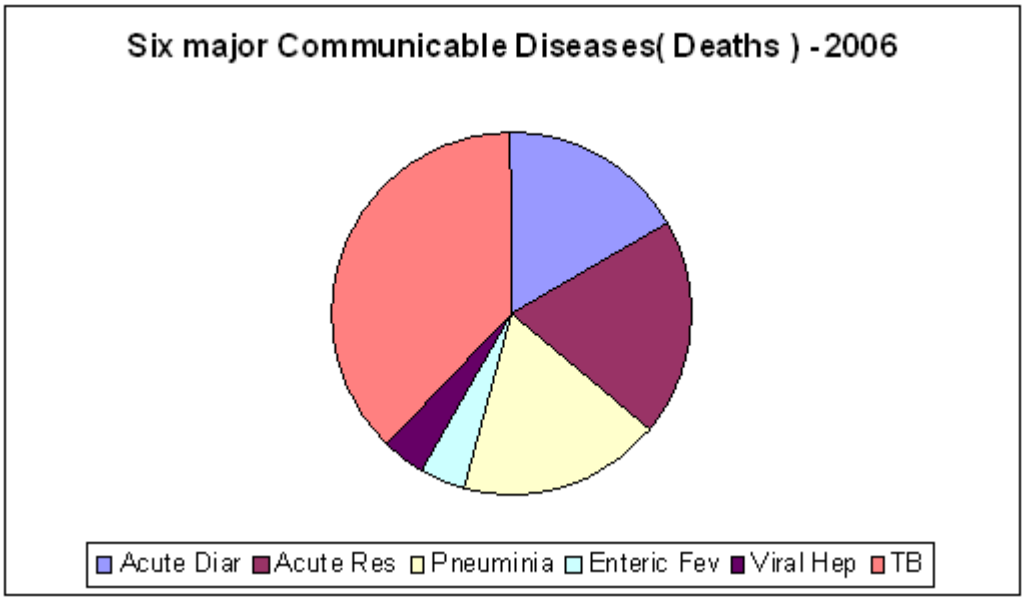
Source: Study by IIPS based on Census 2001 and DLHS 2002-04.

Percentage of households by bathroom availability & Type of drainage within the house in Delhi in 2001 , (Census**).**
Source : Census of India 2001,RGI.

Total no. of households	Households having bathroom facility within the house		Type of connectivity for waste water outlet					
Total	Rural	Urban	Closed drainage		Open drainage		No drainage	
			Rural	Urban	Rural	Urban	Rural	Urban
2554149	4.05	66.96	0.91	48.25	4.04	36.74	1.69	8.37



INDIA
Source : Monthly Health Condition Reports from Directorate of Health Services of States / Uts.



INDIA
Source : Monthly Health Condition Reports from Directorate of Health Services of States / Uts.

Delhi data 2006

Cases / Deaths due to Cholera in Delhi in 2006.

Jan to March		Apr to June		July to sept		Oct to Dec		Progressive total					
								Cases			Deaths		
C	D	C	D	C	D	C	D	Males	Females	Total	Male	Female	Total

43	0	461	0	439	0	109	0	626	426	1052	0	0	0

Delhi has the highest reported cases.

Source : Weekly reports of Directorate of Health Services of States / Uts

Cases and Deaths due to acute diarrhoeal diseases in Delhi in 2006.

Male		Female		Total		Reference period upto
Cases	Death	Cases	Death	Cases	Death	
56689	49	37709	36	94398	85	Dec 2006.

Source : Monthly Health Condition Reports from Directorate of Health Services of States / Uts.

Cases and Deaths due to Enteric Fever in Delhi in 2006.

Male		Female		Total		Reference period upto
Cases	Death	Cases	Death	Cases	Death	
8429	10	5345	8	13774	18	Dec 2006

Source : Monthly Health Condition Reports from Directorate of Health Services of States / Uts.

Knowledge of Diarrhea management by district.

District	Percentage of women whose child suffered from Diarrhoea	Percentage of women aware of	
		Diarrhoea Management	ORS
Central	11.1	79.6	48.9
East	8.0	78.9	49.0
New Delhi	15.1	59.8	28.5
North	10.7	84.1	52.7
Northeast	10.7	66.9	30.3
Northwest	15.9	87.3	27.5
South	15.6	60.9	24.2
Southwest	4.4	71.0	54.3

West	6.4	68.4	23.5
Delhi	11.3	73.1	33.0

Source : DLHS 2002-04.

As can be seen from the above data safe drinking water is available in almost 98% households and some toilet facility is available to almost 78% of households. Quiet a significant chunk of population still has open / no drainage system..

Issues in hand:

Contaminated water leading to 1 Cholera.
2.Other Acute diarrheal diseases
3.Worm infestation.
4. Enteric Fever
5. Viral Heapatitis

Lack of adequate water for use : 1. Scabies

Stagnant Water Collections : 1. Dengue
2. Malaria

. Regarding Safe drinking water it is important to see as to how much water is available and for how long in the day. In most areas the water supply is only for short period of time during the day and people have to collect and store water for the day . The amount of water available is not sufficient especially in the summer months.

Strategies :'

1.Provision of adequate water for domestic use.
2.Ensuring the safety of water used for domestic purposes.
3.Ensuring personal and domestic hygiene necessary to prevent spread of water borne diseases.
4. Ensuring safe disposal of excreta
5.Ensuring safe solid waste disposal.
6. Ensuring safe disposal of waste / excess water.

Application of some of these strategies have constraints but in the long run they have to implemented for permanent sustainable solutions and sooner the uphill process is begun , the better.

The immediate focus on :

5. Setting up of health and sanitation committees in all the villages in the urrent year. Subsequently in slums.
6. Ensuring that the NVBDCP is taking care of the water collections / other mosquito breeding places.
7. Facilitate setting up of household and community toilets. (activity incentivised for ASHA)
8. BCC regarding
   a). storage / usage of available water.

b). Chlorination of water.
c). Personal and Domestic hygiene.

The convergence between different stakeholders will be at the level of

1. **Integrated District Health Society.**
2. **At the grassroot level of the health and sanitation Committees.**
3. **At the household level through ANMs / ASHAs.**

HEALTH AND SANITATION COMMITEES.

Regarding CHSCs ,Southwest district has taken the lead in setting up the Committees but the funding mechanism has not been institutionalized as no PRI like statutory bodies.

Proposal for the urban slums / resettlement colonies .

To form a health and sanitation Committee for every 2000 population. ASHA will help in constituting this Committee in her area. ANM will be a member of five such committees in her area. Instead of opening an account for each of these Committees, an account will be opened at the Unit level which will be operated by the MO I/C and the respective ANM. The work required will be decided by the Committee and the payment can be made from this account. Each Committee will maintain a register with the details of work done and payments made so that they know the balance available for further activity.

It is proposed to take up this activity in five ASHA Units located in slums / resettlement colonies spread out over various districts. ASHA Units have been identified for strengthening and will be provided with a CDEO cum assistant who will assist in this added work of record keeping and basic accounting .

The same funding pattern may be utilized by the Rural Committees.

Financial Implications :

Activity	**Expenditure per unit**	**Total**	**2008-09**	**Remarks.**
Setting up of 182 health and sanitation committees in all the villages by the end of 2007 .	10000	1650000	18.20 lacs	16.50 already available from 2006-07 budget. N R H M Flexipool

Setting up of HSCs in Five ASHA Units (5 lac population)	5 lacs per unit (50 Committees per block).	25 lacs	25 lacs	N R H M Flexipool
IEC Material to be disseminated through the HSCs / ASHAs , ANMs	100000 per district	100000 x 9	9 lacs	N R H M Flexipool
Total expenditure			52.20 lacs	NRHM Flexi

DISTRICT WISE BREAKUP OF THE ACTIVITIES:

S N .	Activity	Districts							
		Unit Cost	**NW**	**North**	**NE**	**South**	**SW**	**West**	**East**
1.	**Convergence with NACP**								
a.	Bld Storage Unit		14.34	15.09	15.09	0	14.34	15.9	14.34
2.	**Convergence with ICDS**								
a.	Weighing Machines for AWWs	1500/-PER AW	X 963 = 14.45	X 292 = 4.38	X 484 =7.26	X1140 =17.10	X 223 = 3.35	X 222 = 3.33	X 500 = 7.5
b.	IFA & Other logistics	Under RCH	x	x	x	x	x	X	X
c.	Hoardings	400 per MAW	X 200 =0.8	55 = 0.22	X120 = 1.8	X 228 = 0.912	X 45 = 0.18	44 = 0.18	X 125 = 0.50
e.	H & N days	900 per Day	x	X	x	x	x	x	X
d.	District specific Daris	1000	x	x	**x**	x	**x**	2.2 Lac	**x**
	TOTAL		15.25	4.6	9.06	18.02	3.53	5.71	8.0
3.	**Convergence with Education**								
a.	Monitoring activities	1600/-	X50 = 0.80La	X50= 0.80Lac	X 50= 0.80La	X50= 0.80Lac	X50= 0.80Lac	X50= 0.80Lac	X 50= 0.80Lac
b.	School Health Fairs	0.25 lac	X	x	x	X3 = 0.75	x	x	X 2 =0.50
c.	School Health Clinics with focus on adolescents		99.6	X	**x**	99.6	**x**	**x**	**X**
	Total		100.4	0.80	0.80	101.15	0.80	0.80	1.30
4.	**Convergence with Water & Sanitation**								
a.	H&S Committees	0.10lac	X 35 =3.5	X5 =0.5	X27 =2.7	X23 =2.3	X 40 =4.0	X30 =3.0	X 22 =2.2
b.	IEC Material	1 lac	1lac	1 lac	1 lac	1 lac	1 lac	1 lac	1 lac
c.	Slum H&S Committees One ASHA unit	5 lac	5 Lac	5 lac	x	5.0 lac	5.0	5.00 Lacs	x
	TOTAL		9.5	6.5	3.7	8.3	10	9.0	3.2

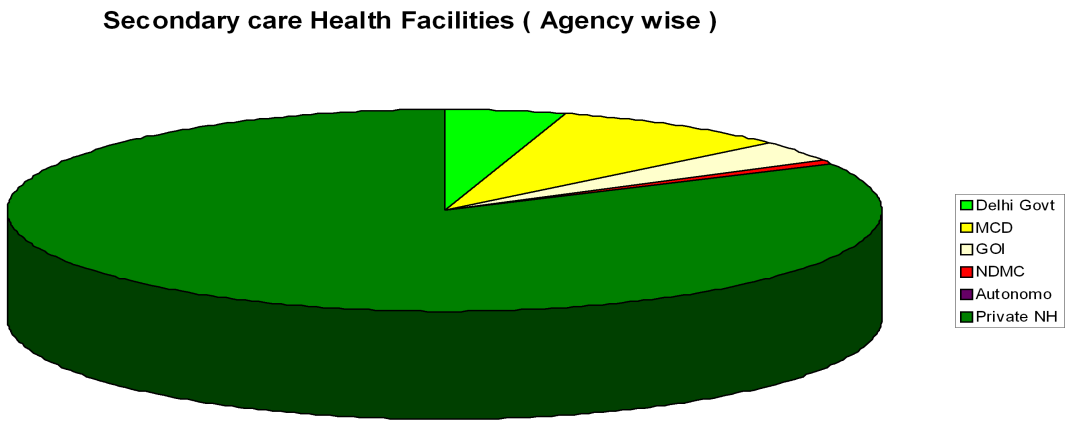
Chapter 14

INNOVATIONS

1. Public Private Partnerships

There is no denying the fact that Private sector is a very important and fast growing healthcare provider. The Public health sector has failed to keep pace in quantity and quality with the needs of rapidly growing population. Setting up full fledged Governmentt units in all the unserved and underserved areas will take time and moreover a serious debate is now on about the cost effectiveness of existing public structures which have failed to deliver effectively .

