REVISED OPERATING MANUAL
FOR
PREPARATION AND MONITORING
OF
RCH-II & IMMUNISATION COMPONENTS OF NRHM STATE PROGRAMME IMPLEMENTATION PLANS (PIPs)

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TECHNICAL AND MANAGEMENT SUPPORT AGENCY

DONOR COORDINATION DIVISION

MINISTRY OF HEALTH & FAMILY WELFARE

GOVERNMENT OF INDIA

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1. INTRODUCTION

BACKGROUND

Reproductive and Child Health (RCH) II, 2005-12

1.01 The implementation of RCH II commenced on April 1, 2005 and the duration of the programme was originally for 5 years i.e. until March 31, 2010. In 2010, RCHII was extended till 2012 to be co-terminus with National Rural Health Mission (NRHM).

1.02 RCH II is largely financed by GoI with support from various development partners (DPs). A system of six monthly Joint Review Missions (JRM) led by GoI with support/ participation from stategovernments and Development Partners (DPs) has been established for periodic review. Since October 2009, one of the biannual JRMs has been clubbed with annual review of NRHM through Common Review Mission (CRM). For details of RCH II, refer to: "RCH Phase II – National Programme Implementation Plan, MoHFW".

National Rural Health Mission (NRHM), 2005-12

1.03 NRHM encompasses RCH II, immunisation, disease control programmes and integration with nutritionand water and sanitation in an effort to address determinants of health and better utilization of resources. Several NRHM initiatives/ "Additionalities" would have a synergistic impact on achievement of RCH II goals/ outcomes; these include community mobilization for health action, capacity building of PRIs, flexible/ untied funds for local health action, support for ensuring that selected health facilities perform to predetermined (IPHS) standards, institutional arrangements consisting of State and District Health Missions, single Health Society at state and district,etc. For details of NRHM refer to 'National Rural Health Mission (2005-2012) – Mission Document, MoHFW, GoI.

RCH II PIP PLANNING AND MONITORING PROCESS

1.04 Every year, all states and union territoriesprepare Programme Implementation Plans (PIP) which are appraised by various divisions in MoHFW and the final plan is approved by the National Programme Co-ordination Committee (NPCC). The States then implement the programme based on the approvals given in the Administrative Approval / Record of Proceedings (RoP) of NPCC. The PIPs and RoPs of previous years are available on the ministry's website.

1.05 For six years (2005-06 to 2010-11), all 35 states and union territories prepared a state program implementation plan (PIP) for RCH II. The PIPs have a number of positive features:

- States are now focusing on outcomes. Expenditure is being seen as a means to achieving an end.

- The PIPs are quite holistic with targets for outcomes, strategies based on a situation analysis, a work-plan and budgets. Some of the States provide detailed quarterly budgets and physical targets.
- The PIPs demonstrate a wide range of innovative interventions. For example: better utilisation of a ANM's time by ensuring that vaccines/ medicines are delivered at her door step, a scheme to help "entrepreneurial" doctors and nurses to establish their own practice in less developed areas, birth waiting rooms in selected health facilities, computerised name wise monitoring of pregnant women until the new born has received all vaccinations, Janani Express for referral transport - this is only a partial list.
- Overall, states have responded positively to the opportunity given to them to set their own goals and formulate need based strategies. There is increasing ownership of PIPs in the States. A reasonable consultation process has been followed and it is apparent that considerable effort has gone into preparation of the PIPs. For 2010-11, each State has set monitorable targets for itself. Also expected outputs have been defined for each budget head.

Current challenges

1.06 The transition from implementing a large number of schemes to managing outcomes is an extremely difficult task. While there has been considerable progress since 2005, there are a number of challenges ahead:

- Absence of systems approach tohealth is affecting the RCH plan implementation adversely. Many steps taken are adhoc and are not sustained in absence of a system.For example HR System: while most of the states are recruiting contractual staff in huge numbers there is no system forHR which should have included sub-systems for recruitment, selection, posting/ transfers, performance appraisal, contract renewal, career progression/ professional development, absorption in state cadre etc.
- The district health action -plans still do not address the local issues/requirements fully. Though the DHAPs are prepared, they are not fully incorporated into the State PIP. The district allocation is made on population/pro-rata basis and often does not cater to the priorities of the district.
- States still seem to have difficulties in preparing an internally consistent PIP i.e. where the situation analysis, goals, strategies, activities, work plan, and budget all tell the same story.
- The basis for setting targets could be more robust/ evidence based. For example, if institutional deliveries are targeted to increase from say 45% to 55%, most states do not attempt to estimate the required increase in absolute number of institutional deliveries, assess capacity of different facilities and hence the number of facilities which need to be operationalised. Subsequently, targets for institutional deliveries would need to be set for each facility and closely monitored. In the absence of such analysis, it is difficult to judge whether the proposed strategies will lead to achievement of targets. In 2010-11,

this problem was tackled to some extent by RCH planning in high focus districts with the help of teams from MoHFW.

- Quarterly break-up of targets and budgets which is necessary for more effective monitoring is not furnished by all the states. Quite often, the description of the intervention does not match the budget; there are missing elements of cost and large "lump sum" figures.
- Apart from RCH II flexi pool funds, there are several other sources of funds for RCH related activities. These sources could be the state, Additionalities under NRHM, Twelfth Finance Commission, DPs, etc. However, since the PIPs focus on only RCH II flexi-pool allocation, it is difficult to get a complete picture of all funding for RCH. Further there is a danger of double counting.
- Systematic monitoring against the PIP is yet to take place. The emphasis is still on inputs/ physical achievements, while expenditure is tracked separately. Since 2009-10 most of the districts have started reporting HMIS data. However the states are yet to use the HMIS data to chart their progress against the target effectively. Holistic monitoring leading to reporting of analysis of variances (outcomes, physical targets, work plan, expenditure) would lead to a more informed basis for corrective action.

PURPOSE AND SCOPE OF THIS MANUAL

1.07 In the context of the above background, the purpose of this manual is to facilitate:

- Improvement in preparation of RCH II PIPs by states
- Self appraisal of PIPs by states
- Holistic monitoring of their own performance by states (outputs, outcomes, physical targets, work plan, expenditure).
- Uniform booking ofexpenditure across districts and states.

1.08 The Manual will also act as a training tool for planning and monitoring of RCH PIP, especially in case of changes in staff.

Scope of the Manual

1.09 This Manual covers preparation of state PIPs for RCH II i.e. Part A and Immunization i.e. Part C of the NRHM Plan and is closely interlinked with the DHAP manual. The NRHM DHAPs will feed into the RCH II State PIPs.

1.10 This manual is an updated version of the earlier "Operating Manual for Preparation and Monitoring of RCH-II Component of NRHM State PIPs", March 2007 / updated in 2008. Key additions are:

- Immunisation (Part C) added.
- Monitorable/performance indicators focusing on outputs/ utilisation of facilities & staff

- New initiatives such as newborn care facilities (NBC, NBSU,SNCU,NICU etc.), maternal death review (MDR)
- Use of web based HMIS
- Procurement planning
- Lessons learnt includingin terms of booking of costs

Target groups

1.11 This Manual is intended to be a user friendly tool to assist a range of stakeholders involved in planning and monitoring of RCH II state PIPs. Target groups for this manual include:

- State NRHM Mission Director and key RCH II health managers at state Level
- SPMU and DPMU staff
- Members of the team constituted for preparation and monitoring of PIPs

STRUCTURE OF THIS MANUAL

1.12 Chapter 2 sets out the conceptual framework in terms of key underlying principles, and subsequently provides an overview of the planning and monitoring process. Chapter 3 sets out the desirable structure of the PIP including formats for targets, work plan and budgets for RCH including Immunization. It includes suggestions for preparation of situation analysis leading to identification of core issues adversely affecting RCH performance of the state followed by how to set targets and evaluate strategies. Approach to preparation of the budget and appraisal criteria are also covered. Chapter 4 deals with monitoring of state performance with respect to the approved PIP. Chapter 5 deals with immunization (Part C) of the PIP.

OTHER RELEVANT GUIDELINES / DOCUMENTS

1.13 This manual should be seen together with various guidelines provided by MoHFW. These have been listed in Annex 1 and are available on the ministry's website (www.mohfw.nic.in). Members of the state and district planning teams should have ready access to a copy of the above. It is assumed that members of the State and district planning teams are well versed with the RCH II National Programme Implementation Plan of MoHFW, GoI.

2. CONCEPTUAL FRAMEWORK AND OVERVIEW OF THE PLANNING AND MONITORING PROCESS

2.01 As mentioned in Chapter 1, this Manual addresses preparation and monitoring of the state RCH II and Immunisation PIP i.e. Parts A and C of the NRHM PIP. This chapter sets out the conceptual framework in terms of key underlying principles and subsequently provides an overview of the planning and monitoring process.

2.02 States are expected to build on the PIPs prepared for previous years and take into account the experience so far in RCH II/ Immunisation, in terms of successes as well as the constraints faced in achieving outcomes while preparing the PIP for 2011-12.

KEY UNDERLYING PRINCIPLES

2.03 The statePIP must reflect key underlying principles of RCH II especially:

- An explicit pro-poor focus through identification of vulnerable groups/high focus districts with relatively poor performance against RCH II indicators and ensuring that their needs are met. This would mean concentrating resources (staff,medical supplies, closer supervision, etc) to areas with the worst health outcomes and the greatest need. In 2010-11 GoI identified 264 high focus districts in the entire country (See Annex- 10). **The State may add any other high focus districts if needed. The criteria for including a district as a high focus should be explicitly stated. A detailed plan for addressing the needs of these districts is a must.**
- Emphasis on results: The RCH II PIP should make commitments to deliver results in terms of goals i.e. MMR, IMR and TFR as well as underlying outcomes such as institutional delivery, full immunisation, contraceptive prevalence rate and unmet need. Expenditure is a necessary but not sufficient condition to achieving improved performance on outcomes. Hence during approval of 2010-11 PIPs, States were asked to set monitorable targets for themselves and the monitorable targets are now a part of Administrative Approval / Record of Proceedings (RoP) for each state. States would need to set similar realistic targets for outcomes by districts/ blocks and monitor performance against outcomes, rather than merely track expenditure. The targets need to be broken down into quarterly targets so that quarterly monitoring is possible and corrective steps (wherever needed) can be taken.
- Prioritization of initiatives as per the need of the State is a must, given multiple needs in health sector and limited resources.The state will need to first operationalize facilities in high focus districts and those having adequate patient load.
- States must specify a minimum of 10% of the funds allocated to districts as genuinely untied i.e. districts have the freedom to prepare their own schemes in response to local conditions. In the past, most states preferred to run state schemes and districts were essentially expected to plan for implementation of these schemes. While this approach has the advantage of administrative convenience, the purpose of giving districts flexibility to develop their own strategies in accordance with local conditions is defeated.

- Innovative approaches to improve reproductive and child health outcomes especially among vulnerable population and in urban slums; these could include partnerships with private sector, social franchising and demand side subsidy. Pilots initiated so far in RCH II would need to be rigorously evaluated and up scaled, if warranted.
- All state PIPs must have a infection management and environment plan (IMEP) / plan for bio-medical waste management.

States may also design an incentive mechanism, where better performing districts/centres are entitled to a performance bonus.

Sources of funds

2.04 Funds for reproductive and child health related activities are available from a variety of other sources apart from RCH II flexi pool. These sources include state budget, NRHM Additionalities, Twelfth Finance Commission, Development Partners etc. In their respective RCH II PIPs, states are expected to capture all sources of funds which can be exclusively attributed to RCH services and their allocation. In addition the source of funds for each activity in the PIP should be identified.

2.05 States should also ensure that same activity should not be budgeted under part A and B both. All RCH related activities should be budgeted under RCH Flexipool Part A and activities which cater to all the programmes should be budgeted under Mission Flexipool Part B (Refer Annex 6 and 7)

District Plans

2.06 As mentioned in chapter 1, districts would be preparing a single District Health Action Plan (DHAP) for NRHM including RCH II. For this purpose, a guideline ("Broad framework for preparation of District Health Action Plan, August 2006") has been issued by MoHFW and is available on the website of the ministry. This manual assumes that the DHAPs would be prepared in accordance with the above manual and these would feed into preparation of the RCH II PIP.

Relative roles of state and districts

2.07 While districts have primary responsibility for outcomes/ delivery and utilisation of services in their respective geographic areas, the state would typically be responsible for various support functions such as release of funds on time, dissemination of guidelines, distribution of medical supplies, training of trainers, etc. The state PIP should spell out the role of the state especially the specific areas for which the state is directly accountable. In the PIP work-plan the post of the officer responsible for a particular head/activity should be clearly indicated. Similar exercise should be carried out for DHAPs.

Reporting against the RCH II PIP

2.08 On a quarterly basis, states would be expected to report holistically against the commitments in the PIP in terms of:

- Achievement against monitorable indicators
- Physical achievement vis-à-vis the activities in the work plan; and corresponding expenditure against each activity
- Variance analysis: If the targeted outcomes/ outputs have not been met, the reasons for the shortfall; corrective action planned/ taken and, if necessary a modification in the targets.

The above need to be provided separately for high focus districts (consolidated) and for the State as a whole.

OVERVIEW OF THE PLANNING AND MONITORING PROCESS

2.09 An overview of the planning and monitoring process for RCH II state PIPs is schematically shown in Exhibit 2.01. The starting point is the constitution of the state and district planning teams, allocation of flexible and other funds to districts and state level /other agencies (SIHFW, IEC bureau, M&E, logistics, urban local bodies, etc) and training of their respective planning teams. Districts are envisaged to prepare NRHM DHAPs in accordance with the prescribed guidelines; state level "spending agencies"/ functions would need to prepare plans in support of DHAPs. The State may also use the formats recommended for State PIP for districts.