Forging Public Private Partnerships with Non Governmental sector, especially the nonprofit one is increasingly being seen as a means of providing immediate relief in unserved and underserved areas and also being explored as long term alternatives to setting up cumbersome heavy investment units.



As can be seen Pvt Nursing homes and Hospitals are the predominant source of the secondary healthcare .

Primary Healthcare Delivery in Unserved and Underserved areas.

Establishing Public Private Partnerships with the Private sector and the nonprofit sector (NGOs) to provide healthcare services in unserved geographical and service areas seems to be an accepted and viable mode of penetration into these vulnerable segments. In context of Delhi , it was proposed to cover underserved / unserved pockets by following modalities:

1). Population clusters of less than 10000 – Mobile Health Teams.(This is not being loaded on the Mission and will be taken care of by the reallocation / addition of mobile clinics in the already existing Mobile Health Scheme of Directorate Health Services, Delhi Government.

2). For 50000 to 75000 population clusters , hitherto unserved / underserved,
a). Seed PUHCs to started to provide immediate relief and plan for comprehensive PUHC over next two years under the existing agencies / Mission.
b). In presence of an eligible & willing partner , PPP with Local PVT / NGO institutions to be explored .
3). 10000 to 20000 Clusters – PPPs with Local GPs / NGOs.
4).100000 and above to be covered by SNGO Scheme already formulated by GOI.

Two Partnerships have been initiated recently in our STATE and one is in final stages . These are :

1. Public NGO Partnership with HOPE Foundation.
2. MAMTA Scheme .
3. PPP for diagnostics has been recently finalized and is expected to be introduced soon.

1. PPP with "Hope foundation" .

(A Public NGO Partnership)

In Northeast District a Primary urban health facility is being operationalised to cater to a hitherto underserved population of approximately 1.5 lacs in Sonia Vihar slums in partnership with HOPE Foundation. MOU has been signed between the two partners .The centre will cater to the core 50000 population around the centre and in addition also cover the one lakh population beyond this with its outreach activities.
HOPE foundation (HOPE) will cover the cost of the space / rental / electricity and water till September 2010. A phone will be provided by HOPE foundation to receive and make emergency calls. Human resource will be shared between the between the partners.

S.No.	Staff Designation	Number	Organization	Comments
1	Doctors	2	IDSH. Northeast District.	Preferably one male and one female doctor from RCH flexipool
2	ANM/Nurse	3	Hope	Till the end of the project.
3	Community Supervisors	3 + 3	Hope	3 For Sonia Vihar 3 For Rajeev Nagar

4	Community Link Workers	25	Hope	For home visits, these are more qualified than usual BSs.
5	Pharmacist	1	One from Hope till the end of the Project and one from IDHS,CDMO , (NE).	For duration of program, one to keep stores, one to dispense.
6	Lab Technician / Assistant	1	Hope (for 1 year) then IDSH.	HOPE will pay for one technician for 1 year, then CDMO will provide. Equipment and consumables provided by CDMO.
7	Dresser	1	Hope (1 year) then IDHS . CDMO , NE Dist.	
8	Support Staff / Cleaner	1	Hope	Till the end of the Project.
9	Security Guard	2	Hope	Till the end of the project.
10	Senior Residents on voluntary basis from Dept. of SPM , UCMS.	2	Department of Community Medicine UCMS	For Wednesday and Fridays only.

Financial Implications :

1). Two MOs @ 25000 per month.
2). One Pharmacist @ 15000 per month.
3). Basic Lab (including LT) : 3.0 lac .
4). Equipment : 2 lac
5). Delhi Govt will be providing the drugs and other consumables (with financial implications of around 39 lacs per year).

This centre will provide primary healthcare and cater to the core 50000 population around the centre and in addition also cover the one lac population beyond this with its outreach activities. The catchment area will be defined by the IDHS , NE District . This intervention will lead to a reduced incidence and degree of diarrhea, pneumonia and preventable (including the vaccine preventable) diseases among infants and children and improved health of mothers in the targeted slums. The proposed PPP will implement behavior change communication at household and community level to raise awareness and improve health seeking behavior and at the same time ensure availability of quality services available through the Primary Urban Health Centre being setup in Sonia Vihar.

Financial implications:12.8 lacs (NRHM Flexipool)..

2. Mamta Friendly Hospital Scheme .

A) Scheme

1. **Introduction**: Government of NCT of Delhi is committed to provide equitable, quality healthcare for its citizens especially, the maternal and child segment of its population. An important component of healthcare aimed at reducing the Maternal and Infant Mortality is provision of "Institutional Delivery" for pregnant women. In Delhi, approx. 3.2 lac deliveries take place every year and 63% (as per NFHS 3 survey report, 2005) of these are institutional deliveries with pockets of populations within the NCT of Delhi with much lower rates of institutional deliveries. The Government is trying to universalize institutional deliveries. However, there are constraints like lack of adequate Government health facilities equipped and functional to provide the comprehensive obstetric services for the mother and the newborn and overburdened Govt. hospitals
2. **Financial Package to the Private hospital:** The private hospital / private nursing home shall be given Rs. 4000/- (Rupees four thousand only) on provision of comprehensive services to pregnant woman, which includes three Antenatal check ups, Immunization with Inj. TT, investigations including ultrasound, institutional delivery whether normal or caesarian or complicated, essential new born care, birth doses of vaccines to neonate and one post natal check up. There is provision of part packages also wherein Rs. 3000/- (Rupees three thousand only) is given when institutional delivery with essential new born care, birth doses of vaccines to neonate and one post natal check up is done; Rs. 2000/- is provided to the partner private hospital when only 3 ANCs with investigations and TT immunization is done.
3. **Healthcare Services for the beneficiary:**

(a) At least three antenatal checkups with all necessary investigations including ultrasound of pregnant woman registered under the scheme.

(b) Provision of Injection TT and Iron Folic Acid Tablets to all pregnant women as per RCH Schedule.

(c) Provision of institutional delivery facilities, including emergency obstetric care to all registered pregnant women and essential new born care to the new born including administration of birth doses of vaccines to newborns.

(d) One postnatal checkup within first week of delivery but not later than 14 days

4. Eligibility Criteria for beneficiaries under the scheme

(a) The pregnant woman must belong to the BPL / SC / ST Category and should be a resident of Delhi.

(b) The pregnant woman should not be less than 19 years of age.

(c) The pregnant woman should not have more than one living child.

5. Registration of beneficiaries under the scheme:

The pregnant woman shall be enrolled under MAMTA only after production of the following documents:

(a) Proof of age: - Ration Card / School Certificate / Birth Certificate / Affidavit / any other relevant document/ clinical assessment of the attending doctor in absence of any other proof. Proof that she is a resident of Delhi. (Ration Card / Election I-Card / Any other document indicating specific address).

(b) Affidavit regarding number of living children.

(c) Registration of pregnant women will be preferably done in the first trimester (12 weeks).

(d) BPL Card / Certification of BPL Status from the SDM / Certificate of SC / ST issued by competent authority.

6. Other Benefits

a) The woman delivering under MAMTA scheme will also be entitled for cash incentive of Rs. 600/- available under Janani Suraksha Yojna

b) If woman under the MAMTA scheme delivers a girl child then the girl child will be entitled to receive benefits under 'Protection of Girl Child Scheme', a scheme of Directorate of social welfare, GNCTD.

B) STATUS

Govt. of India has already approved the scheme in the previous year and a budget of Rs. 300 lac was provided. The state cabinet also approved the scheme in 2007-08 and modalities of its implementation were worked out by a committee constituted for this purpose by Chairman, state health society, Delhi. The districts are entering into agreements with private hospitals and the scheme is likely to be operational very soon. The scheme was to be operationalized in 6 districts of Delhi in the year 2007 -08 and the target was 6000 deliveries in comprehensive service mode.

C) CONSTRAINTS

1. Expression of interest was invited from more than 400 registered nursing homes in Delhi, district wise for participation in the scheme. However, the response was lukewarm in the range of 1-2 in North east district to 8-10 in west

district. Total responses not exceeding 25 -30. This does not represent the agreements signed, which may be even lesser. Delhi Medical Association represented that the remunerations provided under the scheme to private hospitals is on lower side, especially when cesarean is to be done or blood transfusion is to be done in complicated delivery. It was conveyed that nursing homes in private sector are ready to participate if the package is revised on higher side.

2.Another constraint is the funds for publicity, which is very essential for dissemination of the scheme to the targeted population. Under the previous funding pattern (2007 -08), Rs. 300 lac was provided for 6000 deliveries meaning thereby Rs. 5000/- per delivery, out of which Rs. 4000/- was the package for nursing home and Rs. 100/- was meant for link worker/ASHA and rest for publicity/ IEC. Before the scheme is launched the publicity is absolutely essential otherwise the potential beneficiaries will be unaware about the scheme. Therefore, separate funds are required for publicity, delinked from number of deliveries under the scheme to start with.

D) PROPOSAL

Essentially, the funds are kept at the same level i.e. Rs. 300 lac. Target is revised to 5400 deliveries. As per WHO estimates upper limit for cesarean surgery is 15%. **It is proposed that for these Cesarean deliveries Rs. 5500/ - may be given to private hospital instead of Rs. 4000/- when comprehensive services are provided. In case only delivery is conducted than part of the package where cesarean is done stands revised to Rs. 4500/- instead of Rs. 3000/ - as approved by state cabinet earlier, however, these revisions will be subjected to the approvals of state cabinet once Govt. of India approves the same under NRHM.** In any case private hospital will not be given the enhanced package for more than 15% of such deliveries computed on monthly basis. **Similarly, for the deliveries where blood transfusions are provided than Rs. 500/- shall be provided extra over and above Rs. 4000/- or Rs. 3000/- as the case may be.**

For link worker/ASHA provision of Rs. 100/- shall remain the same. Transportation of pregnant woman shall be covered under emergency transportation facility for emergency obstetric care. **Rs. 40 lac (Rupees forty lac only) is proposed to be kept for IEC/publicity.** The total funds requirement shall remain the same.