State PIP Planning Process

2.10 Planning and budgeting of PIP at State level involves following steps:

- Initial technical strategising and planning
  - The planning teams for various technical components under a senior person (the Joint directors /consultants /officers) should be responsible for the individual components. For example maternal health should be led by the senior officer responsible for MH with help of relevant concerned personnel (consultant MH, JSY, officers responsible for RTI/STI, SACS officers, data officers responsible for collecting data from districts). The team should be responsible for situation analysis (based on data available from surveys, HMIS, State MIS, and other sources), setting targets (which should be divided into quarters and should be an aggregate of all district targets), formulating strategies, work plan and budget for MH in consultation with districts.
- Integration of all technical plans
  - Once the plans for all the technical components are completed, the SPM/Consultant planning along with technical staff should integrate all the components functionally.

E.g. under MH there might be plans to recruit more ANMs at PHCs, child health may also have similar strategy. The team should assess whether one ANM can cater to the needs of both MH and CH. During integration the team should try to ensure optimal utilization of resources.

- Reclassification
  - Once this exercise of integration is completed, the team should identify the cross cutting components (HR, infrastructure, training etc) and budget theseunder the appropriate head. For example MH budget head would have JSY compensation, program cost of RTI/STI, safe MTP services etc. whereas HR needed for maternal health initiatives would be budgeted under HR and infrastructure (A.9.1)and equipments like stethoscope, weighing machine etc. would be budgeted under Procurement of equipment (A.13.1.1). Refer to Annex 6 for contents under specific budget heads and Annex 7 for non-permissibles under RCH budget. The above exercise would enable the State to classify the budget under natural heads (HR, infrastructure, procurement, training etc.) as well as under technical strategies (MH, CH etc.). .
- Consolidation
  - Finance personnel, should check the rates and units and calculation of budgets and finally consolidate the budget. As shown in Exhibit 2.01, costing of the PIP would be an iterative process.
  - Subsequent to drafting of the PIP, a state level workshop should be conducted and after incorporation of comments the PIP would need to be approved by the respective State Health Mission/Society and the NPCC, MoHFW. Implementation of the PIP should lead to improvement in outcomes and hence favourably impact the current situation (analysis). This would then be the starting point for the planning process in the subsequent year.

EXHIBIT 2.01: STATE PIP PLANNING PROCESS

START UP
- State level planning team constituted
- Allocation of funds to districts
- District planning guidelines disseminated
- District staff trained

District NRHM plans

Background and current status
- Demographic and socio-economic features
- RCH outcomes and service utilization
- Public health infrastructure
- Private and NGO health services/ infrastructure
- DP (donor assisted) programmes
- Institutional arrangements and organizational development
- Programme finances

Progress and lessons learnt from RCH II implementation

Situation Analysis
- MH, CH, FP, ARSH,Immunization
- District / sub-district variations
- Health infrastructure/ facilities
- Human resources development including training
- Inequity/ gender
- Logistics
- HMIS

NRHM Additionalities

Programme goals, outcomes, outputs, strategies and work plan

Costing of PIP

Drafting of PIP

State level workshop

Review and approval by SHS Executive body, and GoI

Implementation / monitoring and review

3.STRUCTURE OF THE PIP

3.01 This chapter sets out the structure of the RCH II state PIP. Details including formats are provided in Annex 3 including Annexes 3a to 3f, and in Annex 8 including Annexes 8a to 8g.

BROAD CONTENTS OF THE STATE PIP

3.02 The broad structure of the PIP is as follows:

RCH II PART A

1.EXECUTIVE SUMMARY OF THE PIP (not more than 5 pages)

(Indicate (a) where we are now and where do we wish to go by 2012 in terms of indicators (use format in Annex 2). (b) how do we propose to get there i.e. steps taken to improve the existing systems and overcome the barriers in implementation e.g. HR – system of recruitment, and key strategies to meet the goals including e.g. sourcing of anaesthetists and gynaecologists, improving client contact time for ANMs, public-private partnerships, social franchising, etc (c) programme management arrangements including monitoring and evaluation mechanisms and (d) how much will it cost (use format in Annex 3c).

2. TECHNICAL AREAS

(Under each area, PIP should include situation analysis; previous performance; lessons learnt; interventions and activities planned – formats for the same are provided in Annex 8)

2.1 Maternal Health

2.2 Child Health

2.3 Family Planning

2.4 Adolescent Reproductive and Sexual Health (ARSH) including menstrual hygiene

2.5 Urban RCH (Maternal Health, Child Health, ARSH, Family Planning)

2.6 Tribal health (Maternal Health, Child Health, ARSH, Family Planning)

2.7 Vulnerable groups (Maternal Health, Child Health, ARSH, Family Planning)

3. CROSS CUTTING AREAS

(Under each area, PIP should include situation analysis; previous performance; lessons learnt; interventions and activities planned)

3.1 Infrastructure (including Infection management and environment plan) (civil up-gradation for SHCs/ PHCs/CHCs/ FRUs etc. for strengthening labour rooms, maternitywards, operation theatre).

3.2 Human Resources (including current status and posting of available human resources across districts, requirement of additional HR based on current / estimated case load and facility operationalisation plan)

3.3. HMIS/ M&E

3.4 BCC

3.5 Quality assurance

3.6 Training *(assessment of training load, improving quality, assessing impact, strengthening of infrastructure, outsourcing)*

3.7 Equity/ gender

3.8 Financial management

3.9 Convergence/Coordination {*Indicate objectives of convergence vis-à-vis RCH II goals e.g. improved delivery of services on the ground and more optimal utilization of funds. Define coordination mechanisms (intra, with other departments such as WCD and on-going DP assisted programmes) at state and district/ sub-district levels including how the mechanism will lead to achievement of objectives}*

4. PROGRAMME MANAGEMENT ARRANGEMENTS

(Provide revised organization charts at state and district levels clearly specifying the State and District Programme Management units for RCH II, linkages with Health and Family Welfare Department and synergy/ optimisation with management structures specific to on-going DP assisted projects.. The proposed organization structure should be consistent with RCH II goals and strategies and reflect expertise in various areas including district planning, HRD, quality, equity/ gender, financial management etc. Provide brief job descriptions including indicators for assessment of performance and delegation of powers. Key aspects such as background of person having overall responsibility for RCH II at state and district levels and assured tenure of at least 3 years; establishment of programme planning and monitoring systems, etc need to be addressed).

5. WORK PLAN

(The Workplan should preferably be presented by means of a bar chart showing the above objectives, strategies and activities. A cross-check should be carried out to examine whether implementation of the activities on the bar chart would prima facie lead to achievement of goals set earlier against indicators in Annex 3b. WORK PLAN WOULD ALSO INCLUDE ACTIVITIES WHICH MIGHT NOT HAVE A BUDGET IMPLICATION. The workplan should be provided as per the format provided in Annex 3d)

6. BUDGET

(An RCH II activity could be funded by various sources other than RCH II flexi pool. These could be NRHM Additionalities, DP programmes, Finance Commission, and State's own funds. The budget break up should spell out the source of funding. Budgets should be prepared strategy and activity wise and consolidated. ***The PIP should spell out the budget for high focus districts and consolidated State-wide budget.*****The budget is to be prepared as per Annex 3c – summary budget, and Annex 3e – detailed activity-wise quarterly budget.***)*

6. MONITORING AND EVALUATION

This section should specify:

- Key indicators for measuring progress (a list of indicators has been provided in Annex 3b. States may wish to identify other indicators)
- Key financial indicators to assess the project's budgetary and financial health
- Steps to implement timely and accurate HMIS, including strengthening of facility based monitoring

Annexes to be submitted with the PIP:

1. Self appraisal of state PIP against appraisal criteria
2. Targets for monitorable indicators
3. Summary of budget
4. Work plan
5. Detailed budget
6. District wise allocation

(The formats for the above Annex 1-6 have been provided in Annexes 3a to 3 f respectively of this Manual. Please note that Annex 3b had been modified and monitorable indicators have been added)

Part C Immunization

1. Situation Analysis

2. Progress So Far – achievement and expenditure in 2009-10 and 2010-11 (April-December)

3. Objectives, Strategies and Activities for 2011-12

The Immunisation chapter of the PIP should essentially cover the aspects below (detailed guidelines provided in Annex 8c)

a) HR status (and steps to ensure tenure of at least 3 years)
   - State Immunization Officer in place: Yes/No
   - Number of districts without DIO (out of total no. of districts):

RI staff at district level	Required	Sanctioned	In position	Vacant
Cold chain handlers				
Cold chain mechanics				
Any other				

b) System put in place for alternate vaccine delivery and its impact

c) Systems put in place to ensure:
   - Microplanning of Immunization
   - Strategy for increasing coverage, including vulnerable population -urban slums, migrants, tribal pockets
   - Proper maintenance of cold chain equipments
   - MIS for efficient inventory management for vaccines and other supplies
   - Strategy to reduce vaccine wastage
   - Integration of UIP and pulse-polio
   - Co-ordination among ANM, AWW and ASHA

4. Budget

3.03 Suggestions for how to prepare the above sections of the state PIP are provided in subsequent sections of this manual.

Situation analysis

3.04 The description of background, current status and situation analysis**under each technical head**should be restricted to health and related socio-economic matters only. The situation analysis for the state as a whole should be based on:

- The background, current status and situation analysis of each district as reported in the respective DHAPs.
- State level data on performance in terms of IMR, MMR, TFR as well as various other outcome, process and output/ input indicators derived from both surveys as well as state's own HMIS.

Consolidation of situation analysis of DHAPs

3.05 The consolidation of situation analysis mentioned in DHAPs in conjunction with state level data should lead to an improved understanding of current status and key issues affecting RCH outcomes as well as variations across districts.

3.06 For each item of the background and current status and situation analysis (refer Annex 3), systematically consolidate district wise data. Reconcile these figures with state level data wherever this is available e.g. population/ demographics, state performance in terms of indicators for RCH II goals and outcomes, etc. This reconciliation is necessary in order to ensure sanctity of the reported figures.

3.07 Apart from providing the consolidated state level figures, provide an indication of the variation across districts for each item.

3.08 High focus districts may have common issues. For example, a district with low institutional deliveries is more likely to have some combination of relatively few fully operational FRUs and 24 x 7 PHCs, poor referral transport and poor health seeking behaviour. They may also have minimal organized private sector health facilities, large number of vacancies in public facilities, etc.

3.09 This should lead to a set of common strategies across all districts and some high focus district specific strategies. Hiring of contractual staff and JSY are examples of the former; whereas staff in less developed districts may need to be compensated through e.g. special incentives.

3.10 The above analysis of DHAPs should then lead on to identification of issues to be primarily addressed by state, and those which need to be addressed at the district/ sub-district levels. Preparation of training materials, training of district level trainers, HMIS design and prompt release of funds to districts are examples of the former; whereas improved supervision and in service training of ANMs would be under the purview of districts.

Progress& lessons learnt

3.11 The state PIPs for 2005-11 set out various strategies in the areas of maternal health, child health, family planning, adolescent reproductive and sexual health as well as in the areas of institutional strengthening and programme management. States should critically examine the implementation of these strategies and the extent of achievement vis-à-vis targets set for various indicators. This should lead to decisions regarding strengthening some strategies and perhaps discarding others. In the case of pilots that are considered to be successful, states should consider a stringent evaluation followed by possible replication across the state.

3.12 In case of underutilisation of funds examine reasons (time-consuming procedures, insufficient delegation of powers, etc) and identify appropriate solutions. Also examine reasons for delays in reporting back of expenditures and identify corrective steps to be taken. This will not only improve timely and accurate reporting of utilisation, but also allow matching of physical progress and financial expenditure. Some States have linked further releases to districts with reporting back of expenditures and seen good progress.

RCH II Programme Objectives and Strategies

Setting of targets

3.13 Targets need to be set for key indicators (refer Annex 3b) for the state as a whole. States should provide a basis for setting targets. In order to ensure that the targets are realistic, states may wish to consider the following:

- Below average / average districts may wish to achieve outcomes achieved by average/ best districts in the state. The best districts in the state could set themselves targets in line with performance of the better districts in other states. District wise targets should then be consolidated for the state as a whole and compared with the better/ best performing states in the country, before a final determination of the target is made.

- A review of the state's own past performance, especially last year in terms of improvement in outcome /other indicators would again provide some insight into setting targets.

Identification of strategies

3.14 Before identification of appropriate strategies, states may wish to consider and evaluate a range of options. The first step is to set a benchmark for service level. For example, the guidelines for operationalisation of FRUs states that women requiring comprehensive emergency obstetric care should have access within one hour of the need being identified. In this case, a starting point is to map all existing departmental/ private sector/ other facilities and assess existing transport arrangements in order to identify number, capacity and location of facilities required to meet the one hour criterion. Subsequently, there are several possible options:

- Examine feasibility of putting into place an ambulance facility/ referral transport; this could lead to significant increase in number of persons having access to an existing facility within the norm of one hour.
- Fully operationalise existing FRUs, starting with facilities requiring the least inputs and in areas where the need amongst the poor is the greatest. For blood bank facilities try and enter into an arrangement with Red Cross.
- Where ever appropriate facilities exist in the commercial private sector or with other government agencies including e.g. defence, public sector companies, etc enter into an arrangement / partnership such that the underserved women get access.
- Upgrade existing CHCs/ other facilities to FRUs starting with the district hospital.
- Appropriate private sector facilities may not exist in less developed areas. But an NGO or Charitable organization may be interested in establishing a unit in partnership with government.

In detailing strategies take into account various guidelines which have been issued by MoHFW. These have been listed in Annex 1.

Internal consistency

3.15 States should try and ensure internal consistency within the PIP such that the goal, outcomes, outputs, activities, workplan and costs are systematically linked with each other. For example, in order to reduce MMR, it would be necessary to increase complete ANC checks and deliveries by SBA, reduce unsafe abortions and increase availability and utilisation of RTI/STI services. In order to increase institutional deliveries, functional facilities (24 x 7 PHCs, FRUs) would be one of the key outputs for which activities required would be to train and post staff, strengthen infrastructure and motivate staff. These activities should then be shown on a work plan and the costs estimated. This approach should lead to a systematic assessment of activities and costs required for improving each outcome and the goal of improving MMR.