E) FUNDS: Rs. 300 lac (NRHM Flexi pool).

3. Public Private Partnership for Diagnostic Services:

In Delhi, the dispensaries under Delhi government and M& CW centres/ Maternity Homes under Municipal Corporation of Delhi are the major

service providers to the population at large as far as Primary Health Care is concerned. However, one of the major lacunae in the services available in these facilities is deficient diagnostic services or non-availability of these at all. Under the mission these structures are being strengthened in terms of provision of adequate technical manpower for Mother Labs, a lab catering to a cluster of 5 – 6 Delhi Govt. Dispensaries and providing many biochemical and haematological tests. Furthermore, 50 M&CW Centres under MCD are being provisioned with Basic Labs with facilities of few basic tests to begin with. However, to cater to large number of patients attending these health facilities and in terms of availability of comprehensive tests needed, these measures might not prove adequate, thus defeating the objective of easy availability & accessibility of comprehensive and quality primary health care services to the most needy near to their abodes. Non – availability of many of these tests at primary health care facilities also leads to crowding and pressures on secondary and tertiary hospitals affecting the quality of services there and discontentment amongst the service seekers. Many a times the patients have to spend out of their pockets to avail these tests at private centres. Many vulnerable fall into debt trap due to costly tests. Therefore, under the mission a scheme of Public Private Partnership was conceptualised in year 2007 – 08 for diagnostics services and a provision of Rs. 100 lac was kept in NRHM Additionalities for the same.

Chairman, State Health Society, Delhi constituted a committee to draw a micro plan of its implementation in decentralized manner. Committee has since submitted its report and is being vetted by the concerned to chalk out the finer issues. The scheme is likely to be launched in the first quarter of 2008 –09. the funds are kept at the same level ie. Rs 100 Lac @ Rs. 10 lac for each district and Rs. 10 lac for any contingency of the scheme.

Under the scheme, the tests to be conducted at private diagnostics centres have been identified and categorized broadly in to the following categories:

- Biochemistry
- Haematological
- Culture and Serological
- Radiology

Tests under each category are also identified which shall be essentially available at the periphery. The rates at which expression of interest is to be invited are based on CGHS rates for the same. The bid process is decentralized to the cluster of dispensaries following the pattern of Mother Labs. The criteria of distance from the health facility are taken for selection of private lab, besides some quality assurance mechanisms, internal as

well as external. Monitoring and audit is also part of the operationalization of this scheme. Once the scheme is launched it will ease burden on people as well as on secondary/tertiary care hospitals.

Funds Required: Rs. 100 Lac from NRHM Flexipool.

4. Developing a Community Model for smooth implementation and monitoring of the programme in an Urban Setting .

One of the major bottlenecks in implementation of the ground / community level interventions is lack of CBOs / statutary units (akin to PRIs of rural setup) to take on the responsibility and the funds laid aside for community use. It has been decided to examine the existing CBOs and all such community based units which are being used by other departments like slum wing , UD in slums and DC office for other existing schemes.

Different Community based NGOs who have been working to make SHGs and CBOs will be involved and in coordination with the local health facility and its field workers and ASHAs , replicable community models for our slums/ JJ Clusters / resettlement colonies will be developed .

Existing urban models in other States will also be examined.

ASHA is already visualized as an important effort at communitisation and initiation of local health planning by the people for themselves. Health and nutrition days / Health and Sanitation Committees have to now gel into the local peripheral units inseperably.

Once a suitable , replicable model is developed , it will be formalized for state wide application.

This effort will be taken up at state level and in each district after selecting a target slum/ resettlement colony. For this a small fund of 2 lac per district and at State level has been kept.

BUDGETARY REQUIREMENTS:

@ Rs 2 lacs per district X 9 + State level (Rs 2 lacs) = **Rs 20 lacs (NRHM FLEXI)**

5. Setting Up of ROGI KALYAN SAMITIS :

Setting up of Rogi Kalyan Samitis is another vital activity to ensure community involvement and monitoring of local health initiatives. Setting up of RKS for hospital / Maternity homes / Primary health facilities has to be completed over next three years.

GOI guidelines are available . They have to be adapted to our existing conditions and in harmony with existing State policies and political will.

Once the guidelines for the State have been formalized , RKS will be institutionalized in selected facilities in 2008-09. Provision of 4 lacs per district has been sought for this purpose and 2 lacs has been sought at the State level to hold deliberations and sensitization workshops for the policy makers and stakeholders.

Financial Implications : 4 lacs x 9 + 2 = Rs 38 lacs (NRHM FLEXI)

6. Janani Suraksha Yojana

A scheme for pregnant women from BPL/SC/ST Famlies to help them in accessing Govt / accredited Pvt Facilities for childbirth.The scheme provides a Cash incentive for the lady and the link worker facilitating this access. Details in RCH Plan.

7. Referral Chain & Care of the Vulnerable:

Existence of multiple agencies delivering health at primary, secondary and tertiary level without any defined uniform system of population linkages and referral is another big challenge in Delhi faced by the health sector. This is further compounded by the paucity of functional secondary care units .Lack of defined referral linkages results in certain units becoming overburdened and others which have been languishining despite having basic infrastructure continuing to function suboptimally and not making any effort to shoulder the load of patients generated in their catchment area.

STRATEGIC INTERVENTION:

1. The Mission Plan envisages building a system of population assignations to all primary healthcare facilities. Linking these facilities to the identified specific secondary care units – FRUs , Maternity homes , colony hospitals , district hospitals . These units in turn will be linked with the Tertiary care units.
2. The population in the catchment will be identified and given health cards. The health cards will have the name of the facility for their access , assured services which shall be available there and the secondary care unit which have been identified to cater to their needs.
3. Each anganwadi shall have the name of the attatched health centre / ASHA displayed. Similarly each primary health facility shall have the name of the anganwadi centres below and secondary care units / Maternity homes above

attatched to it displayed in the PUHC. It will also have information about the MAMTA Friendly hospitals / Pvt accredited laboratory etc.

4. Each secondary care unit / FRU shall have the names of the Primary healthcare facilities displayed on it.

Family health Card and booklet will be uniform for all health facilities. The 'family health book' will be designed to include dedicated pages for each member in the family for necessary entries by health functionaries whenever health services are sought. With ASHA in position each 400 houses cluster will have an ID number and it will be easy to attatch these ASHA units . ASHA will play a crucial role in helping the families understand the importance of keeping & using the health book safely.

Since the exercise is new & resource & time intensive, the state plans to introduce it in selected habitations of two districts in the first year one in North East & the other in East. On the success & experience gaining, other districts are planned for inclusion in next years plan.

The advantage of this scheme will be the following:

a. Patients can seek complementary & referral service from any of the health facilities within the district, irrespective of the agency and records will be maintained in the family health book.
b. Follow-up and tracking (for drop-outs in ANC, immunization, post natal care, etc) will be easy.
c. Morbidity and mortality for impact analysis (& subsequent policy analysis) will be possible in this group.
d. Hospitals will be providing priority attention to such patients coming through the referring PUHC along with this family health book.
e. Cross referral amongst PUHCs will be possible irrespective of the agencies.
f. Priority and subsidized care (to be met by the state through NRHM Funds) for private diagnostic services and nursing homes will be possible and will be well documented.
g. This booklet will be developed through incorporating feedbacks and inputs from other states where it is being followed and is planned to include educative information on all the government welfare schemes to the weaker section of the society, scheme of benefit to the girl child, small family benefits, list of facilities within the districts wherefrom the health and other services can be sourced.

For finalising the modalities, interactions with stakeholders at different care level, designing the software, booklets, linkages displays, carrying out ground work at the State level a provision of 10 lac is sought.

For actual implementation -- systematic listing / codification of population , publicizing the activity , production and issuing Family health booklets , linkage displays at various levels and all other activities related with execution of this exercise 20 lacs is sought per district for two districts . The activity was approved in PIP 2007-08.

Total Budgetary requirements: Rs 10.00 lacs from NRHM Flexipool.

7. Risk Pooling:

Due to the suboptimal functioning of primary healthcare facilities and paucity of functional secondary care structures & overcrowded tertiary care units ,poor patients are many a times forced to seek healthcare from private sector even when they cannot afford it. Sometimes, they are even forced to seek services from 'quacks' jeopardizing their own and family health in the process. The 'out of pocket' spending for health care in private sector by this most vulnerable population leads to further aggravation in poverty in this group with vicious cycle of ill health negating the Millennium Development Goals in the process.

Health insurance for this segment is seems an immediate source of relief to this vulnerable segment.As a beginning, a selected percentage of Antodaya families as listed within the BPLs are planned to be covered through group insurance for selected medical illnesses and pregnancy related services to the woman and children. This step is considered as critical from equity consideration as well as from the perspective of achievement of millennium development goal of improved survival in the most vulnerable population.

About one lac families in Delhi belong to this Antodaya group and considering insurance premium at the rate of Rs. 300/- per family a total of Rs. 3.00 crore per year will be required for this. The scheme will need policy clearance & technical formalizations and a basic ground level system on which the scheme will be mounted. For conceptualizing & undertaking the required ground work a provision of 10 lac is sought . the activity was cleared in PIP 2007-08 and funds are available .

Financial Implications : 10 lacs from NRHM Flexipool.

9. GIS MAPPING of existing health infrastructure , populations , and referral Linkages :

It is the Primary level care that in itself can take care of most of the morbidities & mortalities, strengthening the existing facilities / structures & adding new where required thus becomes imperative .

Mapping of Health Facilities and Populations with defined referral linkages for healthcare delivery / services in terms of Primary / Secondary / Tertiary Healthcare is not only a vital activity in current scheme of things but a mandatory activity without which optimization and accountability in delivery of healthcare cannot be achieved.

GIS (Geographical Information System) Mapping : GIS Mapping of the available information gives an insight and spatial clarity for planning / prioritizing area specific interventions.

Mapping has two components -- **Micro and Macro Mapping** :

The Micromap component which becomes vital for activities at the Primary Healthcare facility level (detailing of the 50,000 population attatched to the centre)-- for functioning of the ANM , ASHA , Anganwadi workers and in this each house acquires an address / individuals with names and descriptions and their specific health needs . It is to be done primarily by the ANMs supervised by the Medical Officer of the facility. They may be assisted in this by ASHAs and Anganwadi Workers.

The Macromap Component – At or above the 50,000 population Unit level .This is placement of Health facilities and broad population segments on a map. This will include :

I. Mapping of Health Facilities

1. Different categories of Health Facilities -- providing Primary Health care , Secondary Health care and Tertiary / Superspeciality Healthcare .
2. Agencies – The above mentioned categories should include Mapping of Health facilities of different agencies , including Delhi Govt / MCD & IPPVIII / NDMC / Armed Forces / ESI / CGHS / Pvt Institutions / NGOs.