Programme management arrangements

3.16 In order to obtain a clear understanding of the programme management arrangements, states should provide detailed organisation charts for the department of health and family welfare at state, district and sub district levels including position of the state and district programme management units (set up with staff on contract). DP programme related structures, where applicable should also be shown. Ensure that the proposed organization structure is consistent with RCH II goals and strategies and reflect expertise in various areas including district planning, HRD, quality, equity/ gender, M&E, BCC, financial management etc. Provide brief job descriptions including indicators for assessment of performance and delegation of powers. Key aspects such as background of person having overall responsibility for RCH II at state and district levels and assured tenure of at least 3 years; establishment of programme planning and monitoring systems, etc need to be addressed. The programme management would also include system of supportive supervision at state, district and block level.

Work plan

3.17 For each strategy, states would need to spell out activities required for implementation. The level of detail for activities should ideally be such that it is possible to hold a single person responsible for its execution. The strategies and activities should be presented by means of a bar chart broken down by quarters as shown in Annex 3d. ***The work plan would also include the activities which are necessary for implementing a strategy but might not have a budgetary implication.*** Please note that the strategies/ activities shown in Annex 3d are for purposes of illustration. States are expected to develop their own strategies and activities based on their own situation analysis. The same strategies and activities, as developed by the state for Annex 3d, should also be used while developing the detailed budget in Annex 3e. While the choice of strategies and activities is to be determined by the state, please do not change the framework/ numbering system provided in annex 3d. ***If a strategy or activity shown in Annex 3d is not relevant, leave the corresponding activity number blank. For new activities use the corresponding "others" rows and elaborate***.

Procurement

3.18 The procurement of drugs and supplies as well as equipments under RCH is of two kinds:

1) Those supplied by GoI in kind
2) Those procured by the State from RCH and its own budget

3.19 The State needs to fill up Annex 5 for procurement which lists the items to be supplied by GoI. The items can be categorised into drugs, equipments, supplies/devices and others. The State should provide balance stock as on a particular date for all the items needed, followed by expected receipt and expected consumption. The projected need/demand for items in 2011-12 needs to be filled for all the items on the basis of total requirement, available stocks and wastage factor etc.

Budget preparation

3.20 This section sets out suggestions for preparation of budgets in terms of the basis and level of detailing. Formats/ templates have also been provided.

(For additional information on what to book under the different budget heads, as well as key concerns to address while preparing the budgets, refer Annexes 6 and 7)

Extent of flexibility

3.21 States have complete freedom to utilize the RCH II flexi pool allocation provided by MoHFW for improvement in RCH II outcomes, except a few non-permissible which are listed inAnnex 7.

Basis for budget preparation

3.22 The starting point for preparation of the budget is the work plan shown in Annex 3d. Costs should, as far as possible be estimated separately for each activity in the work plan.

3.23 Separate budgets should be prepared for each quarter. A format has been provided in Annex 3 e. Please note:

- As far as possible, estimate the quantity of work to be carried out in each quarter for 2011-12. Examples of quantity of work are: number of staff to be recruited, number of facilities to be operationalised and so on.
- For each activity, estimate the rate or unit cost. As mentioned earlier, RCH II does not lay down any norms. States can estimate a reasonable unit cost on the basis of past experience and taking into account local conditions.
- Where a quantity and rate cannot be estimated, states can estimate a lump sum amount. But this should be the exception.
- The same strategies and activities should be used for the detailed budget (Annex 3e).
- **States to provide details of activities (physical targets and corresponding costs) for high focus districts and for the State (consolidated)**

3.24 After the format in Annex 3e has been prepared separately for each quarter, consolidate these to arrive at the summary budget in Annex 3c.

3.25 The physical targets for the quarter must match the figures in the format for current status and monitorable targets (Annex 3b).

Process of iteration

3.26 The preparation of the budget is necessarily a process of iteration, since the RCH II flexi pool allocation will not be sufficient to meet the complete requirements. Once a first cut of the budget has been prepared, this would need to be extensively discussed within the State Planning Team and the State NRHM Director in order to:

- Re visit and agree priorities. Please note that the allocation of funds should be in line with the situation analysis. For example, if a state has a very high MMR, then greater emphasis to 24x7 PHCs providing basic obstetric care is likely to give faster results compared to operationalising FRUs. Similarly, if the sex ratio is a major cause for concern, then greater allocation to implementation of the PNDT Act/ collaboration with education department for IEC/BCC, other measures is necessary.
- Identify other sources of funds
- Scale down targets for outcomes

Typically the budget would need to be reworked several times before consistency between the situation analyses, targeted outcomes, strategies, work plan and allocation of funds is achieved.

Budget review

3.27 Once the budget has been finalised, an in-depth independent review of the budget should be carried out by a chartered accountant to ensure internal consistency and accuracy of figures.

Finalisation of the RCH II chapter of state NRHM PIP

3.28 States may wish to follow the structure of the PIP provided in Annexes 3 and 8. Subsequent to preparation of the first draft of the PIP, a state level one day workshop should be held in order to share key features of the PIP especially the situation analysis and strategies and to obtain feed back/ suggestions.

3.29 Apart from key departmental staff, participants at the workshop should include elected representatives, NGOs and experts as well as representatives from related departments such as Woman and Child, PHED and Panchayati Raj.

Self Appraisal of the State PIP

3.30 States are urged to carry out a self appraisal of the state PIP against a set of criteria. A format for doing so has been provided in Annex 3a. As shown, the self appraisal should be carried out against 36 criteria classified as:

	No of criteria
Overall	2
Programme management	8
Institutional strengthening	15
Technical	7
Work plan	1
Costs/ budget	3

	36

3.31 As shown in Annex 3a, the criteria have been further classified as “mandatory” and “desirable “. The self appraisal (format) should be an integral part of the state PIP to be sent to MoHFW. **The States should take care to mention the page numbers along with remarks in the self appraisal format.** The States should also note that self appraisal format is for appraisal of the PIP, hence ‘yes’ against a criteria should be mentioned only when the PIP fulfils the criteria.

4. PROGRAMME MONITORING

4.01 On a quarterly basis, states would be expected to report holistically against the commitments in the PIP in terms of:

- Achievement against the monitorable targets and key outcomes/ outputs
- Physical achievement vis-à-vis the activities in the work plan using the HMIS data and corresponding expenditure against each activity
- Variance analysis: If the targeted outcomes/ outputs have not been met, the reasons for the shortfall; corrective action planned/ taken and, if necessary a modification in the targets

4.02 Once the data has been compiled, states are urged to:

- Identify large adverse variances both in terms of physical targets as well as expenditure
- Understand reasons for variances and agency responsible (this could be state, particular district, urban local bodies, SIHFW etc)
- Identify corrective action to be taken
- Initiate steps to implement corrective action

The reporting format in Annex 4 (to be provided later) together with the above variance analysis indicating corrective action, as well as a brief description of key achievements should be sent to DC Division, MoHFW in the month following the reporting quarter.

5. IMMUNIZATION

5.01 Overall objective of the immunization programme is to achieve 100% coverage for all the antigens (OPV, BCG, DPT, measles including hepatitis B and JE where applicable). The principles and planning process explained in the previous chapters are applicable to immunization as well.

5.02 Planning for immunization would include assessment of the total number ofVHND/ immunization sites needed to cater to the entire population. The sites would include sub-centres, PHC and other health facilities, AnganWadi Centres (AWC), other sites in villages/hamlets without AWCs. The existing plan and data at PHCs would provide the number of sites under each ANM and the ANMs schedule would provide the number of sessions she holds. Developing a micro-plan would involve figuring out the difference between the number of sessions needed and number of sessions being held, reasons for shortfall in coverage and ways to bridge the gap. The states need to identify areas within the state which have low coverage and may require a more focussed approach. The State and districts should use data from surveys, data collected through the state systems and HMIS for situation analysis and micro-planning. Micro-plan would also include plans to bring the children and pregnant women to the session sites primarily through ASHA. The state also needs to figure out how the vaccines/vaccinator would reach the immunization sites. Strategies may include a system of alternate vaccine delivery. Functionality of cold chain equipments and their maintenance should also be addressed in the PIP.

5.03 **Issues to be addressed in PIP:** Among other issues the PIP should also include mechanisms of convergence between AWW and ANM, better utilization of services of second ANM, system of supportive supervision and periodical review and monitoring. The State also needs to ensure that key officers such as State Immunization Officer and District Immunization Officer are in place and there are systems to ensure stability of their tenure.

5.04 **Planning and budget formats:Annex 8d and Annex 9** provide planning and budget formats for immunization. The budget for 2011-12 should be summarized in the format given in annex.

6. DOS AND DON'TS FOR PREPARATION OF RCH II CHAPTER OF PIPs FOR 2011-12
(based on lessons learnt during appraisal of PIPs for 2005-11)

A. PIP PREPARATION

DOs:

1) Complete documentation of plan and its mode of execution should ideally be documented and filed so that change in personnel (because of transfer or otherwise) does not affect execution or implementation of plan

2) Spell out process of plan preparation, status of DHAPs, process of integration of DHAPs in the final PIP, and status of facility surveys.

3) Set targets realistically through back of the envelope calculations; for FRU & 24x7 PHC operationalisation and SBA, anaesthesia, and EmOC training consider targets set by MH division. Back of envelope calculations will provide a check on feasibility of achieving targets.

4) Indicate:

   a) Current position of human resources, where they are posted, gaps, etc.

   b) Current status of facilities, especially facilities "functioning" as FRUs and 24X7 PHCs – whether all inputs are available as per GOI guidelines and strategy for ensuring rapid operationalisation

   c) Training load by target segment and type, training capacity and steps to mitigate mismatch.

   (All the information given should be cross-checked with HMIS and FMR.)

5) Situational analysis to include utilization of services and past trends. Please do not copies paste information available from the tourism or other such websites. Only mention information relevant to health.

6) Progress and lessons learnt from implementation of RCH II during 05-11, including e.g. the following areas that are inadequately being implemented:

   1. Ensuring timely and transparent payments for JSY
   2. Birth micro planning
   3. Promoting 48 hours stay post delivery
      a. Policy and arrangements for providing diet
      b. Systems for transport back home
   4. Systems for infant / child death audit
   5. Strategy for fixed day static services for family planning
   6. Quality of skill-based training
   7. Reducing vaccine wastage
   8. Facility based monitoring of utilization
   9. Monitoring utilization of key HR
   10. Assessing impact of 2nd ANM on performance of sub-centres

7) Formats in the Operating manual need to be followed i.e. summary budget, detailed quarterly budget and work plan with quarterly targets for activities, and targets for monitorable indicators.
8) District wise allocation of funds and basis for allocation to be provided.
9) Internally consistent document to be ensured by SPM. In particular, ensure that:
   a) Targets provided for various activities in the narrative match with the targets provided for the same activities in the budget.
   b) Targets for physical activities in the budget match with the targets for intermediate indicators
   c) Quarter-wise physical targets / financial targets tally with the figures provided in the summary budget
   d) All strategies/ activities planned for are also budgeted
   e) Activities budgeted for are reflected in the workplan/ narrative
10) The annexes for budget have formats in excel. Formulae have been inserted to automatically summate the subheads as well as to prepare the summary budget. In case more rows are needed to include additional activities, insert it under other activities without deleting the row for summation
11) Quarterly financial budget should not be based on annual budget divided equally across the quarters; it is important to link the budget with the quarterly work plan. If the former is carried out, there would be large adverse variances; this can be rather awkward, especially since states are now expected to carry out a variance analysis each quarter.
12) As far as possible avoid:
    a) Large lump sum amounts proposed for activities without break up of unit costs and activities.
    b) Double budgeting i.e. booking of similar items under RCH II as well NRHM Additionalities.
    c) Activities/ strategies not budgeted as per budget heads specified in the Operating Manual.

B. PIP MONITORING: QUARTERLY PROGRESS REPORTS

DO'S

1) Establish reporting system from district/ block level. Avoid duplication with MIES format and NRHM reports. Ensure consistency with figures reported in the FMR. SPM and DPMs to be responsible for preparation of reports.
2) Completed physical and financial QPR (including calculation of activity-wise variances), and Progress on Intermediate indicators
3) Variance analysis based on:
   a) QPR;

b) progress on work plan activities without costs

c) outcomes (HMIS data; monitorable indicators)

d) field visits

e) district wise variances

4) Subsequent to preparation of the report, a variance analysis meeting chaired by State NRHM Director to identify corrective action.

5) Final quarterly report to include a description of key achievements, problems identified and proposed action/ action taken

6) Timely submission of these reports (By the end of month following the reporting quarter)

Common Errors

1) Physical progress missing

2) Financial targets not provided against the actual expenditure

3) Unit of measure not specified

4) Quarterly progress reported does not match with the reported progress on monitorable indicators

5) Inconsistency in data reported in HMIS

6) Variances reported as actual figures rather than %

ANNEX 1

LIST OF RELEVANT GUIDELINES/ DOCUMENTS

ANNEX 1

LIST OF RELEVANT GUIDELINES/ DOCUMENTS

1 RCH Phase II – National Programme Implementation Plan (2005-2012), Ministry of Health & Family Welfare, Government of India (including CD with 15 studies)

2 Broad framework for preparation of District Health Action Plans, August 2006, NRHM, Ministry of Health & Family Welfare, Government of India

3 National Rural Health Mission (2005-2012) - Mission Document, Ministry of Health & Family Welfare, Government of India

http://www.mohfw.nic.in/NRHM%20Mission%20Document.pdf

4 National Rural Health Mission (2005-2012), Frequently Asked Questions, Ministry of Health & Family Welfare, Government of India

5 JananiSurakshaYojana – Guidelines for Implementation http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm

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

7 Guidelines for Operationalising First Referral Units, Maternal Health Division, Department of Family Welfare, MoHFW, Government of India, 2004

8 Operational Guidelines for Implementation of Integrated Management of Neonatal and Childhood Illness (IMNCI), July 2006

9 F-IMNCI Facilitators Guide, MoHFW, GoI, 2009

10 Guidelines for Constitution of RogiKalyanSamitis / Hospital Management Societies.

11 Guidelines for Use of Sub-Centre (SC) Funds Under NRHM

12 Guidelines for Indian Public Health Standards (IPHS) for Primary Health Centres, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, March 2006

13 Guidelines for Indian Public Health Standards (IPHS) for Sub Centres, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, March 2006

14 Guidelines for Department of Family Welfare Supported NGO Schemes, NGO Division, Ministry of Health & Family Welfare, Government of India

15 TOT Manual for MNGOs, NGO Division, Ministry of Health & Family Welfare, Government of India, December 2005

16 Procurement Guidelines for RCH II Project, Ministry of Health & Family Welfare, Government of India, July 14, 2006

17 Finance and Accounts Manual for State Health Society/SCOVA & District Health Societies, Ministry of Health and Family Welfare, Government of India.