II . Mapping of Populations with special focus on vulnerable populations

- Slums
- JJ Clusters

- Unauthorised Colonies.
- Villages

III. Defining Health Facility / Population Linkages :

Ultimate aim is to optimize the service delivery . This is possible with defining of definite catchment areas for each facility from where a determined healthcare / service has to flow to the community.
a).Linkages of populations to the anganwadis and each anganwadi to a Health centre.
b). Linkage of population to a Primary health unit and of a Primary health unit to the secondary care unit.
c).Linkage of the Secondary Care Units to the Tertiary care and Superspeciality Hospitals .

Phases of implementation:

Mapping of existing Health Facilities / Populations will be the first phase activity and the Defining of Referral Linkages to be the second phase activity as it will evolve with Facility Surveys / Baseline surveys / strengthening of existing units and development of new ones .Therefore phase one can be accomplished early although phase two will take some time.

A Committee was constituted for GIS Mapping of the existing health facilities and populations with special focus on slums , J J Clusters , unauthorized colonies , resettlement colonies and villages . The Committee will complete the first phase of Mapping exercise and will make it available for use by health functionaries by March end 2008.The activity and a provision of 20 lacs was approved by GOI in 2007-08. No additional funds are sought.

Financial Implications : 20 lacs from NRHM Flexipool.

Activity Frame work family health cards / Books:

Goal	Objective	Strategy	Activities	Sub activities(timeline)	Outcome indicators	Means Verification
Decreased IMR,MMR,TFR(Improved Survival)	Reaching the Vulnerable with effective services	Population Linkages with Dedicated facilities	Creating a Core Group for technical & implementation oversight, finalize Health Book & Uniform ANM register contents, Mapping of Vulnerable populations (BPL,SC ,STs) living in slums	Field Survey(4 months) GIS (concurrent 4 months) mapping Mapping facilities(4 months concurrently) Issuing family health book with ID Number(designing contents ,finalizing mode of issue, printing, Registration of families	Monthly increase in Number of Users visiting with Health Book No. of missed beneficiaries tracked (% Increase over months) % increase in ANC, Immunisation, referrals % increase in SC/BPL women seeking services from Linked Private facilities	Data /records facilities
		BCC for service seeking	Designing & then disseminating info on benefit of health book (local munadi), Informing families should be visiting facility only with the book Safe storage of book			
		Service/system of delivery strengthening	Appointing one dedicated data person for registration & issue at each linked PUHC Creating a web page for recording as per the MIS of GOI performance(service sought) of various programmes. Tracking missed beneficiaries/de-faulters			

Chapter 15

CAPACITY BUILDING / TRAININGS

Training is the single most important input in any process to improve the quality of health services.

Having acknowledged the fact it must be ensured that:

- Staff of all categories undergo periodic trainings
- The trainings provided are relevant and contextual to the health worker being trained.
- Training is provided at the right place, at the right time and by the right person equipped with the right knowledge and training skills.
- Effect of training in enhancing the work capacity and quality is evaluated.

To achieve the abovementioned goal, the training / capacity building component in health care delivery system will have to be accorded high priority and dedicated time at all levels. Accordingly due emphasis has been given to the Capacity building component in the District / State PIP.

TASKS identified:

A). Building Data base of the potential trainees:

Individuals to be trained in all categories from all agencies ie. GNCTD, MCD, ICDS, NGOs and the database so formed has to be periodically updated. This will include:

Those needing training at State Level
a). Programme Officers .
b). Trainers.
c). Senior Health Functionaries of Health and other convergent sectors
d). District Commisioners / other Civil Servants .
e). Community representatives , NGOs .

:

Those at District Level
a). Link workers on pattern of ASHA Scheme.
b). Anganwadi Workers & helpers .
c). Traditional Birth attendants.

d). ANMs
e). Pharmacists.
f). Lab assistents / Technicians.
g). PHNs
h). Staff Nurses
i). Nursing orderlies
j)..Safai Karamcharis
k). Medical Officers
l).NGO functionaries.
m). Community Representatives .

B). Training Venues / Facilities

- Identifying and linking Training Venues / Facilities already present in the State / District. (belonging to any of the above mentioned agencies)

- Facilitating presence of one District level furnished training venue equipped equipment / aids required for trainings .and basic housekeeping staff

C). Building Database of and linkages with Resource persons/ Departments / Institutions which can help in imparting these trainings.

D). Making available training modules relevant to each category of trainees

Examining, reviewing, updating the existing one and designing new wherever required.

E). Devising a functional mechanism for assessing impact of Training and implementing the same .

Existing Infrastructure: State Level.

I). Training Officers:

1).At present there is dedicated Staff in State Training Cell for Family Welfare which looks after trainings related to Reproductive and Child Healthcare .
2).There is dedicated staff in Directorate of Health Services looking after CME / other trainings.
3).Trainings relevant to National Programmes being organized from time to time by respective Programme Officers.
4) A dedicated training coordinator has been appointed at the state level under DSHM who would be looking after the trainings at the state level.

II).Fully equipped training venues;

1). DFW TC needs renovation and furniture which is proposed in this PIP.
2). DHS Training venue is being strengthened from the State Plan Funds.
3). Regarding the building/ strengthening of the state / district level has already been proposed .There is no adequately spaced and well equipped training venue / conference hall / Library for in-service doctors. One such facility which will also have teleconferencing facility is proposed. State will provide the venue and renovations, Furniture / AV aids / Library books / E resource /required staff is sought from the mission . In this PIP Rs 50 lacs are proposed for this activity to have a DSHM conference hall / library / training centre in the state.

Existing Infrastructure: District Level

1).Dedicated Training Officer: Nil.
The already overburdened administrative staff takes care of the sporadic Training activities coming from National / State level.

2).District Level Training Venues. Nil
At present there are no District Level Training Venues and for trainings /workshops held at the district level alternatives have to be hired or borrowed from other agencies in the district.

Proposed activities for the Year 2008-09.

State Level:

1. Setting up of Standing Committee for Trainings to review the progress made at the State and District level.
2. Strengthening the state level training Units.
3. Training Activities. .
4. Establishing fully equipped state level Conference & lecture hall / Library / E resource facility.
5. State officials will also be visiting to other well performing states for evidence based learning& sharing of experience for concurrent /future policy & programmatic course corrections as a part of Training/Capacity building efforts of the State.

District Level:
1). Provision of a District Level Training Venue as the number of intra district trainings is going to increase markedly.
2). Recruitment of District Training Officer dedicated to looking after the trainings Who will be responsible for the following:
- Identify all categories of staff requiring trainings from different stakeholder agencies with their numbers.

- Prepare a database on the trainings needed , resource persons available / need to be trained at the state level / NGOs, Pvt Institutions in the districts which can help in training activities.
- Prepare a calendar of training activities of functionaries at all level and submit the same with financial implications (budget requirement) as a part of District Health Action Plan.
- District level implementation of the activities with the help and in co-ordination with the State Training Units.
- Periodical upgradation of data.
- Coordination with other health agencies at the district level.
- Preparation of reports and timely submission.
- Upkeep and functioning of the district level Training Venue

3). Recruitment of a steno and data entry operator to support him.

4). Recruitment of class IV for the training centre. Recruitment of four class IV for the training centre.

5). Training Activities

A detailed activity schedule with financial implications follows.

The State Level strengthening and provision of district level Venues will be completed within five months of sanction of funds:

S.No	Activity	Cost / Unit	No. of Units	Expenditure for 2008-09	Funds from
	Activity	**One Time**	**Recurring**	**Total**	
A.	**State Conference hall/library/ E-resource**	35lacs	15lacs	50 lacs	NRHM flexi
B	**District**				
1	**a) Rent** *(if no space available)		1,20,000x12x7	100.8 lacs	NRHM flexi
2	**b) Minor Repairs**/Civil works/Maintenance if Govt. Space is available				"
	i) Air Conditioner	25000x4		1lakh	"
3	**c) Furniture and Sound System**	2lacsx8	2000x12x9	18.16lacs	"
	d) Equipment				"
	i)Overhead Projector	40,000x1		0.4lacs	
	ii)LCD Player with Screen				
	iii)TV				

	iv)Computer with printer and Fax	60,000x8		4.8 lacs	
	v)Handy cam	25000x1		0.25 lacs	
5	**e)Staff**				NRHM flexi
	i) District Training Officer		20000x12x9	21.6lacs	
	ii) Data Entry Operator		8000x12x9	8.64lacs	
	iii) Class IV & NO to look after the venue(4 per District)		4000x4x12x9	17.28 lacs	
	TOTAL	57.45 lacs	165.48 lacs	**222.93 lacs**	**Total 222.93 (NRHM flexi)**

*** The rent amount for hiring space has been proposed as per the rates of commercial properties, if you approve.**

3.	**TRAINING ACTIVITIES at STATE LEVEL**					**Funds from**
		Expenditure for unit	**No. of units**	**Expenditure for 2007-08**	**Expenditure for 2008-09.**	
	Training of District Teams for Planning and Implementation of DHAPs 5 days / batch of 50	**5 lacs**	**2**	**10.0 lacs**	**10.0 lacs**	**NRHM Flexipool**
	Training of District Teams for planning and implementation of DHAPS one day / batch of 20	**25000**	**5**	**125000**	**1.25**	**NRHM Flexipool**
	Training of District Finance Officers Two days / batch of 20	**25000**	**2**	**50000**	**50000**	**NRHM Flexipool**
	Training/ Workshops of Sr. Healthcare Functionaries on policy matters ie. in HRM/ PPPs etc. 2 Batches of 50 for 1	**60000**	**4**	**2,40,000**	**2.4 lacs**	**NRHM Flexipool**

	day each.					
	Management training for medical Officers(a batch of 20 eachx10 batches x one day each)	**22400**	**10**	**-**	**2.24 lacs**	**NRHM Flexipool**
	Workshop on Communitization (2batch of 50 each for one day)	**77000**	**2**	**-**	**1.54 lacs**	**NRHM flexipool**
	Workshop on Sharing Best Practices**(2batches of 50 each for one day)**	**77000**	**2**	**-**	**1.54 lacs**	**NRHM Flexi**
	Additional Trainings for Officers/individuals involved in NRHM at various levels				**10 lacs**	**NRHM flexi**
	Training of Master Trainers ASHAs				**1.7lacs**	**State funds**
	Training of Trainer For ASHAs				**8.11lacs**	**State Funds**
	Trainings for NGOs			**5.0 lacs**	**5.0 lacs**	**NRHM Flexipool**
	Stationary				**1.0 lacs**	**NRHM Flexi pool**
	Total				**45.28 lacs**	**NRHM Flexi**