18 Quality Assurance Manual for Sterilisation Services, RSS Division, Ministry of Health and Family Welfare, Government of India, October 2006.

19 Standards for Male and Female Sterilisation Services, RSS Division, Ministry of Health and Family Welfare, Government of India, October 2006.

20 Family Planning Insurance Manual, RSS Division, Ministry of Health and Family Welfare, Government of India, December 2005.

21 Project Implementation Plan for Vulnerable Communities under RCH II, Ministry of Health and Family Welfare, Government of India, December 2004.

22 Guidelines for setting up blood storage centres at FRUs, Ministry of Health & Family Welfare, Government of India.

23 Guidelines for Operationalising primary health centres for 24 hours services Ministry of Health & Family Welfare, Government of India.

24 Guidelines for SBA training, Ministry of Health & Family Welfare, Government of India.

25 Guidelines for Training of MBBS doctors in life saving anaesthetic skills, Ministry of Health & Family Welfare, Government of India.

26 Guidelines for Training of MBBS doctors in Emergency Obstetric Care, Ministry of Health & Family Welfare, Government of India.

27 National Guidelines on Prevention, Management, and Control of Reproductive Tract Infections including Sexually Transmitted Infections, Maternal Health Division and National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India, November 2006.

28 Comprehensive Abortion Care Training and Service Delivery Guidelines, MoHFW, GoI, 2010.

29 Policy Guidelines on Vitamin A, Zinc and Iron Folic Acid Supplementation

30 Operational Guidelines on Maternal and Newborn Health

31 NavjaatShishuSurakshaKaryakram, Basic Newborn care and Resuscitation Program, Manual and Facilitators Guide, MoHFW, GoI

32 Operational Guidelines on Maternal and Newborn Health, GoI, 2010

ANNEX 2

OVERVIEW OF RCH PERFORMANCE

ANNEX 2

OVERVIEW OF RCH-NRHM PERFORMANCE (2005-11): FACILITY OPERATIONALISATION AND TRAINED SERVICE PROVIDERS

S. No.	Area	Indicator	Number of facilities/HR				Service utilisation* (average per month per facility/ trained provider)		
			Planned (2005-11)	Total Achievement (2005-11, till November 2010)	Percentage (%) Achievement	Plan for 2011-2012	Services	Based on performance during Apr-Nov 2010	Projection for 2011-12
1	**Facility Operationalisation**	No. of FRUs Operationalised					C-sections		
							MTPs		
							Male sterilisations		
							Female sterilisations		
2		No. of 24x7 PHCs Operationalised					Normal deliveries		
							MTPs		
							Male sterilisations		
							Female sterilisations		
							IUD insertions		
3		No. of sub-centres operationalised as delivery points					Normal deliveries		
							IUD insertions		
4		No. of SNCUs operationalised					Newborns treated		
5		No. of NBSUs operationalised					Newborns treated		
14	**Capacity Building**	EmOC training					C-sections		
15		LSAS training					C-sections		

S. No.	Area	Indicator	Number of facilities/HR				Service utilisation* (average per month per facility/ trained provider)		
			Planned (2005-11)	Total Achievement (2005-11, till November 2010)	Percentage (%) Achievement	Plan for 2011-2012	Services	Based on performance during Apr-Nov 2010	Projection for 2011-12
16		SBA					Deliveries conducted		
17		MTP					MTPs		
18		RTI/STI							
19		IMNCI							
20		F-IMNCI					Children and infants treated		
21		NSSK					Newborns resuscitated		
22		Minilap					Sterilisations		
23		NSV					Sterilisations		
24		Laparoscopicsterilization					Sterilisations		
25		IUD					IUD insertions		

NOTES: * - No. of cases / no. of facilities (or trained providers) / 8 (months)

e.g. Average FRU utilisation for C-sections = Total No. of C-sections at FRUs during April – November 2010, divided by Total no. of FRUs operational as at November 2010, divided by 8 (no. of months)

ANNEX 3 a

FORMAT FOR SELF ASSESSMENT OF STATE PIP AGAINST APPRAISAL CRITERIA

ANNEX 3 a

FORMAT FOR SELF ASSESSMENT OF STATE PIP AGAINST APPRAISAL CRITERIA

CRITERIA		**REMARKS** *{Yes (Y) or No (N)* *If Yes, specify page no. of state PIP}*
A. OVERALL		
1	Has the state PIP been reviewed in detail by a single person to ensure internal consistency? If yes, by whom? (Mandatory)	
2	Has a chartered accountant reviewed the budget in detail? (Mandatory)	
B. RCH II PROGRAMME MANAGEMENT ARRANGEMENTS **Has the state PIP spelt out the programme management arrangements already in place and additional steps to be taken? These include:** ***(Mandatory)***		
1	Firming up the background and **tenure** (at least 3 years) of person having overall responsibility for RCH II and key programmes at state and district levels including the district RCH and Immunization Officers; delegation of powers	
2	Steps to ensure that RCH II is high priority for the District Collector e.g ensuring regularity of DHS /DHM meetings	
3	Extent to which **supportive supervisionstructures** at state and district / sub-district levels is consistent with expertise required for programme strategies; job descriptions including person specifications, delegation of powers and basis for assessment of performance; strategy and time bound plan for sourcing of staff vacancies, if any	
4	Steps to establish financial management systems including funds flow mechanisms to districts; accounting manuals, training, audit	
5	Steps to ensure performance review of district program managers	
6	Capacity building of programme management staff at state and district levels	
7	Steps to ensure/establish quality assurance committees in the districts	
8	Steps to ensure systems for holistic, monitoring (outcomes, activities, costs) against the state PIP including variance analysis	
C. INSTITUTIONAL STRATEGIES Has the state PIP spelt out the steps undertaken for the following and additional steps required? **(Mandatory)**		
1	Have **DHAPs** been prepared for all districts (as a minimum for all high focus) ? If not, for how many?Basis of the allocations for district budget?Has the approach to incorporating DHAPs in the state PIP been	

CRITERIA	REMARKS *{Yes (Y) or No (N) If Yes, specify page no. of state PIP}*
spelt out? 2 Are the DHAPs based on (1) **detailed facility survey** indicating gapsin HR, equipment, etc and (2) **prioritisation** of facilities for operationalizationtaking into account criteria such as patient load, travel time, lack of availability of private sector services, etc	
3 Review of HRD practices in order to motivate staff and increase effectiveness e. g. appropriate criteria for placement of staff/rational deployment, rationalisation of work load of ANMs, performance appraisal based on e. g. improvement in MMR/ IMR/TFR related process indicators, career-progression and professional development, package of incentives (monetary and non-monetary) for postings in less developed districts, transfer and posting policies, work load assessment to justify additional HR requirement, plan for sourcing additional HR (current, medium and long term plan), improved supervision	
4 (a) Strengthening ofweb based HMIS with emphasis onusage ofdata for improved decision making/ initiation of corrective action. Steps for strengthening and capturing of data from Civil Registration System. Steps to implement facility level data.(b) Steps to implement/ ensure effective use of **pregnant woman and new born child tracking system**.	
5 **Improved logistics**/ management of drugs & medical supplies in order to ensure continuous availability of essential supplies at various health facilities including SHC and ASHAs/ community	
6 Development of revised criteria (e. g. travel time, cost, potential patient load, referral arrangements, etc) for location of**new** facilities	
(Desirable criteria)	
7 Provision for MoU with districts	
8 Strategy for piloting public-private partnerships and social franchising and subsequent scale up. Ensure PPP contracting are results based	
9 Functional review of State Health and Family Welfare Department including respective roles of state, district, block and community level (including PRI) institutional structures; delegation of powers; organisational emphasis to key functions such as quality, HRD and training	
10 Optimising the utilization of **existing** health facilities/ scope of relocation based on load/ utilisation, distance/ travel time and cost especially for the poor/women and taking into account availability of private/ NGO run facilities, Monitoring of facility-wise throughputs/utilization	
11 Training Strategy (Mandatory) The training strategy should strengthen existing training schools to function	

CRITERIA	REMARKS *{Yes (Y) or No (N) If Yes, specify page no. of state PIP}*
as District Health Resource Centres. Training should be channelized through these institutions. The strategy should also indicate target groups (e. g. medical officers,staff nurses, ANMs, etc), estimate training load and provide broad details of training programmes including objective, trainee selection, broad course content, duration of training, and mechanisms for assessment of quality/ impact, monitoring of utilization of skills, post training support etc.Strengthening the training management function including the institutional arrangement at state/ district levels, especially seniority of head of training function is particularly important.	
12 BCC strategy (Mandatory) Development of a service oriented BCC strategy should be based on an assessment of the current status of knowledge, attitudes, beliefs and practices regarding issues concerned with MMR, IMR, TFR and ARSH; and factors likely to influence necessary change in behaviour. Creation of awareness of key aspects such as breast feeding and PNDT act is particularly important. Based on evidence, the strategy should aim to determine appropriate combination of messages and media and a mechanism for assessing impact at appropriate stages. The institutional arrangement including role of state and district and strengthening capacities for BCC is again important.	
13 Convergence/ coordination arrangements *(Mandatory)* Have steps taken to ensure convergence within state DHFW (e.g. how to leverage NRHM Additionalities for RCH) and with other key departments such as DWCD and PRI? Have all externally funded programs/projects having a bearing on RCH been reflected in the State PIP and convergence (organisation structures; staff; resources) arrangements spelt out?	
14 Pro poor strategy *(Mandatory)* Does the SPIP demonstrate how pro poor and gender strategies are mainstreamed into RCH II? The recommendations of the equity and gender studies and contained as ***supporting documents in the National PIP*** are of relevance. Some steps that could be taken are e. g. a arrangements for collection and reporting of disaggregated data; gender needs of female health service providers e. g. addressing the needs of ANMs, LHVs, and doctors; policy for encouraging staff to work in less developed districts; strategy developed for creating gender and equity consciousness amongst various stakeholders especially programme staff and community.	
15 Infection Management and Environmental Plan / IMEP *(Mandatory)* Does the SPIP have a clear plan for dissemination of IMEP guidelines and operationalising IMEP in health facilities in a phased manner?	

CRITERIA	**REMARKS** *{Yes (Y) or No (N)* *If Yes, specify page no. of state PIP}*
16 ***Sustainability(Mandatory)*** In the case of facilities and resources created from state funds, the strategy to ensuring sustainability is another criterion for appraisal of state PIPs. Sustainability could be addressed through e. g. introduction of user charges with cross-subsidy for BPL families, higher allocations in the state budget and taking steps to place family welfare in the community's agenda.	
D. TECHNICAL STRATEGIES *(Mandatory)* *(Has the state spelt out steps taken / or constraints faced so far in RCH II and identified corrective actions for the following?).* 1 Separate goals and strategies for MMR, IMR, TFR and ARSH based on evidence and in consonance with the results of the situational analysis. The SPIP should specify, for example:	
2 MMR: steps to ensure availability of anaesthetists and gynaecologists, at FRUs; 24 hour delivery services at 50% PHCs with skilled providers to provide BEmOC services; coverage of inaccessible villages by ANMs; emergency transportation between village (cost per case to the government to be mentioned), BEmOC centres and FRUs. If states plan to pursue PPP or demand side financing options these should also be shown as strategies. In particular **attach list of (1) fully operationalized 24/7 PHCs; FRUs (2) facilities prioritised for operationalization in the coming year (3) districts where a system of maternal death review is in place.** JSY: Steps taken to ensure transparent and timely payment VHND:ensure availability of full complement of RCH services MCH tracking system: coverage, timelines and validation mechanism Referral system including arrangements to drop the women home after delivery Diet, clean environment, water etc for facilitating 48 hours stay post delivery	
3 IMR: steps to ensure strengthen and accelerate immunization activities(how are sessions planned, system for alternate vaccine delivery, cold chain maintenance, system for assessment and reduction of vaccine wastage,strategy to cover children in special populations esp. urban slums, migrants etc, HR positions at state and district level), essential new born care, promotion of breast feeding and timely initiation of complementary feeding, micronutrient supplementation,collaborating arrangements with ICDS for immunisation and IMNCI services and ensuring IMNCI service package is delivered, monitoring of performance of IMNCI trained personnel,	

	CRITERIA	**REMARKS** *{Yes (Y) or No (N)* *If Yes, specify page no. of state PIP}*
	availability of IMNCI drugs. Specify if micro-plans are available for all immunization sessions.Explain how the State plans to tackle the problem of low birth babies? **Attach list of (1) Operationalized SNCUs (2) NBSUs (3) facilities with New born care corners and priority locations for coming year.** School health programme- strategy and coverage	
4	TFR: steps to increase the availability of quality sterilization services by training more providers or increasing the range of sterilisation methods by emphasizing NSV, minilap and traditional tubectomy in addition to laparoscopy and ensuring service availability on fixed days static services at specified no of CHCs and PHCs. For increasing the use of spacing methods, approaches to be pursued to increase availability of methods (including emergency contraceptive) at the community levels through community based distributors, social marketing or private sector. **Attach list offacilities providing fixed day sterilization services at district level, Sub-district level and block level and priority locations for the coming year**	
5	Adolescent Reproductive & Sexual Health/ ARSH Plan for provision of ARSH services – training, ARSH clinics, awareness programmes for various stakeholders; Linkages with State AIDS Control Society; Any school/college based interventions – peer educators, training of teachers, etc.	
6	Quality strategy Has the PIP spelt out the strategy and activities for assuring quality of service delivery at public facilities? This would include steps for implementation of GoI guidelines, an accreditation system and necessary institutional arrangements. The institutional arrangement for implementing the accreditation system is particularly important.	
7	Strategy and activities for quality assurance of private sector facilities/ service providers similar to the above ***(Desirable).***Arrangements for diagnostic facilities through PPP	
E. WORK PLAN *(Mandatory)*		
1	Is the work plan consistent with stated components/ objectives, strategies and activities? and whether the proposed phasing of activities would lead to targeted increase in delivery/ utilisation of services ? The Work Plan should separately address each component of the PIP showing objectives, strategies, activities and should be in quarters with physical targets against activities.	