B. Trainings at the District Level						
	Training of Master Trainers for AWWs / helpers.	**10000 per district**	**9**	**90000**	**90000**	**NRHM Flexi pool**
	Community representatives / Civil Servants 20 x 5 batches	**50000 per district**	**9**	**450000**	**4.5 lacs**	**NRHM Flexi pool**
	a).IPC Training for MOs / PHNs/ ANMs / ASHAs/ AWWs	**Details in BCC Component**		**12.14 lacs**	**12.14lacs**	**NRHM Flexi**
	b). Inventory & Stock keeping (PM) **A batch of 20 x one day**	**13000 per Tr.**	**X 9**	**54000**	**1.17 lacs**	**NRHM Flexi**
	Introduction of Programmes(MOs) **Two batches of 25 each x1day**	**38400per district**	**X9**	**-**	**3.46lacs**	**NRHM Flexi**
	Introduction of Programmes(PMWs) **Six batches of 25 eachx1 day**	**99000**	**X9**	**-**	**8.91 lacs**	**NRHM Flexi**
	Management trainings (PMWs)	**66000per district**	**X9**		**5.94 lacs**	**NRHM Flexi**

	Four batches of 25 eachX1 day					
	Sensitization on 'Gender Issues in health Care'(MOs) **Three batches of 25 eachx1 day**	**57600per district**	**X9**		**5.18 lacs**	**NRHM Flexi**
	Sensitization on 'Gender Issues in health Care'(PMWs) **Six batches of 25 eachx1 day**	**99000 per district**	**X9**		**8.91lacs**	**NRHM Flexi**
	ASHAs					
	a).Old ASHA (Induction+ Refresher)	**5636 per ASHA**	2500 in 2007-08	**127.32 lacs**	**138 lacs**	**State Funds**
	b).New ASHA (Induction Trainings)	**3776 per ASHA**	3000 in 2007-08	**34.67 lacs**	**200.94lacs**	**State Funds**
	Total				**390.05 lacs**	

NP: New training norms have been used in budgeting trainings as per the Govt of India Norms.

Total Budget required for Capacity Building Component:

ACTIVITY	Expenditure 2007-08	Funds from
For infrastructure Strengthening (rental , Equipment ,maintenance ,staff)	222.93 lacs	NRHM Flexi pool
For training activities	86.58 lacs 102.39 Lacs 348.75 Lacs	NRHM Flexi pool RCH Flexi pool State Funds
Total Budget required	**309.51 lacs** **102.38lacs** **348.75lacs**	**NRHM Component** **RCH Component** **STATE Component**

Chapter 16

BEHAVIOUR CHANGE COMMUNICATION

There has to be **a paradigm shift** from the conventional IEC Planning wherein a myriad of messages is prepared and distributed for dissemination in various forms with no post activity evaluation to the disease / issue specific ,behaviour change sought in the target group with a mandatory post activity evaluation.

This BCC approach will have following characteristics:
1). It will be behaviour specific .
2). There will be active community participation in directing the design of strategy.
3). The endpoint being the desired change in the selected behaviour to be assessed with parameters which are objectively quantifiable and amenable to documentation.

PLAN FOR STATE BCC BUREAU:

The BCC activity of the NRHM in the State of Delhi through the convergence mode needs a very practical approach keeping in mind the uniqueness of the city-state with regard to the target audience spread across different economic and social strata distinctly different in their health seeking behaviour. Although availability of service is considered the best BCC, but it needs to be seen that the target audience does not get influenced beyond recovery by the massive product campaign prevalent in the society. Comparing the BCC implementing structure of Delhi with that of other states the following should be the guiding lights of the further action in this regard:

- The BCC bureau under the Delhi State Health Mission (DSHM) to be set up for making strategy in the light of NRHM BCC policy, implementation, feed back monitoring and capacity building of the different agents in the health structure.

- Setting up a resource and training centre, this will observe the changes in the social behaviour of people and accordingly keep developing the BCC strategy bringing in newer components in it with the help of the experts of

social science and communication. Also the newer techniques of different existing media should be brought into implementation to ensure presence of our target in the ambit of the BCC of DELHI STATE HEALTH MISSION.

- As inter personal communication is the most preferred way to take the message into minds of the target audience, it is required to conduct regular development of the communication skills of the change agents with training on the use of different folk cultural tools and other cultural and behavioural science methods to deal with the population who have migrated from a rural setting to the ocean of multicultural waves in Delhi.

- As the NRHM structures ensures the scope for creative and innovative initiatives, it is necessary to provide more amount of intra-organisation communication, which will work as the feedback of our activity and help in formulating the following steps.

- Regarding feedback analysis it is required to recruit professional agencies for collection and scientific analysis.

- For the success of the programmme it is required to unify the message and the communication strategy to be implemented through medical officers posted in health facilities and hospitals, ANMs, field workers and most importantly ASHA. Besides, the existing outdoor, print and electronic media should be used in the most effective manner ensuring space for accommodating interactive media through different innovations, sensitive to the local need.

For implementation of the above the following set up may be considered for approval:

STATE LEVEL

State level BCC Committee: This committee will consist of representative of various related departments and official agencies, CDMOs, NGO, experts on communication, State BCC Manager under the Chairmanship of the Mission Director.

BCC Bureau -Personnel:

I

- **Graphic Designer** -1-Rs.12,000/- per month consolidated
- **Media assistant** -1-Rs.12,000/- per month consolidated

BCC Bureau- Infrastructure

- **Room for keeping IEC materials/equipments on Rent**- Rs. 10,000/- per month- Rs.1,20,000/- p.a.
- **Conference-cum-training room**

  With audio-visual facilities- Rs. 15 lac with equipments like interactive PA system, film and slide projection system

- **Mobile video projection system**- Rs.1 lac
- **Furniture** (incl. that of BCC store room and training room)- 3 lac
- **Transportation cost** (On hire basis) (Incl. daily official travel, exhibitions and distribution of IEC materials etc.)- Rs. 10,000/-p.m. i.e Rs.1.2 lac p.a.
- **Fax and photocopier** machine- Rs. 2 lac
- **Computer with scanner, printer**-Rs.2 lac
- **Video and still digital camera** (1 each)- Rs. 1 lac
- **Contingency**-Rs.1 lac

Grand total- Rs.30,28,000/- (Rs. Thirty Three Lac Twenty Eight Thousand Only) for the first year

The recurring expenditure- Rent+ Transportation+Misc.+salary = Rs.6,28000/- (Rs. Six Lac Twenty Eight Thousand Only)

The planners at the district and state level will be required to :

1). Select few desired behaviour changes vital to achievements of targets / or those which can improve the Health indicators causing concern.

2). Identify the target audience that needs to be addressed for these changes.

3). Find out key factors which can lead to this behaviour change . For this formative research might be needed which can be undertaken locally or at the State Level . This survey will also provide the baseline against which the success of the employed BCC strategy can later be measured.

4). Formulate key messages. Accordingly choice of different media / communicators will emerge.

5).Ensure Capacity building / training of the staff to be involved in BCC activities

6).Preparation / large scale production / dissemination of the material. The process of designing will be undertaken at the state level with inputs from District officers.

7). Regular monitoring and evaluation of the BCC Activities and the outcomes.

Components of the BCC Plan :

1. Capacity building at the district level .
2. Chosen BCC Specific Plan component ..
3. Capacity Building of field staff
4. Background IEC Material .
5. Monitoring and Evaluation Component.

Infrastructural Capacity Building

ACTIVITY	Expenditure per unit	Units	Expenditure 2008-09	Expenditure 2009-10	Funds from
State Bureau		1	30.28	6.28	NRHM Flexi
Districts BCC Units					
Staff : District BCC Officer . Data entry	22500/- per month.x12 8000/- per month x 12	9 9	24.30 8.64	24.30 8.64	NRHM Flexi
Equipment Computer with printer with fax	60000/-	9	5.40	xxxxxxx	NRHM Flexi
Mobillty	600 /- per day x 10 days per month x 12	9	6.48	6.48	NRHM Flexi
	Total		75.1	45.7	NRHM Flexi

Specific Behaviour Change Strategies chosen (eg).:

1.To save the girl child
2.To increase acceptance of spacing methods

1. Behavior change needed: to make the girls as precious to parents as boys.
Target audience: Young parents and parents to be Mother in laws and father in laws
2. Behavior change needed :.Increase the usage of contraceptive methods for family planning
Target Audience: Parents having more than one child

Behavior change needed	**Key Factors that will influence this change**	**BCC Activities**	**To be done by**	**Process Indicator**	**Output Indicator**	**Outcome Indicator / Impact Indicator**	**Budget for 2008-09.**
1. No to sex selection before birth. 2. No to female foeticide. 3 . E q u a l importance to female and male child for nutrition / health s e e k i n g b e h a v i o u r /	1.Belief that only boys take care of the parents in old age 2. Concept that Girls are a liability. 3. Ability to withstand pressure from in laws / community . 4. Fear of law as female foeticide	1. IPC by the ASHAs. 2. FGDs / Talks by ANMs/ PHNs/MOs. 4. . Essay painting Competition in schools on the relevant theme.. 5. Stalls in RCH Camps / Health Melas	1. ASHAs 2. ANMs 3. PHNs 4. MOs To be organized by the BCC officer .	Number of ASHAs / ANMs / PHNs/ MOs trained in IPC. Number of ANMs / PHNs trained for FGDs / PA Techniques. Number of such competitions held.	1. How many parents still believe that only girls can take care. 2. How many parents feel confident of resisting pressure of parents / relatives / with in. 3. How many parents / in laws are aware of the punishment for indulging in sex	Increase in Male: Female Sex Ratio at birth and to an extent 0-6 child ratio in the area under intervention.. Decrease in school drop out of female children. Increased coverage for female child	**Community & folk Media** (District Level) a. FGDs- (1 in 2 months) 6 X 9 X 1000/-= 54000/- b. No of Essay / Painting/ Quiz Competitions (1 in 6 months) 2 X 9 X 5000/-=90000 c) Role plays 1 in 2 months 6 X 9X 500/- = 27,000/- d. No. of Street plays – 10X 9 X 3000=2,70,000/- **Total – Rs 441000/-** **Electronic Media** a) Cable TV Publicity –

education..	is a crime . 5.Awareness of schemes for the girl child.	. 6. Radio jingles / TV Spots on the above themes. Articles / stories in National Dailies / magazines.	State Level	Number of stalls hosted in a given period of time. Number / quality of ads / writeups in print media over a given period of time.	selection and female foeticide. 4. How many parents are aware of the different schemes for girl child. 5. How many middle class / upper middle class women feel that sex selection is a crime and they will never indulge in it / or condone anyone else indulging in it.	vaccination.	20,000 X 9 = **1,80,000/-** **Others** a) Haat – in weekly markets Honorarium to two deputed staff @ 200/- per person Decoration @ 500/- per haat Total – 25 days X 900 = 22500 X 9 districts = **202500/-**
							823500/-
2. .Plan their family using temporary methods of contraception	1.Hesitation & fear of side effects of spacing methods 2. lack of awareness regarding a. Methods available b. service providers	1. IPC by the ASHAs. 2. FGDs / Health Talks by ANMs/ PHNs/MOs. 4. Role plays , Nukkar Natak	1. ASHAs 2. Dais 3. ANMs 4. PHNs 5. MOs Designed and printed at State Level after inputs from the district BCC officers / Field research.	Number of ASHAs / ANMs / PHNs/ MOs trained in IPC. Number of ANMs / PHNs trained for FGDs / PA Techniques. .	1.Percentage of people using spacing methods 2.Consumption patron of available contraception	Decrease in birth rate. especially 2nd and 3rd child birth	**Community & Folk Media (District Level)** a. FGDs- (1 in 2 months) 6 X 9 X 1000/-= 54000/- b. No of Essay / Painting/ Quiz Competitions (1 in 6 months) 2 X 9 X 5000/-=90000 c) Role plays 1 in 2 months 6 X 9X 500/- = 27,000/- d. No. of Street plays – 10X 9 X 3000=2,70,000/- b) Health Talks- 50 X 400/- =20000