CRITERIA	**REMARKS** *{Yes (Y) or No (N)* *If Yes, specify page no. of state PIP}*
F. COSTS/ BUDGET *(Mandatory)* Key criteria are:	
1 Does the budget follow the prescribed formats? Information on district wise allocation (annex-3f) and the criteria to be provided along with information on special allocation to High focus districts over and above the pro-rata allocation and allocation to facilities (to be based on case load).	
2 Are districts allocated a certain amount / % of total allocation as genuinely untied i.e. districts can propose district schemes? If yes, how much?	
3 Absorptive capacity: If very ambitious utilisation of funds is envisaged compared to performance in earlier years, then what are the steps proposed to be taken to bring this about?	

ANNEX 3 b

MONITORABLE INDICATORS

ANNEX 3b

MONITORABLE INDICATORS[1]

(against each indicator, States are to provide consolidated quarterly targets for high focus districts and for the State)

SN.	INDICATOR	2010-11		2011-12									
		Baseline (Apr-Nov 2010)		Q1 Target		Q2 Target		Q3 Target		Q4 Target		Annual Target	
		HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total
A	**Maternal Health**												
A.1	*Service Delivery*												
A.1.1	% Pregnant women registered for ANC in the quarter												
A.1.2	% PW registered for ANC in the first trimester, in the quarter												
A.1.3	Institutional deliveries (%) in the quarter												
A.2	*Quality*												
A.2.1	% unreported deliveries in the quarter												
A.2.2	% high risk pregnancies identified (a) % women having hypertension												
	(b) % women having low Hb level												
A.2.3	% of Home Delivery by SBA (i.e. assisted by doctor/ nurse/ ANM)												
A.2.4	C-sections performed (%) (a) in Public facilities												

[1]Guidance note on the indicators is provided in Annex 3b-1 below

SN.	INDICATOR	2010-11		2011-12									
		Baseline (Apr-Nov 2010)		Q1 Target		Q2 Target		Q3 Target		Q4 Target		Annual Target	
		HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total
	(b) in private accredited facilities												
A.2.5	% of deliveries discharged after at least 48 hours of delivery (out of public institution deliveries)												
A.2.6	% of still births												
A.2.7	%age of maternal deaths audited												
A.3	*Outputs*												
A.3.1	% of 24x7 PHCs operationalised as per the GoI guidelines												
A.3.2	% of FRUs operationalised as per the GoI guidelines												
A.3.3	% of Level 1 MCH centres operationalised												
A.3.4	% of Level 2 MCH centres operationalised												
A.3.5	% of Level 3 MCH centres operationalised												
A.3.6	% ANMs/ LHVs/ SNs trained as SBA												
A.3.5	% doctors trained as EmOC												
A.3.6	% doctors trained as LSAS												
A.4	*HR productivity*												
A.4.1	% of LSAS trained doctors giving spinal anaesthesia												
A.4.2	Average no. of c-sections assisted by LSAS trained doctors												

SN.	INDICATOR	2010-11 Baseline (Apr-Nov 2010)		2011-12 Q1 Target		Q2 Target		Q3 Target		Q4 Target		Annual Target	
		HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total
A.4.3	% of EmOC trained doctors conducting c-sections.												
A.4.4	Average no. of c-sections performed by EmOC trained doctor												
A.4.5	Average no. of deliveries performed by SBA trained SN/LHV/ANM												
A.4.6	% of SBA trained ANMs conducting deliveries												
A.5	*Facility utilization*												
A.5.1	% of FRUs conducting C-section												
A.5.2	Average no. of c- sections per FRU												
A.5.3	Average no. of MTPs performed in FRUs												
A.5.4	Average no. of deliveries per 24x7 PHCs												
A.5.5	Average no. of MTPs performed per 24x7 PHC												
A.5.6	% of SC conducting at least 5 deliveries per month												
B	**Child Health**												
B.1	*Service Delivery*												
B.1.1	Children 9-11 months age fully immunised (%)												

SN.	INDICATOR	2010-11		2011-12									
		Baseline (Apr-Nov 2010)		Q1 Target		Q2 Target		Q3 Target		Q4 Target		Annual Target	
		HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total
B.1.2	% children breastfed within 1 hour of birth												
B.1.3	% of low birth weight babies												
B.2	*Quality*												
B.2.1	%age of women receiving PP check up to 48 hrs to 14 days												
B.2.3	% drop out from BCG to measles												
B.3	*Outputs*												
B.3.1	% of SNCUs operationalised												
B.3.2	% of stabilisation units operationalised												
B.3.3	% of new born baby care corners operationalised												
B.3.4	% of personnel trained in IMNCI												
B.3.5	% of personnel trained in F-IMNCI												
B.3.6	% of personnel trained in NSSK												
B.4	*Facility utilization*												
B.4.1	Average no. of children treated in SNCUs												
B.4.2	Average no. of children treated in NBSUs												
C	**Family Planning**												

SN.	INDICATOR	2010-11		2011-12									
		Baseline (Apr-Nov 2010)		Q1 Target		Q2 Target		Q3 Target		Q4 Target		Annual Target	
		HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total
C.1	*Service Delivery*												
C.1.1	% of total sterilisation against ELA												
C.1.2	% post partum sterilisation												
C.1.3	% male sterilizations												
C.1.4	% of IUD insertions against planned												
C.1.5	% IUD retained for 6 months												
C.1.6	% Sterilization acceptors with 2 children												
C.1.7	% Sterilisation acceptors with 3 or more children												
C.2	*Quality*												
C.2.1	% of complications following sterilisation												
C.3	*Outputs*												
C.3.1	% doctors trained as minilap												
C.3.2	% doctors trained as NSV												
C.3.3	% doctors trained as laparoscopic sterilisation												
C.3.4	% ANM/LHV/SN/MO trained in IUD insertion												
C.4	*HR productivity*												

SN.	INDICATOR	2010-11		2011-12									
		Baseline (Apr-Nov 2010)		Q1 Target		Q2 Target		Q3 Target		Q4 Target		Annual Target	
		HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total	HF districts	State total
C.4.1	Average no. of NSVs conducted by trained doctors												
C.4.2	Average no. of minilap sterilisations conducted by minilap trained doctors												
C.4.3	Average no. of laparoscopic sterilisations conducted by lap sterilisation trained doctors												
C.4.4	Average no. of IUDs inserted by MO trained in IUD insertion												
C.4.5	Average no. of IUDs inserted by MO trained in IUD insertion												
C.4.6	Average no. of IUDs inserted by SN/ LHV/ ANM trained in IUD insertion												
C.5	*Facility utilisation*												
C.5.1	Average no. of sterilizations performed in FRUs												
C.5.2	Average no. of sterilizations performed in 24x7 PHCs												

ANNEX 3b - 1

GUIDANCE FOR INDICATORS

SN.	INDICATOR	NUMERATOR		DENOMINATOR	
		PARAMETER	SOURCE OF DATA	PARAMETER	SOURCE OF DATA
A	**Maternal Health**				
A.1	*Service Delivery*				
A.1.1	% Pregnant women registered for ANC in the quarter	No. of women registered for ANC	HMIS	Estimated no. of pregnant women	M&E division / State projections / State target
A.1.2	% PW registered for ANC in the first trimester, in the quarter	No. of PW registered for ANC in the first trimesterin the quarter	HMIS	Total No. of women registered for ANC in the quarter	HMIS
A.1.3	Institutional deliveries (%) in the quarter	No. of deliveries reported in public & private institutions	HMIS	Estimated no. of deliveries	M&E division / State projections / State target
A.2	*Quality*				
A.2.1	% unreported deliveries in the quarter	Estimated no. of deliveries (quarterly) – {Total no. of deliveries reported in the quarter (home + institutional)}	M&E division / state projections or State target, HMIS	Estimated no. of deliveries in the quarter	M&E division / State projections / State target
A.2.2	% high risk pregnancies identified (a) % women having hypertension	Total no. of PW having high BP	HMIS	Total no. of women registered for ANC	HMIS
	(b) % women having low Hb level	Total no. of PW having low Hb	HMIS	Total no. of women registered for ANC	HMIS
A.2.3	% of Home Delivery by SBA (i.e. assisted by doctor/ nurse/ ANM)	No. of home deliveries conducted by SBA	HMIS	Total no. of home deliveries	HMIS

SN.	INDICATOR	NUMERATOR		DENOMINATOR	
		PARAMETER	SOURCE OF DATA	PARAMETER	SOURCE OF DATA
A.2.4	C-sections performed (%) (a) in Public facilities	No. of c-sections performed in public facilities	HMIS	Total no. of deliveries in public facilities	HMIS
	(b) in private accredited facilities	No. of c-sections performed in private accreditedfacilities	HMIS	Total no. of deliveries in private accreditedfacilities	HMIS
A.2.5	% of deliveries discharged after at least 48 hours of delivery (out of public institution deliveries)	No. of public institution deliveries discharged after 48 hours	HMIS	Total no. of deliveries reported in public institutions	HMIS
A.2.6	% of still births	No. of still births reported	HMIS	Total births reported (live births + still births)	HMIS
A.2.7	%age of maternal deaths audited	No. of maternal deaths audited	HMIS	No. of maternal deaths reported	State MIS
A.3	*Outputs*				
A.3.1	% of 24x7 PHCs operationalised as per the GoI guidelines	No. of 24x7 PHCs operationalised	HMIS	No. of 24x7 PHCs planned for operationalisation	PIP / ROP
A.3.2	% of FRUs operationalised as per the GoI guidelines	No. of FRUs operationalised	HMIS	No. of FRUs planned for operationalisation	PIP / ROP
A.3.3	% of Level 1 MCH centres operationalised	MCH centres operational as level 1 as per GOI guidelines	State MIS	Total MCH centres planned as level 1	PIP / ROP
A.3.4	% of Level 2 MCH centres operationalised	MCH centres operational as level 2 as per GOI guidelines	State MIS	Total MCH centres planned as level 2	PIP / ROP
A.3.5	% of Level 3 MCH centres operationalised	MCH centres operational as level 3 as per GOI guidelines	State MIS	Total MCH centres planned as level 3	PIP / ROP

SN.	INDICATOR	NUMERATOR		DENOMINATOR	
		PARAMETER	SOURCE OF DATA	PARAMETER	SOURCE OF DATA
A.3.6	% ANMs/ LHVs/ SNs trained as SBA	No. of ANMs/ LHVs/ SNs trained in SBA	HMIS	No. of ANMs/ LHVs/ SNs planned for SBA training	PIP / ROP
A.3.5	% doctors trained as EmOC	No. of doctors trained in EmOC	HMIS	No. of doctors planned for EmOC training	PIP / ROP
A.3.6	% doctors trained as LSAS	No. of MOs trained in LSAS	HMIS	No. of MOs planned for LSAS training	PIP / ROP
A.4	*HR productivity*				
A.4.1	% of LSAS trained doctors giving spinal anaesthesia	No. Of LSAS trained MOs giving spinal anaesthesia	State MIS	Total No. of LSAS trained doctors	PIP / ROP, HMIS
A.4.2	Average no. of c-sections assisted by LSAS trained doctors	No. of C- sections assisted by LSAS trained MOs	State MIS	No. of LSAS trained doctors	PIP / ROP, HMIS
A.4.3	% of EmOC trained doctors conducting c-sections.	No. of EmOC trained MOs conducting C-sections	State MIS	Total No. of EmOC trained doctors	PIP / ROP, HMIS
A.4.4	Average no. of c-sections performed by EmOC trained doctor	No. of C-sections performed by EmOC trained MOs	State MIS	No. of EmOC trained doctors	PIP / ROP, HMIS
A.4.5	Average no. of deliveries performed by SBA trained SN/LHV/ANM	No. of deliveries performed by SBA trained personnel	State MIS	No. of SBA trained personnel	PIP / ROP, HMIS
A.4.6	% of SBA trained ANMs conducting deliveries	No. of SBA trained ANMs conducting deliveries	State MIS	Total No. of SBA trained ANMs	State MIS
A.5	*Facility utilization*				
A.5.1	% of FRUs conducting C-section	Total no. of FRUsconductingc-sections	Facility HMIS	(Cumulative) No. of FRUs operational as per GOI criteria	PIP / ROP