							Total –461000/- **Electronic Media** a) Cable TV Publicity – 20,000 X 9 = **1,80,000/-** **Others** a) Haat – in weekly markets Honorarium to two deputed staff @ 200/- per person Decoration @ 500/- per haat Total – 25 days X 900 = 22500 X 9 districts = **202500/-** **8,43,500/-**
IEC Activities for ASHA & Mamta Scheme							
Utilizing Govt. Schemes and services for improving the health status of their family	a. Accepting the change in health delivery system with an open mind	Print Media – Brochures - b) Leaflets - c) Exhibition panels / roll up spring balance d) Newspaper Ads Outdoor Activities - Hoardings -Inside Metro panels c) Metro panel at entry & exit of metro station	Designed and printed at State Level after inputs from the district BCC officers / Field research	Brochures / hoardings / leaflets etc. designed to be assessed in terms of content and quality of portrayal / dissemination / painted sites / installation in terms of placement.	1.No of beneficiaries of Mamta scheme 2 No of OPD registry cases and institutional delivery. 3 No of immunization given	Increase in no of beneficiaries and decrease in morbidity due to diseases	**Print Media** a) Brochures - Rs.9 Lac b) Leaflets - Rs.9 Lac c) Exhibition panels / roll up spring balance (sets of 5 panels 1 set for each district) Rs.90,000 d) Newspaper Ads – 20 lacs **Outdoor Media** a. Hoardings . b) Inside Metro panels c) Metro panel at entry & exit

		Electronic Media- a. Cable TV Publicity b) Radio Ads c) TV Ads					of metro station - **Total – 9500000** **Electronic Media** a) Cable TV Publicity – r Radio Ads = c) TV Ads **Total – 100 LACS**
						Total	**100 LACS**

4. .Monitoring and evaluation to be carried out by the State BCC / District BCC officer . Staff and vehicle support already budgeted.

Funds for development and printing of monitoring formats .= 0.50 lac
Funds for Surveys / Formative research . = 4.5 lac

Total Budget For Behaviour Change Communication Component

	Activity	**State/District**	**Expenditure 2008-09**	**Expenditure 2009-10**	**Funds from**
a).	Strengthening Infrastructural Component : (Staff / Equipment /Vehicle.)	State+District	75.1 lacs	45.7lacs	NRHM Flexipool
b).	Strategy Specific Plan Budget: PNDT	District	91500 x 9	Xxxxx	PNDT (available) RCH
c).	Save the girl Child	District	93722x9	93722x9	(BCC specific campaigns to be supported from the RCH BCC budget .)
d.	Asha / Mamta	District	10,30,000x9	10,30,000x9	NRHM
e	Asha / Mamta	State	90	90	NRHM
f).	Monitoring , evaluation & formative research	State	5	5	NRHM
Total BCC Component Budget:			**a). from NRHM** **b).from RCH**	**Rs 26280000/-** **Rs 1667000/-**	

Chapter 17

MANAGEMENT INFORMATION SYSTEM:

Managing Information System at the peripheral health facility, at the district level and State level is receiving due emphasis. Under the Mission it is envisaged to simplify and streamline collection, transmission , collation and compilation of data coming from the field . This collected data has to be interpretation friendly and it has to be examined and evaluated by the empowered officials to institute online rectification .

The main tasks are :

1. To adapt the existing formats and make them meaningful , user friendly.
2. To make them available for use .
3. Train the staff deputed to collect and collate the data and transmit it within specified timeline.
4. Put in place a system of periodical review at different levels.

Software and Hardware required for the MIS: Computerization of the potential PUHCs ,ASHA Units and Maternity homes and provision of CDEO for these units has been sought. In the year 2007-08, 60 Computers and 60 CDEOs were approved and West District and Central district have been taken for this computerization. In the current PIP further demand as per districts requirements is being projected. The district and their peripheral units (irrespective of the agencies in the districts) are planned to be linked through a common server right up to the state level **over the next three years in a phased manner.** Expertise of the IT departments of various agencies in the State will be utilized for technical support in this regard.

Today recording and analysis system at the primary health care level is a big challenge due to the deficiency of dedicated and trained staff. Once the CDEOs are in place, the MO has to clearly give the data especially the diagnosis / t/t which can be recorded by the CDEO.

It is assumed that once such a system is in place, the quality and coverage's of primary and secondary health care will show a definite improvement .

Status : Funds released to the West and Central Districts.

For the year 2008-09 Computers / CDEO requirement is as follows:

S.No.	District	Expenditure for 2008-09					Remarks
		Computors with printer with internet facility	C D E Os	Expenditure		Total (Lacs)	
				One Time	Recurrent Exp*		
1.	Northwest	32	32	0.6 x 32 = 19.20	32 X 0.08 x 8= 20.48	39.68 lacs	
2.	North	11	11	0.6 x 11 = 6.6	11 X 0.08 x 8= 7.04	13.64	
3.	West	Already provided.	32	*0.6 x 32	32 X 0.08 x 12= 30.72	30.72	*already released
4.	Southwest	13	13	0.6 x 13 = 7.8	13 X 0.08 x 8 = 8.32	16.12	
5.	South	29	29	0.6 x 29 = 17.40	29 X 0.08 x 8 = 18.56	35.96	
6.	East	14	14	0.6 x 14= 8.4	14 X 0.08 x 8 = 8.96	17.36	
7.	Northeast	10	10	0.6 x 10 = 6.0	10 X 0.08 x 8 = 6.4	12.4	
8.	Central	28	28	*0.6 x 28	28 X 0.08 x 12 = 26.88	26.88	*already released
9.	New Delhi						
10.	STATE MIS	2	2	0.6 x 2 = 1.2	2 X 0.08 x 8 = 1.28	2.48	
	TOTAL		142			195.24	

*Districts have already been given funds for computers and accessories.

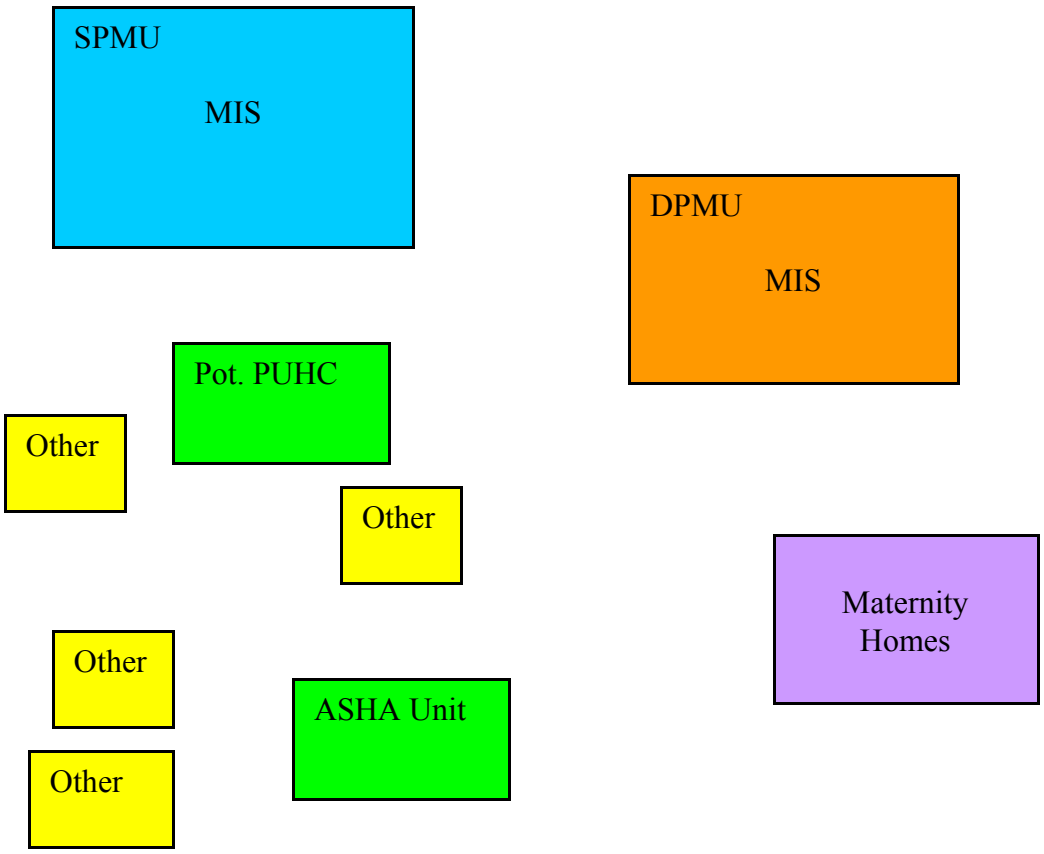
** Budgeting for CDEO & Computer for Maternity Homes is budgeted under Maternity Homes strengthening.

***One Time Exp of 60.000/- includes Computor with accessories , AMC, Internet x 12 mths , Stationary – Formats .

**8* Additional funds to the tune of 2 lacs for technical support on this for looking after the computerized facilities and development of the formats

Uniform , easy to carry in the field & Simple to use ANMs registers incorporating GoI MIS – to be used by all ANMs irrespective of their agency/ administrative authority. This is necessitated due to the multiplicity of agencies & need for them to be functionally unified. For preparation and dissemination of these registers a provision of 10 lacs is sought.

In the current year 2008-09 , the potential PUHCs / ASHA Units and Maternity homes being taken up for strengthening are going to be linked up with the DPMU with the help computer and CDEO thru internet facility.