SN.	INDICATOR	NUMERATOR		DENOMINATOR	
		PARAMETER	SOURCE OF DATA	PARAMETER	SOURCE OF DATA
A.5.2	Average no. of c- sections per FRU	Total no. of c-sections conducted in FRUs	Facility HMIS	(Cumulative) No. of FRUs operational as per GOI criteria	PIP / ROP
A.5.3	Average no. of MTPs performed in FRUs	Total no. of MTPs conducted in FRUs	Facility HMIS	(Cumulative) No. of FRUs operational as per GOI criteria	PIP / ROP
A.5.4	Average no. of deliveries per 24x7 PHCs	Total no. of deliveries conducted in 24X7 PHCs	Facility HMIS	(Cumulative) No. of 24x7 PHCs operational as per GOI criteria	PIP / ROP
A.5.5	Average no. of MTPs performed per 24x7 PHC	Total no. of MTPs conducted in 24x7 PHCs	Facility HMIS	(Cumulative) No. of 24x7 PHCs operational as per GOI criteria	PIP / ROP
A.5.6	% of SC conducting at least 5 deliveries per month	No. of SCs conducting at least 5 deliveries per month	State MIS	Total no. of SC conducting deliveries	State MIS
B	**Child Health**				
B.1	*Service Delivery*				
B.1.1	Children 9-11 months age fully immunised (%)	No. of children 9-11 months fully immunised	HMIS	Estimated no. of infants (11 months)	M&E division / State projections / State target
B.1.2	% children breastfed within 1 hour of birth	No. of children breastfed within one hour of birth	HMIS	No. of live births	HMIS
B.1.3	% of low birth weight babies	No. of children weighed less than 2.5 kg	HMIS	No. of children weighed at birth	HMIS
B.2	*Quality*				
B.2.1	%age of women receiving PP check up to 48 hrs to 14 days	No. of women receiving PP check up	HMIS	No. of deliveries reported	HMIS

SN.	INDICATOR	NUMERATOR		DENOMINATOR	
		PARAMETER	SOURCE OF DATA	PARAMETER	SOURCE OF DATA
B.2.3	% drop out from BCG to measles	No. of children received Measles vaccine	HMIS	No. of children received BCG vaccine	HMIS
B.3	*Outputs*				
B.3.1	% of SNCUs operationalised	No. of SNCUs operationalised	HMIS	No. of SNCUs planned for operationalisation	PIP / ROP
B.3.2	% of stabilisation units operationalised	No. of NBSUs operationalised	State MIS	No. of NBSUs planned for operationalisation	PIP / ROP
B.3.3	% of new born baby care corners operationalised	No. of NBCCs operationalised	State MIS	No. of NBCCs planned for operationalisation	PIP/ ROP
B.3.4	% of personnel trained in IMNCI	No. of personnel trained in IMNCI	HMIS	No. of personnel planned for IMNCI training	PIP / ROP
B.3.5	% of personnel trained in F-IMNCI	No. of personnel trained in F-IMNCI	State MIS	No. of personnel planned for F-IMNCI training	PIP / ROP
B.3.6	% of personnel trained in NSSK	No. of personnel trained in NSSK	State MIS	No. of personnel planned for NSSK training	PIP / ROP
B.4	*Facility utilization*				
B.4.1	Average no. of children treated in SNCUs	Total no. of children treated in SNCUs	Facility HMIS	Total no. of SNCUs operational	State MIS
B.4.2	Average no. of children treated in NBSUs	Total no. of children treated in NBSUs	Facility HMIS	Total no. of NBSUs operational	State MIS

SN.	INDICATOR	NUMERATOR		DENOMINATOR	
		PARAMETER	SOURCE OF DATA	PARAMETER	SOURCE OF DATA
C	**Family Planning**				
C.1	*Service Delivery*				
C.1.1	% of total sterilisation against ELA	No. of sterilisations reported	HMIS	Estimated no. of sterilisations (ELA)	FP division / state projections
C.1.2	% post partum sterilisation	No. of post partum sterilisations reported	HMIS	Total no. of female sterilisations reported	HMIS
C.1.3	% male sterilizations	Total no. of male sterilizations reported	HMIS	Total no. of sterilizations reported	HMIS
C.1.4	% of IUD insertions against planned	No. of IUD insertions conducted	HMIS	No. of IUD insertions planned	PIP/ROP
C.1.5	% IUD retained for 6 months	No. of IUDs retained for 6 months	State HMIS	Total no. of IUD insertions	HMIS
C.1.6	% Sterilization acceptors with 2 children	No. of sterilisation acceptors with 2 children	State HMIS	No. of sterilisation acceptors	HMIS
C.1.7	% Sterilisation acceptors with 3 or more children	No. of sterilisation acceptors with 3 or more children	State HMIS	No. of sterilisation acceptors	HMIS
C.2	*Quality*				
C.2.1	% of complications following sterilization	No. of complications reported following sterilisation	HMIS	Total No. of sterilisations	HMIS
C.3	*Outputs*				
C.3.1	% doctors trained as minilap	No. of doctors trained in minilap	HMIS	No. of doctors planned for minilap training	PIP / ROP

SN.	INDICATOR	NUMERATOR		DENOMINATOR	
		PARAMETER	SOURCE OF DATA	PARAMETER	SOURCE OF DATA
C.3.2	% doctors trained as NSV	No. of doctors trained in NSV	HMIS	No. of doctors planned for NSV training	PIP / ROP
C.3.3	% doctors trained as laparoscopic sterilisation	No. of doctors trained in laparoscopic sterilisation	HMIS	No. of doctors planned for laparoscopic sterilisation training	PIP / ROP
C.3.4	% ANM/LHV/SN/MO trained in IUD insertion	No. of ANM/LHV/SN/MO trained in IUD insertion	HMIS	No. of ANM/LHV/SN/MO planned for IUD insertion training	PIP / ROP
C.4	*HR productivity*				
C.4.1	Average no. of NSVs conducted by trained doctors	No. of NSVs conducted by trained doctors	State MIS	Total No. of NSV trained doctors	PIP / ROP, HMIS
C.4.2	Average no. of minilap sterilisations conducted by minilap trained doctors	No. of sterilisations conducted by minilap trained doctors	State MIS	Total No. of minilap trained doctors	PIP / ROP, HMIS
C.4.3	Average no. of laparoscopic sterilisations conducted by laparoscopic sterilisation trained doctors	No. of laparoscopic sterilisations conducted by lap sterilisation trained doctors	State MIS	Total no. of laparoscopic sterilisation trained doctors	PIP / ROP, HMIS
C.4.4	Average no. of IUDs inserted by MO trained in IUD insertion	No. of IUD insertions by MO trained in IUD insertion	State MIS	Total No. of IUD insertion trained MOs	PIP / ROP, HMIS
C.4.5	Average no. of IUDs inserted by MO trained in IUD insertion	No. of IUD insertions by MO trained in IUD insertion	State MIS	Total No. of IUD insertion trained MOs	PIP / ROP, HMIS
C.4.6	Average no. of IUDs inserted by SN/ LHV/ ANM trained in IUD insertion	No. of IUD insertions by SN/ LHV/ ANM trained in IUD insertion	State MIS	Total No. of IUD insertion trained SNs/ LHVs/ ANMs	

SN.	INDICATOR	NUMERATOR		DENOMINATOR	
		PARAMETER	SOURCE OF DATA	PARAMETER	SOURCE OF DATA
C.5	*Facility utilisation*				
C.5.1	Average no. of sterilizations performed in FRUs	Total no. of Sterilizations done in FRUs	Facility HMIS	(Cumulative) No. of FRUs operational as per GOI criteria	PIP/ ROP
C.5.2	Average no. of sterilizations performed in 24x7 PHCs	Total no. of Sterilizations done in 24x7 PHCs	Facility HMIS	(Cumulative) No. of 24x7 PHCs operational as per GOI criteria	PIP/ ROP

ANNEX 3c

FORMAT FOR SUMMARY BUDGET

ANNEX 3 c

RCH II: SUMMARY BUDGET 2011-12

(Rs. Lakhs)

Budget head	Qtr I		Qtr II		Qtr III		Qtr IV		Total RCH II		NRHM	Others (specify e.g. State budget, Finance Commission, Development Partners etc.)	TOTAL
	High focus districts	State total	High focus districts	State total	High focus districts	State total	High focus districts	State total	High focus districts	State total			
1 Maternal Health													
(a) JSY													
(b) Others													
Sub total MH													
2 Child Health													
3 Family Planning													
(a) Sterilisation and IUD compensation and NSV camps													
(c) Others													
Sub total FP													
4 ARSH													
5 Urban RCH													
6 Tribal RCH													
7 Vulnerable groups													
8 Innovations / PPP/ NGO													

Budget head	Qtr I		Qtr II		Qtr III		Qtr IV		Total RCH II		NRHM	Others (specify e.g. State budget, Finance Commission, Development Partners etc.)	TOTAL
	High focus districts	State total	High focus districts	State total	High focus districts	State total	High focus districts	State total	High focus districts	State total			
9 Infrastructure and Human Resources													
10 Institutional strengthening (HRD practices, logistics, M&E/ HMIS, QA)													
11 Training													
12 BCC/ IEC													
13 Procurement													
14 Programme management													
14. TOTAL RCH II													

ANNEX 3d
FORMAT FOR WORK PLAN

(Attached separately)

ANNEX 3 e

DETAILED RCH II BUDGET

(Attached separately)

ANNEX 3 f

ALLOCATION OF RCH II FLEXIBLE FUNDS TO DISTRICTS (2011-12)

ANNEX 3f

ALLOCATION OF RCH II FLEXIBLE FUNDS TO DISTRICTS ()

District / Budget head	District 1	District 2, etc.	Total
1 Maternal Health			
(a) JSY			
(b) Others			
Sub totalMaternal Health			
2 Child Health			
3 Family Planning			
(a) Sterilisation & IUD compensation and NSV camps			
(b) Others			
Sub totalFamily Planning			
4 Adolescent Reproductive and Sexual Health			
5 Urban RCH			
6 Tribal RCH			
7 Vulnerable groups			

District / Budget head	District 1	District 2, etc.	Total
8 Innovations / PPP/ NGO			
9 Infrastructure and Human Resources			
10 Institutional strengthening (HRD practices, logistics, M&E/ HMIS, QA)			
11 Training			
12 BCC/ IEC			
13 Procurement			
14 Programme management			
Total RCH II			
Immunization (Part C)			
Grand Total RCH			

ANNEX 4

QUARTERLY PROGRESS REPORT FORMAT

(To be provided separately, after approval of the PIPs)

ANNEX 5

PROCUREMENT FORMAT

ANNEX 5

PROCUREMENT FORMAT

SN.	ITEM	TYPE OF ITEM TO BE PROCURED	Balance stock available as on date (please specify date and unit of measure)	Expected receipt till 31st March 2011 (from GoI as well as other sources)	Expected usage of supplies by 31st March 2011	Expected stock balance as on April 01, 2011	Demand for 2011-12	Unit cost (Rs.)	Total cost (Rs.)	REMARKS
		a	*b = reference date for planning purpose*	*c*	*D*	*e = (b+c)-d*	*f*	*g*	*h = f*g*	
Maternal and Child Health										
1	Kit A for sub centre									
2	Kit B for sub centre									
3	Essen. Obs. Kit PHC									
4	Emergency Obst. Kit FRU									
5	SBA Kit PHC									
6	SBA Kit CHC/FRU									
7	SBA Kit DH									
8	Drug Kit for Sick New Born PHC									
9	Drug Kit for Sick New Born FRU									
10	Drug Kit for Sick New Born CHC									
11	Emergency Drug Kit for New Born & Child PHC									
12	Em Drug Kit for New Born & Child CHC									
13	Em Drug Kit for New Born & Child FRU									
14	Infusion Equipment BIS 21G/25									
15	Bupivacaine Injection-20ml									
16	Lignocaine Injection-02ml									

SN.	ITEM	TYPE OF ITEM TO BE PROCURED	Balance stock available as on date (please specify date and unit of measure)	Expected receipt till 31st March 2011 (from GoI as well as other sources)	Expected usage of supplies by 31st March 2011	Expected stock balance as on April 01, 2011	Demand for 2011-12	Unit cost (Rs.)	Total cost (Rs.)	REMARKS
		a	***b = reference date for planning purpose***	***c***	***D***	***e = (b+c)-d***	***f***	***g***	***h = f*g***	
17	Intracath Cannula for Single Use(Intravascular catheters) BIS-gauze 18									
18	Etofylline BP plus Theophyline IP Combination Injection-02ml									
19	Oxytocin Injection IP-02ml/50									
20	Compound Sodium Lacate Injection IP-500ml									
21	Dextrose Injection 5% IP-500ml									
22	Thiopentone Injection IP-20ml									
23	Dopamine Injection IP-05ml									
24	Ampicillin Injection IP-250mg/13									
25	Hydrocortisone Acetate Injection IP-02ml									
26	Neostigmine Injection IP-01ml									
27	Benzylpencillin Injection IP-300mg									
28	Fortified Procaine Pencillin Injection IP-60mg									
29	Metronidazole Injection IP 100 ml									
30	Hydroxyprogestrone Injection IP-02ml									
31	Insulin Injection IP-10ml									
32	Insulin Zinc Suspension Injection									

SN.	ITEM	TYPE OF ITEM TO BE PROCURED	Balance stock available as on date (please specify date and unit of measure)	Expected receipt till 31st March 2011 (from GoI as well as other sources)	Expected usage of supplies by 31st March 2011	Expected stock balance as on April 01, 2011	Demand for 2011-12	Unit cost (Rs.)	Total cost (Rs.)	REMARKS
		a	*b = reference date for planning purpose*	*c*	*D*	*e = (b+c)-d*	*f*	*g*	*h = f*g*	
	IP-10ml									
33	Sodium Bicarbonate Injection IP-10ml									
34	Sterile Water for Injection IP/25									
35	Phenytoin Injection BP-02ml/5									
36	Sodium Chloride Injection IP-500ml/30									
37	Vecuronium Bromide for Injection USP									
38	Diazepam Tablets-5mg									
39	Doxycycline Capsules-100mg/250									
40	Salbutamol Tablets IP-2mg									
41	Methylergometrine Injection IP/75									
42	Phenytoin Tablets IP-100mg									
43	Intracath Cannula for Single Use(Intravascular catheters) BIS-Size 22									
44	Phenoxy Methyl Penicillin Potassium Tablets IP-250mg									
45	Ketamine Injection IP-10ml									
46	Pentazocine Lactate Injection IP-01ml									
47	Dexamethasone Injection IP-									

SN.	ITEM	TYPE OF ITEM TO BE PROCURED	Balance stock available as on date (please specify date and unit of measure)	Expected receipt till 31st March 2011 (from GoI as well as other sources)	Expected usage of supplies by 31st March 2011	Expected stock balance as on April 01, 2011	Demand for 2011-12	Unit cost (Rs.)	Total cost (Rs.)	REMARKS
		a	***b = reference date for planning purpose***	***c***	***D***	***e = (b+c)-d***	***f***	***g***	***h = f*g***	
	02ml									
48	Adrenaline Injection-01ml/25									
49	Atropine Injection IP-02ml/25									
50	Frusemide Injection IP-02ml									
51	Gentamycin Injection Ip-02ml									
52	Succinylcholine Injection IP-10ml									
53	Pancuronium Bromide Injection BP-02ml									
54	Magnesium Sulphate Injection IP-02ml/6									
55	Promathazine Injection IP									
56	Diazepam Injection IP-2ml									
57	Hypodermic Needle for Single Use-Gauze 22 BIS									
58	Hypodermic Needle for Single Use-Gauze 24 BIS									
59	Hypodermic Syringes for Single Use-2ml BP/BIS									
60	Hypodermic Syringes for Single Use-10ml BP/BIS									
61	Hypodermic Syringes for Single Use-50ml BP/BIS									
62	Hypodermic Needle for Single Use-Gauze 23 BIS/150									

SN.	ITEM	TYPE OF ITEM TO BE PROCURED	Balance stock available as on date (please specify date and unit of measure)	Expected receipt till 31st March 2011 (from GoI as well as other sources)	Expected usage of supplies by 31st March 2011	Expected stock balance as on April 01, 2011	Demand for 2011-12	Unit cost (Rs.)	Total cost (Rs.)	REMARKS
		a	*b = reference date for planning purpose*	*c*	*D*	*e = (b+c)-d*	*f*	*g*	*h = f*g*	
63	Hypodermic Syringe for Single Use-5ml BP/BIS/125									
64	Trimethoprim-80mg & Sulphamethoxazole-400mg Tablets IP(Adults)									
65	Amoxycillin Capsules-250mg									
66	Metronidazole Tablets IP-200mg/500									
67	Fluconazole Tablets IP-150mg									
68	Methyldopa Tablets IP-250mg									
69	Frusemide Tablet IP-40mg									
70	Norfloxacin Tablets IP-400mg									
71	Group 1									
72	Group 2									
73	*Others (please specify)*									
Immunisation										
	Vaccines									
	UIP									
1	BCG (1 Vial of 10 doses)									
2	DPT with VVM (1 Vial of 10 doses)									
3	DT (1 Vial of 10 doses)									
4	TT (1 Vial of 10 doses)									
5	Measles (1 Vial of 5 doses)									
6	T-OPV (1 Vial of 20 doses)									

SN.	ITEM	TYPE OF ITEM TO BE PROCURED	Balance stock available as on date (please specify date and unit of measure)	Expected receipt till 31st March 2011 (from GoI as well as other sources)	Expected usage of supplies by 31st March 2011	Expected stock balance as on April 01, 2011	Demand for 2011-12	Unit cost (Rs.)	Total cost (Rs.)	REMARKS
		a	***b = reference date for planning purpose***	***c***	***D***	***e = (b+c)-d***	***f***	***g***	***h = f*g***	
7	Hep-B (1 Vial of 10 doses)									
8	JE (1 Vial of 5 doses)									
Pulse Polio										
9	bOPV (1 vial of 20 doses)(emergency)									
10	bOPV (1 vial of 20 doses)(regular)									
11	tOPV (1 vial of 20 doses)									
12	mOPV1 (1 vial of 20 doses)									
13	mOPV3 (1 vial of 20 doses)									
14	*Others (please specify)*									
Cold Chain Equipments										
1	Cold Box (Large)									
2	Cold Box (Small)									
3	Ice Packs									
4	Vaccine Carrier 4 Ice Pack									
5	WIC (nos)									
6	WIF (nos)									
7	ILR(S) (nos)									
8	ILR(L) (nos)									
9	Deep freezer(L) (nos)									
10	Deep Freezer (S)through (nos)									
11	Vaccine Van 4 Wheel (nos)									
12	Vaccine Van 2 Wheel (nos)									
13	*Others (please specify)*									

SN.	ITEM	TYPE OF ITEM TO BE PROCURED	Balance stock available as on date (please specify date and unit of measure)	Expected receipt till 31st March 2011 (from GoI as well as other sources)	Expected usage of supplies by 31st March 2011	Expected stock balance as on April 01, 2011	Demand for 2011-12	Unit cost (Rs.)	Total cost (Rs.)	REMARKS
		a	*b = reference date for planning purpose*	*c*	*D*	*e = (b+c)-d*	*f*	*g*	*h = f*g*	
Syringes										
1	Disposable Syringe 5 ml (Pieces)									
2	AD Syringe 0.5 ml (Pieces)									
3	AD Syringe 0.5 ml (Pieces)(through UNOPS)									
4	AD Syringe 0.1 ml (Pieces)									
5	*Others (please specify)*									
Family Planning										
1	Cu-T (Pieces)									
2	Emergency Contraceptive Pills (Packs)									
3	Mala-N (Cycles)									
4	Pregnancy detection Kit (Kit)									
5	Tubal Rings (Pairs)									
6	OCP-Others (Cycles)									
7	Mala-D (1 Cycle of 28 Tablets)									
8	Nirodh Condom (Pieces)									
9	Deluxe (Nirodh) Govt Type A (Pieces)									
10	Deluxe (Nirodh) SMO Brand Type A (Pieces)									

SN.	ITEM	TYPE OF ITEM TO BE PROCURED	Balance stock available as on date (please specify date and unit of measure)	Expected receipt till 31st March 2011 (from GoI as well as other sources)	Expected usage of supplies by 31st March 2011	Expected stock balance as on April 01, 2011	Demand for 2011-12	Unit cost (Rs.)	Total cost (Rs.)	REMARKS
		a	*b = reference date for planning purpose*	*c*	*D*	*e = (b+c)-d*	*f*	*g*	*h = f*g*	
11	New Lubricated Nirodh (Condom) SMO Brand Type A (Pieces)									
12	Super Deluxe (Nirodh) Govt Type A (Pieces)									
13	Super Deluxe (Nirodh) SMO Brand Type A (Pieces)									
14	*Others (please specify)*									

Note:

1) Due care has been taken for preparing comprehensive list of items to be procured under RCH; however, state may add any other item as per local needs
2) State needs to define a reference period which is taken as base to start the procurement planning
3) Demand for the year 2011-12 needs to be calculated on the basis of total requirement, stock available, wastage factor etc.
4) Tentative unit cost to be used for planning purpose; this may be revised at central level if needed
5) State should use available sources of data for planning purpose

ANNEX 6

BUDGET HEADS FOR RCH II ACTIVITIES

ANNEX 6

BUDGET HEADS FOR RCH II ACTIVITIES

RCH-II Programme – Classification of certain items of State PIPs to be budgeted under RCH-II PIP

S. No.	**Activities**	**Provision to be made under RCH-II PIPs**	**Corresponding Budget Head (as per FMR/ Operating Manual)**
1	Maternal Health, Child Health, Family Planning, ARSH	➢ All technical strategies pertaining to reduce IMR/ MMR/ TFR as per National Programme Implementation Plan of RCH-II; few illustrations: – Cost of planning, monitoring, quality assurance, implementation if any – VHNDs, outreach camps, referral transport (under MH) – FBNC (SNCU, NBSU, NBCC), HBNC (under CH) – Sterilisation compensation, fixed day services (under FP) NOTE: cost of infrastructure, HR, equipment, drugs, training, IEC/BCC not to be booked under these heads	➢ Maternal Health (A.1), Child Health (A.2), Family Planning (A.3) and ARSH (A.4) respectively
2	Infrastructure & Equipment	➢ Additions / extensions and repairs / renovations of SC/PHC/CHC/FRU such as Labour Room, Operation Theatres, New Born facilities etc. (new constructions to be budgeted under Mission Flexible Pool).	➢ Infrastructure & Human Resources (A.9)
		➢ Strengthening of SIHFW.	➢ Training (A.11)
		➢ Repairs and Renovations of ANM Training School.	➢ Training (A.11)
		➢ Equipment required for operationalisation of facilities (24x7 PHCs and FRUs). ➢ Family Planning equipments such as laparoscope, NSV kits etc.	➢ Procurement (A.13)
3.	Human Resources	➢ Hiring of doctors/specialists and paramedical staff (ANM, LHV, SN, Lab Tech etc.) on contractual basis for operationalising FRUs and 24x7 PHCs.	➢ Infrastructure & Human Resources (A.9)

S. No.	Activities	Provision to be made under RCH-II PIPs	Corresponding Budget Head (as per FMR/ Operating Manual)
		➢ Link workers other than ASHA for rural and slum areas.	➢ Rural areas - Infrastructure & Human Resources (A.9) ➢ Urban slums - under Urban Health (A.5)
		➢ Hiring of contractual ANMs for making SC operational	➢ Infrastructure & Human Resources (A.9)
		➢ Other consultants for MH, CH, IEC, Training, M&E, Finance and Accounts etc. ➢ Computer operators, assistants etc.	➢ Salary of all these staff to be booked under Programme Management (A.14) such as consultant for MH, CH, FP, ARSH, Urban Health, Finance/ Accounts, Training, IEC, M&E, computer operators, assistants etc. NOTE: cost of these should be booked at various levels such as block, district and state; cost to be booked at block level is to become part of BPMU cost under Mission Flexi Pool and rest can be booked under DPMU and SPMU costs.
4.	Programme Management	➢ Establishment of SPMU and DPMU (N.B. Block & Regional PMU and PHC accountants to be budgeted under Mission Flexible Pool). ➢ Training on Programme Management and Financial Management. ➢ Budgeting for workshops, seminars, review missions etc. ➢ Establishing HR systems. ➢ Hiring of vehicles.	➢ Establishment of SPMU/DPMU, budgeting for workshops, seminars, review missions, hiring of vehicles etc. - Programme Management (A.14) ➢ Training on programme & financial management -Training (A.11) ➢ Establish HR systems – Institutional Strengthening (A.10)
5	Training	➢ Training of doctors for multi-skilling. ➢ Training of ANMs/Nurses/Doctors on Maternal Health, Child Health and Family Planning. ➢ All trainings for making facility as FRU, 24 x 7 and providing RCH Services.	➢ Training (A.11)
6	PPP/ Innovations/ NGO	➢ All RCH related PPP including those for making SC/PHC/CHC operational and functional for RCH services.Such as	➢ PPP/ Innovations/ NGO (A.8)

S. No.	Activities	Provision to be made under RCH-II PIPs	Corresponding Budget Head (as per FMR/ Operating Manual)
		making facilities as FRUs, 24 x 7, providing demand side financing referral transports, health insurance, outsourcing management of facilities of NGOs, Partnership and private sector, gender main-streaming, NGO partnership, Community participation.	
7	IEC/BCC	➢ All IEC activities pertaining to RCH services. ➢ All BCC activities as per national strategy under NPIP of RCH-II.	➢ IEC/ BCC (A.12)
8	Convergence	➢ All convergence activities of RCH-II with HIV/AIDS. ➢ All convergence activities with ICDS for RCH Services.	➢ Individual activities under the corresponding technical heads e.g. MH, CH etc.
9	Monitoring and Evaluation	➢ All M&E activities for RCH-II Programme (excluding hiring of contractual data assistant) such as development of comprehensive M&E systems, revising / printing formats etc. ➢ Taking short surveys, evaluation studies for the RCH-II Programme.	➢ Institutional Strengthening (A.10) except: – Establish community monitoring – Mission Flexi Pool – Establish data triangulation – Mission Flexi Pool
10	Drugs and Pharmaceuticals	➢ Equipment related to RCH ➢ Drugs and supplies related to RCH Note: Kits and certain other items (vaccines, FP supplies, cold chain equipments etc) to be procured centrally and supplied in kind to States.	➢ Procurement (A.13)
11	Financial Management	➢ Audit of accounts, e-banking, training computers, accounting software etc.	➢ Programme Management (A.14)
12	Urban Health	➢ Slums in cities with population between 1 to 10 lakh.Initiatives in line with 1 – 10 above and could include hiring to staff on contract, rentals for buildings, repairs, equipment, drugs not provided centrally etc.Insert rows to add activities and choose appropriate head to reflect the cost (i.e. HR, Infrastructure, procurement	➢ Urban Health (A.5)

S. No.	Activities	Provision to be made under RCH-II PIPs	Corresponding Budget Head (as per FMR/ Operating Manual)
		etc.)	
13	Tribal Health	➢ All initiatives to provide RCH services insert rows to add activities and choose appropriate head to reflect the cost (i.e. HR, Infrastructure, procurement etc.)	➢ Tribal Health (A.6)

Note: Costs of all activities related to provision of RCH Services/meeting outcome indicators as per the National RCH-II PIP should be part of the State RCH-II PIP/Work Plan and corresponding RCH base flexible pool allocation.