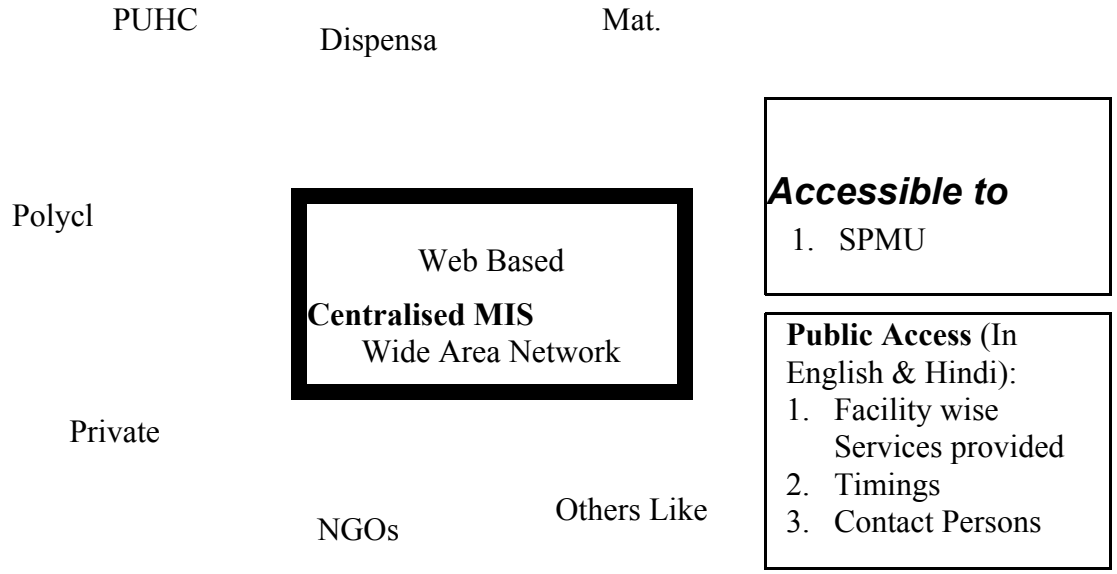
Ultimately a more comprehensive MIS , over next two years is visualized.

Plan for creation of central MIS in Delhi

Background- Delhi has an estimated population of 1.8 Crores. The primary health services to this population are being provided by various agencies working independently like Delhi govt, MCD, NDMC, NGOs, private establishments , ESI Railways , Defence , DVB , DJB etc. The presence of multiple agencies leads to a situation whereby some areas have more than one facility and others being inadequately covered. Another problem is that

there is no common central database available, which will provide information on aspects like services provided, outputs, mortality and morbidity figures etc. Currently most of this information is collected from surveys, which by itself is not adequate for a variety of reasons. In the absence of readily available data, monitoring of services also remains inadequate and incomplete.

Therefore under the state health mission it is planned to develop a central MIS, which will act as a central data repository with access to all. The schematic plan for such a MIS is given below



Expected Outputs:

1. State / District/ Zone wise reporting
2. Periodic activity report
3. Work plans for various entities like districts/ Health Facilities.
4. Status of Work plan
5. Expenditure Status
6. Manpower availability
7. A Portal will be provided for 2 way formal communication

The Central database shall be hosted on dedicated servers. If the state develops data centers as part of SWAN, then the same may also be used. The access shall be provided to all users. For access control a Technical committee shall be responsible. Under the plan a number of web-based formats shall be available for each facility/entity and the user shall directly upload information. Editing facility shall be restricted.

After the concept plan is approved the following next steps are proposed –

1. Notification of a committee by SPMU
2. Assessment of the current MIS/reporting system already available in various establishments. The stocktaking shall also include hardware/software/manpower available in various entities
3. Preparation of bid document with technical details.
4. Hiring of agency through open tendering as per SPMU rules
5. Preparation of software and its testing
6. Launch of the scheme

Time frame – It is expected that the implementation process shall take 6-9 months from the date of notification of the committee.

Financial implication – Under the State plan computers with data entry operators are being provided at all health facilities in a phased manner. Therefore these costs are not being included.

The direct cost implication shall include costs of –

1. Software designing and data base hosting/servers
2. Data base maintenance
3. Training of manpower
4. Contingency including meetings, travel, preparation of bid documents etc. This will also include the cost of hiring of short term consultancy / consultants for planning purposes.

The costs can only be finalized after all the technical details are available and bidding process is over. However based on similar costs in other projects. an initial sum of Rs 10 Lakhs may be required in first year with Rs 50000/- out of this being reserved as contingency.

Total Financial Implications : = 217. 24 lacs

Chapter 18

Monitoring & Evaluation

Monitoring and Evaluation essentially comprises of following components :

1. Secondary Data evaluation.
2. Primary ongoing evaluation by the Supervisors and immediate Incharges using field visits and inspections.
3. Concurrent extraneous evaluation preferably with community involvement.

Mission provides an excellent opportunity to put sound, workable monitoring and evaluation mechanisms in place by revitalizing the existing mechanisms and introducing new ones wherever required.

Improving the quality and completeness of secondary data has already been discussed in the previous chapter.

Primary ongoing evaluation will be at three levels: Facility level , District level and State level. All programmes have their inbuilt monitoring mechanisms with defined process , output , outcome and impact indicators.

The role of the SPMUs & the DPMUs is ingrained in the mechanisms. The planned activities and inputs at the district level and at the PUHC level focusing on the underserved population of the urban slums as reflected in the state PIP will be monitored for progress in implementation.

The Mission Director supported by the State Programme Officers and the Directorate of Health & Family Welfare at the state level will be regularly monitoring through monthly reports & periodic reviews. A quarterly review will be undertaken at the level of Chairman , SHS.

This monitoring and progress appraisal will also facilitate the mid course correction as and when warranted.

Similar district level committee chaired by the CDMO as Mission Director will be reviewing every month along with the District team of Programme officers. This will be followed with a quarterly review under the chair of the District Commissioner.

The monitoring of progress mainly will cover the Physical achievements against planned expectations as per timelines defined, the financial expenditures reports & the HRD/Equipment /Logistic progress made.

The SPMU & DPMUs will be the Nodes for data compilation & analysis

District level monitoring will be focusing on the:

Whether the plan finalization & its submission has been adhered to as per schedule or not? Once approved & funds allocated & released through the IDHS to various programmes have to be monitored for its expenditures & timely reporting. Coordination with specific program officers on the physical achievement on the plan objectives as defined will be facilitated through the

appraisal & analysis of the common MIS every month. The CDMO & his team gets the MIES & Financial statement on progress through the DPMUs & the same is reviewed at the IDHS meetings at monthly intervals.

During the year 2007-08 when a number of infrastructural improvements & facility strengthening (manpower contracting, equipments procurements, repairs & renovations, supplies & logistics etc) have been planned, the same will be monitored at the state level, for assessing progress & to identify constraints & challenges being encountered so that corrective action is possible.

In addition monitoring through secondary data analysis, field monitoring of skills of the service providers (doctor in case of field monitoring by the CDMO or even the ANMs work by the MO/CDMO will be followed. This will serve dual purpose of improving coverage & on performance (quality aspects).

Mobility support to the supervisors & monitors is included as important component of plan.

At the State level monitoring through the State programme officers would be on the respective projects/programs through analysis of district data & comparing amongst various districts. Expenditure statements generally reflect on the progress on various activities that have been planned.

In addition the State Health society & State Health mission would be monitoring & reviewing the progress on the intermediate indicators as reflected in the PIP along with financial statement of progress.

Individual state programmes will also be reviewed at the State level under the Mission at periodic intervals.

BUDGET: (Activity: Meetings at each level, printing of reports & sharing with stake holders, CD writing & sharing, mobility support and honorarium and mobility support for external monitors)

Rs : 10 lacs during 2008-09.

Some basic Process / Output / Outcome Indicators identified for monitoring by MIS feedback:

SNo.	ISSUE/ INDICATORs	CURRENT STATUS	TARGET 2007-08 1Qtr 2Qtr 3Qtr 4Qtr	2008-09	Remarks
1.	ASHA selected / trained				
2.	Number of MAMTA Friendly Hospitals enrolled in the scheme.				
3.	No.& % of Pr. Health Facilities strengthened				

4.	Maternity Homes strengthened				
5.	No of Functional Maternity Facilities 24x7				
6.	No & % of ICDS functional as Mother ICDS				
7.	No of Mother labs functional				
8.	No & % of proposed Private labs arrangements functional				
9.	Functionalization of seed PUHCs.				
10.	No & % of districts holding > 85 % of planned IDHS meetings for review				
11.	No & % of ANMs positions filled (against required)				
12.	No & % of distrctis having full time Programme Manager in the PMU				
9	No & % of district having >90% of the Planned ASHA's in position				

To assess the quality of healthcare systems , the completeness and quality of healthcare being provided at various levels , special formats will be devised . ie. For Laboratory services / for outreach sessions / for suboptimal utilization of certain health facilities / for ascertaining the authenticity of reports being generated at the peripheral units.

Chapter 19

Tentative Allocations and Unutilised funds available.

FUNDS ALLOCATED UNDER NRHM		
S.No.	**Activity**	**Allocated Funds**
1.	**Infrastructure and Maintenance(DFW, Centrally Sponsored scheme through State Treasury)**	**23373.56 lacs**
2.	**RCH Flexipool**	**2729 lacs**
3.	**Mission Flexipool**	**2377 lacs**
4.	**Pulse Polio Immunization**	**1360 lacs**
5.	**Disease Control Programmes(Part D)**	
a)	**RNTCP**	**310.17 lacs**
b)	**NLEP**	**62.52 lacs**
c)	**IDSP**	**40.57 lacs**
d)	**NPCB**	**400 lacs**
e)	**NVBDCP**	**142.01 lacs**
f)	**IDDCP**	**15 lacs**
	Total	**Rs 970.27 lacs**

Programme wise Provisional Unspent Balance		
	2007-2008	
S.No.	**Name of the Programme**	**Amount in Lacs**
1	**RCH Flexipool**	**110.08**
2	**Mission Flexipool**	**2551.04**
3	**Pulse Polio Immunization**	**0**
4	**RNTCP**	**136.75**
5	**NLEP**	**25.8**
6	**IDSP**	**104.9**
7	**IDDCP**	**0**
7	**NPCB**	**65**
8	**NVBDCP**	**25.5**
	TOTAL	**3019.07**

Chapter 20

NRHM Flexipool Budget

S No.	Activity	Budget	Source	Unutilised
I.	**NRHM Additionalities.**			
1.	**SPMU** **DPMU**	118.54 lacs 394.24lacs		
2.	**Baseline Surveys.**	90Lacs		Earlier approved 90 lacs . Reduce to 18 lacs Already available with the districts.
3.	**ASHA**	1471.53 lacs	**STATE FUNDS**	
4.I.	**Strengthening of Pr. Infrastructure**			
a.	Primary health facilities (of MCD / DGD / NDMC.) MOs/ANMs.	------	RCH Flexipool	Exact expenditure available under RCH.
b.	Water cooler with RO / Water dispensers)	49 .0	RCH Flexipool	
c.	Pharmacists	30.60	NRHM Flexipool	
d.	Lab Strengthening	240.36 lacs	NRHM Flexipool	187.64 already approved and available for use.
e.	Telephones	13.82 lacs	NRHM Flexipool	Activity already approved .
4.II	**Strengthening of Maternity Homes.**	614.61 lacs	NRHM Flexipool	Activity approved . 404.2 lacs available .
4.III	**Strengthening of CDMO Office**	50 Lacs	NRHM Flexipool	Activity approved for one Crores last year . Available untilised.
5.	**Coverage of Unserved and underserved areas.**			

a.	Seed PUHCs	384.16	NRHM Flexipool	Approved activity.
c.	PPP – HOPE Foundation + proposed PPP in south district.	12.8 + 10	NRHM Flexipool	Already Approved.
d.	PPP for FP activities. in South and East District	20	NRHM Flexipool	Already Approved.
e.	New FP Unit in SW District.	35		Already Approved.
f.	Dental Mobile Clinics.	200		New activity.
6.	**Capacity Building**			
a.	**State Health System Resource Centre.**	50 lacs.		Already approved.
b.	Training Infrastructure	222.93 LACS	NRHM	Earlier approved for 149.08.Rental has gone up from 50,000 to 1,20,000 per mth.
c.	BCC Infrastructure	75.22		
d.	Stores	262.21 LACS		Activity approved. Rentals increased.
e.	Telemedicine	10 lacs		New activity.
7.	Maintainance Funds	50.25 lacs		
8.	Major construction cost	50 lacs		
9.	Untied Funds	26.35 lacs		
10..	Mainstreaming of AYUSH	20		
11.	Preparation of Annual Report(State +District)	6.5 Lacs	NRHM	Approved in last PIP 2007-08 and is available
II.	**Convergence**			New activity
a.	NACP	88.29		Activity approved.
b.	ICDS	77.4		Activity approved.

c.	Education	208.9		Activity approved.
d.	Water & Sanitation	52.5		Activity approved.
III.	**Innovations**			
a.	MAMTA Friendly Hospitals	300	NRHM Flexi	Activity approved.
b.	PPP for diagnostics	100	NRHM Flexi	Activity approved.
c.	Development of Community Models.	20	NRHM Flexi	Activity approved.
d.	RKS	36	NRHM Flexi	Activity approved.
e.	Risk Pooling	10 lacs	NRHM Flexi	Activity approved.
f.	Mapping	20 lacs	NRHM Flexi	Activity approved.
g.	Referral Linkages	50 lacs	NRHM Flexi	Activity approved.
IV.	Trainings	86.58lac		
V.	BCC	100 lacs	NRHM	
VI.	MIS	217.24	NRHM	Increased.
VII.	Monitoring and Evaluation	10 lacs	NRHM	Activity Approved in last PIP 2007-08 and is available
	TOTAL	4368.975 lacs		

The increase from the last years budget is mainly because of increase in rentals , Increase in the requirements for seed PUHCs, Requirement for Maternity homes and dental mobile clinics.

Budget: NRHM Flexi pool 2008-09 . Districtwise allocation:

S No.	Activity / District	West	SW	NW	South	North	NE	East	Central	New Delhi	State	Total	Remarks.
1.	**SPMU**	x	x	x	x	x	x	x	x	x	108.54	118.54	
2.	**DPMU**	48.453	41.173	31.173	48.453	48.453	31.173	48.453	48.453	48.453	X	394.24	
3.	**Baseline surveys & Facility Survey**	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	x	90.0	
4.	**State Health Resource centre**	x	x	x	x	x	x	x	x	x	**50.0**	50.0	
5.	**Laboratory**												
a.	Pathologist	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**		**32.4**	
b.	LT for Mother lab	**(6)6.48**	**(3) 3.24**	**(6)6.48**	**(5) 5.40**	**(3) 3.24**	**(5)5.40**	**(6)6.48**	**(2)2.16**	**0**	**0**	39.96	
c.	Basic Labs	**24**	**24**	**24**	**24**	**12**	**21**	**9**	**15**	**15**	**0**	168	
6.	**Pharmacists**	**9**	**5.4**	**1.8**	**0**	**7.2**	**0**	**3.6**	**3.6**	**0**		**30.60**	
7.	**Telephones**	**1.94**	**0.96**	**2.08**	**2.66**	**1.38**	**1.4**	**2.1**	**0.6**	**0.7**	**0**	**13.82**	
8.	**Maternity Homes**	**72.12**	**35.24**	**137.1**	**78.04**	**63.24**	**98.88**	**41.91**	**28.72**	**39.36**	**20**	**614.61**	

	Strengthening												
9.	**Strengthening of CDMOs office / other Programme management structures**	**Detailed District specific plans with approval of IDHS / SHS will be accepted.**									50 lacs	50 lacs	
S No.	**Activity**	**West**	**SW**	**NW**	**South**	**North**	**NE**	**East**	**Central**	**New Delhi**	**State**	**Total**	**Remarks.**
10.	**Capacity Building**												
a.	Training Infrastructure	**22.92**	**6.77**	**8.12**	**22.52**	**22.52**	**22.52**	**22.52**	**22.52**	**22.52**	**50**	**222.93**	
b.	BCC Infrastructure	**4.28**	**4.28**	**4.28**	**4.28**	**4.28**	**4.28**	**4.28**	**4.28**	**4.28**	**36.7**	**75.22**	
c.	District Stores	**30.412**	**18.912**	**30.412**	**30.412**	**30.412**	**30.412**	**30.412**	**30.412**	**30.412**	**0**	**262.21**	
d.	Telemedicine	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**10**	**10**	
11.	**Coverage of unserved/ underserved areas**												
a.	Seed PUHCs	**32.2**	**59.4**	**36.64**	**125.74**	**11.38**	**73.28**	**45.52**	**0**	**0**	**0**	**384.16**	
b.	PPP	**0**	**0**	**0**	**10**	**0**	**12.8**		**0**	**0**	**0**	**22.8**	
12.	**Innovations**												
a.	MAMTA	**10**	**10**	**10**	**10**	**0**	**10**	**10**	**0**	**0**	**240**	**300**	
b.	PPP for diagnostics	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**100**	

c.	PPP for FP	**0**	**0**	**0**	**10**	**0**	**0**	**10**	**0**	**0**	**0**	**20**	
S No.	**Activity**	**West**	**SW**	**NW**	**South**	**North**	**NE**	**East**	**Central**	**New Delhi**	**State**	**Total**	**Remarks.**
d.	New FP Centre	**0**	**35**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**	
e.	Dental Mobile Clinics	**Four Dental Mobile Clinics to be set up to cover districts.**									200	200	
13.	**Maintainance**												
a.	CHCs	3.0	0	5.0	2.0	1.0	0	2.0	2.0	0	0	17	
b.	PUHCs	5.5	3.5	3.5	6.0	2.5	5.0	0	2.0	2.5	0	31.5	
c.	SCs	0	0	1	0.75	0	0	0	0	0	0	1.75	
d.	Major construction work	To be released as per approved proposals.									50 lacs	50. lacs	
14.	**Untied funds**												
a.	CHCs	1.5	0	2.5	2.0	0	0	0	0.50	0	0	**6.50**	
b.	PUHCs	2.75	4.75	1	4.0	3.0	0	1	1.0	1.75	0	**19.25**	
c.	SCs	0	0	0.5	0	0	0	0	0.10	0	0	**0.60**	
15.	**Convergence**												
a.	AYUSH	**2 .0**	**2 .0**	**2 .0**	**2 .0**	**2 .0**	**2 .0**	**2 .0**	**2 .0**	**2 .0**	**2.0**	**20.0**	
b.	NACP (Bld Storage units)	15.09	14.34	14.34	0	15.09	15.09	14.34	0	0	0	**88.29**	
c.	ICDS	5.71	3.53	15.25	18.02	4.6	9.06	8.0	2.22	0	11	**77.4**	

d.	Education	0.80	0.80	100.4	101.15	0.80	0.80	1.30	0.80	0.80	1.25	**208.9**	
f.	Water & Sanitation.	9.0	10	9.5	8.3	6.5	3.7	3.2	1.0	1.0	X	**52.50**	
S No.	**Activity**	**West**	**SW**	**NW**	**South**	**North**	**NE**	**East**	**Central**	**New Delhi**	**State**	**Total**	**Remarks.**
16.	**Communitisation**												
a.	Developing Community Models	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	20.0	
b.	RKS	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	x	36.0	
17.	**Referral Linkages**	x	x	x	x	x	20	20	x	x	10	**50**	
18.	**Risk Pooling**	x	x	x	x	x	x	X	x	x	10.00	10.00	
19.	**Mapping**	x	x	x	x	x	x	X	x	x	20.00	20.00	
20.	**Trainings**	x	x	x	x	x	x	X	x	x	**86.58**	**86.58**	Will be given to districts as per trainings .
20.	**BCC**	**Will be allocated to districts according to BCC plans .**									**100**	**100**	

21.	**MIS**	30.72	16.12	39.68	35.96	13.64	12.4	17.36	26.88		24.48	217.24	
22.	**M&E**	x	x	x	x	x	x	X	x	x	10.00	10.00	
23.	**Preparation of Annual Reports**	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	2.0	6.5	
	TOTAL											**4368.975**	

Chapter 21

RCH Budget & Other Vertical Programmes

SUMMARY BUDGET OF RCH for 2008-09

S.No.	Activity	Budget Prepared (Rs. in Lac)
1.	Maternal Health	70.56
2.	Child Health	119.68
3.	Family Planning	75.13
4.	Adolescent Reproductive & Sexual Health	0.80
5.	Urban RCH	48.00
6.	Tribal RCH	Nil
7.	Vulnerable Group	Nil
8.	Innovations/PPP/NGO including PNDT	17.55
9.	Infrastructure & Human Resources	1892.609
10.	Institutional Strengthening	45.22
11.	Trainings	102.6
12.	BCC/IEC	143.72
13.	Procurement	107
14.	Program Management	122.22
	TOTAL	**2745.089**

OTHER ACTIVITIES UNDER RCH in 2008-09

S.No.	Activity	Budget Prepared (Rs. in Lac)
1.	Janani Suraksha Yojna	72
2.	Compensation Funds	215
3.	Mother NGO Scheme	145
	TOTAL	**432**

Grand Total = Rs. 3177.089 Lac

Vertical Programs

S.No.	Program	Funds Proposed (in lacs)
1	NLEP	118.34
2	NPCB	303.5
3	IDSP	302
4	RNTCP	810.41
5	NVBDCP	170
6	IDDCP	15

Chapter 22.

State Contribution

Like last year State's Contribution will be more than 15% of the NRHM budget. At present' the quantum of State Contribution can not be made available as budget of Delhi State for year 2008-09 is yet to be presented in Assembly.

Proposed Outlays for Public health in State Plan

1.Budget proposed for ASHA Scheme for the year 2008-09 (which is being funded by the State Govt) is	**1471.53 lacs**
2. State Contribution in other National programmes	**90 lacs**
3. State funds for NVBDCP & water borne diseases GIN to Municipal Corporation of Delhi (MCD)	**3000 lacs**
4. State funds for NVBDCP thru New Delhi Municipal Council (NDMC)	**75 lacs**
Total	**4636.53 lacs**