ANNEX 7

NON PERMISSIBLE ACTIVITIES IN RCH II

ANNEX 7

NON PERMISSIBLE ACTIVITIES IN RCH II

Sn.	Activity	Where to be budgeted
1.	New Construction*	Mission Flexi pool/State Budget
2.	Purchase of vehicles / ambulances	Mission Flexipool/ State budget
3.	Contingency / operational costs for facilities	Mission flexi pool (untied fund/RKS fund)
4.	Telephone / Mobile phone expenses	Mission flexi pool/State budget
5.	Gardening, beautification of facilities, sanitary services etc.	Mission flexi pool (untied fund/ RKS fund/ Annual Maintenance Grant)
6.	Annual maintenance expenses	Mission flexi pool
7.	Any activity related to Disease Control Programmes e.g. Anti Tobacco campaign, IEC for life style diseases etc.	Mission flexi pool/respective programmes
8.	ASHA cost	Mission Flexi Pool: recruitment, training, support systems Various programmes: incentives
9.	Additional incentive to mothers for institutional deliveries	State budget, if so desired since already covered under JSY. Not permissible for non JSY deliveries
10.	Additional incentives for sterilization acceptors/motivators/service providers	State budget, if so desired since already covered under FP Compensation Scheme

Note:

* Repairs and Renovations of SC/PHC/CHC such as Labour Room, Operation Theatres, New Born facilities etc. are permissible under RCH flexi pool

Equipment required for operationalisation of facilities (24x7 PHCs and FRUs) is permissible under RCH flexi pool

ANNEX 8

PLANNING FORMATS AND GUIDELINES

ANNEX 8a

MATERNAL HEALTH GUIDELINES AND FORMATS

The generic comments placed below will help the states in preparing their PIP for the year 2011-12:

- The state wise comments of MH Division will be shared with the states after receiving PIP for 2011-12 and planning of the activities in the PIP should be done accordingly.
- In case of any difference of opinion due to local/state specific circumstances, the same may please be shared before implementation.
- Any procurement should be done based on competitive bidding and by following Government protocols.
- Procurement of equipment should be need based, linked with its utilization and availability of required manpower.
- Hiring of additional staff should be avoided on generic basis beyond the approved norms and should be linked with case load and quality of service delivery.
- Incentives should be on state specific situation and rationality for the same may be shared.
- A tableonincentivesmust be indicatedgivingdetails onRCH incentivesbeing plannedeitherin NRHMor in RCH.
- Individual incentives should be minimum and need based.
- Incentives to service providers may be given to a group of providers and linked with ensuring quality protocols of the service rendered.
- RCH Drugs/Any other drugs should be budgeted under State head or under NRHM except for the states where World bank has approved their procurement procedure.
- Monitoring visits should be comprehensive for all the programs and should be budgeted under separate headings of monitoring and supervision.
- Platform of Quality Assurance cell at state and district level be utilized for such monitoring visits.
- Monitoring should also be conducted by State/District program officers.
- Some of the states have put their RCH activities particularly related with Maternal Health under NRHM, may be because of budget related issues. Such states must see and conform to the state wise comments given by MH division on all MH related activities whether booked under RCH or NRHM, during appraisal of the PIPs and plan accordingly.

FRU Operationalization:

- Holistic planning for FRUs should be done linking HR, procurement, BSCs, logistics, manpower, training etc.
- Facilities operationalized should be as per GOI Guidelines including establishment of BSCs.
- Besides linking components of HR, infrastructure including BSC etc, preference to be given to those facilities for upgradation and operationalization where delivery load is substantial.
- Geographical mapping must be carried out to identify those facilities for Upgradation to FRUs, which are located in areas with no other functional facility nearby.
- Funds for heads like equipments, infrastructure etc. should be budgeted under respective RCH II/ NRHM head.
- Medical College strengthening is not the part of RCH and can be kept under NRHM Additionality.
- Some state has budgeted DDK for FRUs/CEmOC services. They are requested that DDK should be used only in c/o out reach services.

Operationalization 24* 7 PHCs:

- Holistic planning for operationalization of 24* 7 PHCs should be done and should be linked to infrastructure, procurement, drugs/medicines; state has also to plan for training of MOs esp. in Basic Obstetric Care and SNs/LHVs/ANMs in Skilled Birth Attendance.
- Funds for heads like equipments, infrastructure etc. should be budgeted under respective RCH II/ NRHM head.
- Facilities operationalized should be as per GOI Guidelines.
- Besides linking components of HR, infrastructure including newborn care corners etc, preference to be given to those facilities for up-gradation and operationalization where delivery load is substantial.
- Geographical mapping must be carried out to identify those facilities for upgradation to 24*7 PHCs, which are located in areas with no other functional facility nearby.

A. SERVICES:

1. ANC, INC, PNC:

- State is requested to ensure that post delivery mother should stay for at least 48 hours which is quite necessary to provide full range of care. Any infrastructure improvement plan if needed should be undertaken accordingly.
- Monitoring during OR/VHNDs sessions should be strengthened so that quality of ANC including IFA tab etc, PNC is ensured.
- Tracking of missed out and left out cases of ANC, PNC should be done.
- State has to gear up to provide full ANC of good quality.
- Comprehensive Monitoring plan for these activities should be developed and budgeted.

2. Institutional Delivery including JSY:

- Micro Birth Planning should be emphasized as a part of JSY.

- 48 hr stay post delivery should be emphasized especially among JSY beneficiaries.
- Benefits under JSY should be as per GoI norms.
- Qualities of services being provided under JSY are poor, facilities are overcrowded and beneficiary are discharged before 48 hours, micro plan is not in place, as per JSY evaluation. There is a need for augmenting manpower and provision of beds in the health facilities.
- JSY deliveries should be co-linked with service provision and facility upgradation and budgeted accordingly.
- Tertiary facilities are overloaded so micro plan should promote primary and secondary facilities for services.
- Grievance-redressal mechanism should be established.
- Funds should also be kept for monitoring visits.
- Guidelines on record upkeeping (physical and financial) should be disseminated.
- TBAs should not be promoted as primary provider of deliveries.
- Support to MCs under JSY should not be budgeted under RCH.
- JSY benefits to the clients delivering at accreditated private health facilities can be provided either to the beneficiary or to the service provider from GoI funding, within the approved JSY limit. Any benefits beyond the approved limit needs prior approval from MoHFW.

3. Safe Abortion Services:

- State should plan for Comprehensive Abortion services as per GoI guidelines.
- There should be focus on comprehensive abortion services (MVA, EVA, MA) upto FRU/CHC level and at least MA, MVA at 24*7 PHCs.
- Funds for heads like equipments, infrastructure etc. should be budgeted under respective RCH II/ NRHM head.
- Accreditation of private health facilities also needs to be done to ensure wider availability of this service, through District Accreditation Committee as laid down in the MTP Act.
- District level committee to accredit private sector for MTP services need to be activated and pending applications for accreditation should be processed on priority.
- Physical progress on this may please be shared every quarter.
- Funds should also be kept for monitoring the operationalization of Safe Abortion Services.

4. RTI/STI services:

- Training should be as per the GoI guidelines on RTI/STIs.
- Holistic Plan including training of staff, provision of drugs, lab investigations and convergence with the NACP (THROUGH SACS) is advised for comprehensive RTI/STI services.
- Funds for strengthening of facilities for RTI/STI services have to be kept.
- Funds for heads like equipments, infrastructure etc. should be budgeted under respective RCH II/ NRHM head.
- Ensure privacy and full treatment as per National Guidelines on Prevention, Management and Control of RTI infections including STIs.
- Ensure that Wet Mount is available for Diagnosis at health Facilities.
- Funds should also be kept for monitoring the operationalization of RTI/STI services.

5. Maternal Death Review(MDR):

- **Facility based MDR**: All health facilities should maintain meticulous records of maternal deaths with finer details including patient's particulars and probable cause of death. An audit is conducted at the facility level and subsequently the report is shared with the district CMO for further action. FBMDR should start initially at District Hospital and Medical Colleges and later on at block level and accredited private sector facilities should also be included within scope of these reviews.
- Line listing of maternal deaths occurring at accredited private sector facilities should be done and the records of these deaths subjected to audit at District level.
- **Community based MDR**: Line listing of maternal deaths should be done through the ANMs/ASHAs/ other community resource and the audit of such deaths should be done at the block/district level.
- GoI is in the process of finalizing simple tools for conducting both the audits. However the states can continue the process of maternal death audits as before.
- The tools of **MDR** may be shared with GoI and should be initially limited to 2-3 districts as a pilot and cost involved in such pilots vis-a-vis benefits be analyzed before scaling up.

6. VHNDs:

- Since VHNDS is a platform all RCH activities, so state should ensure that all these activities should take place holistically. The efforts should be for providing all planned services like ANC, PNC, Immunization and Counseling services as per the GOI guidelines.
- Too many types of the out reaches should be avoided and thrust should be on comprehensive VHNDs.
- Wherever possible FGDs should be conducted for maternal deaths taking place.
- Monitoring and ensuring quality in all VHNDs should be done.
- Funds for monitoring of VHNDs session should be kept.
- Stress should be also on missed/lost cases for ANC.
- VHNDs should be linked with provision of facilities at institutions.
- The focus should be on regular VHNDS and mobile units should be utilized only for those areas where VHNDs cannot be organized.
- In RCH II focus is on operationalizing health facilities and as such camp/mobile mode is suggested for hard to reach areas.

7. Referral Transport:

- Every state is advised to have a comprehensive referral policy with scope of flexibility and variations from district to district as per the local need and situations.
- Tribal and hilly areas must have linkages like Palki or similar facilities for bringing the pregnant women upto the road head from where a referral transport can pick her. Such places can be linked with Birth waiting rooms at health facilities on Tamil Nadu pattern.
- There is a need for assured referral linkage both fromthe beneficiary/community to the facilities and also between the facilities.
- State needs to establish such system either through government mechanism or through outsourcing.

- Norms for reimbursement to beneficiary should be as per JSY.
- Outsourcing of referral transport can be preferred than the purchase of government vehicle and regular driver for providing Referral transport.
- Outsourcing of referral transport should be through the process of competitive bidding.
- Cost benefit analysis of referral transport mechanism should be done taking into consideration cost incurred per referral, no of pt being referred to pvt sector and no of lives saved in public sector.
- EMRI model /call centers for referral should be evaluated in terms of cost & benefit before scaling up.
- Payment for referral can be differential and may be linked with range of km travelled.

8. RCH Camps:

- State is organizing RCH Camps since RCH-I but the benefits have not yet been analyzed.
- In RCH II focus is on operationalizing health facilities and as such camp mode is suggested as time gap arrangement restrictedfor hard to reach areas. State should also indicate that how many health facilities have been operationalized in hard to reach areas till now.
- RCH Camps should be organized and funded as per GoI norms.
- Stress should be kept on organizing VHNDS regularly.
- Inter-sectoral co-ordination should be emphasized while organizing these camps.
- Such outreach camps have taken out the focus on operationalization of facilities and this may be one of the reasons for decline in Maternal Health parameters in the state.
- State is requested to analyze the functioning and benefits of Mobile Medical Unit along with the services rendered on pilot basis before scaling up. Such analysis may please be shared with GoI. Since MMU for RCH services is a type of outreach and various types of out reaches hampers the focused activities of ANC, PNC etc being undertaken at VHNDs.
- While planning for such outreach activities it should be ensured that routine service delivery by MOs/ health workers at fixed health facilities (PHCS/CHCs/DHs etc) does not suffer.

B. TRAININGS:

1. Life Saving Anesthesia Training:

- Target for LSAS training should be calculated after taking into account the no. of FRUs to be operationalized, CEmOC target and total no. of specialist to be appointed.
- Target and Achievement of the MOs for 2010-11 and Training plan for 2011-12 should be shared with GoI by the State as per the enclosed formats
- No of traineddoctorsposted atFRUs
- Trainings should be conducted as per GoI norms.
- Training institutes should be strengthened as per the GoI protocols. Funds can be kept under Training head.
- State should ensure that DHs should also be strengthened simultaneously for the practical part of the training. Scaling up can be planned as per GoI road map. Funds can be kept under Training head.

- State should undertake regular monitoring both during and post training.
- State should ensure that MOs are posted at Facilities which have been operationalized for CEmOC services.
- Funds should be kept for monitoring during and after training.

2. CEmOC Training:

- Target for CEmOC training should be calculated after taken into account the no. of FRUs to be operationalised, LSAS target and total no. of specialist to be appointed.
- State should ensure that MOs are posted at Facilities which have been operationalised for CEmOC services.
- Target and Achievement of the MOs for 2010-11 and Training plan for 2011-12 should be shared with GoI by the State as per the enclosed formats
- State should ensure that DHs should also be strengthened simultaneously for the practical part of the training. Scaling up can be planned as per GoI road map. Funds can be kept under Training head.
- Trainings should be conducted as per GoI norms.
- Training institutes should be strengthened as per the GoI protocols. Funds can be kept under Training head.
- State should undertake regular monitoring both during and post training.
- State should ensure that MOs are posted at Facilities which have been operationalised for CEmOC services.
- Funds should be kept for monitoring of the training and post training follow-up

3. BEmOC Training:

- BEmOC training is designed for MOs posted at PHCs. State should ensure that duplication should not take place by giving different names for this training.
- Training should be as per GoI protocols of 10 days.
- Training institutes should be strengthened as per the GoI protocols. Funds can be kept under Training head.
- State should undertake regular monitoring both during and post training.
- State should ensure that MOs are posted at Facilities which have been operationalised for BEmOC services.
- Funds should be kept for monitoring of the training and post training follow-up.

4. Skilled Birth Attendant Training:

- Training should be as per GoI norms. Kindly follow the GoI operational guidelines on the same for 3 week training.
- **State is requested to emphasize that training centres follow protocols of SBA training i.e. practise of partograph, AMTSL, ENBC etc. Funds for centre strengthening can be kept under Training head. Post training skill practise by the trained personnel should be ensured.**
- **State where training is going on at a good pace, it is requested to evaluate the SBA training in the State.**

- **State should undertake regular monitoring both during and post training.**
- Funds for monitoring of the training and post training follow up should be kept

5. **Blood Storage Training:**
    - **Blood Donation Camps are accessory activities but State should also emphasize establishing BSCs/linkages to Blood bank at all the facilities providing CEmOC services.**
    - Training should be as per GoI norms.
    - Also the state is requested to avoid transfers of MOs/LTs who have been trained. If needed transfer should be from one FRU to other.
    - State should develop convergence with SACS for utilizing their resources in training.

6. **MTP Training:**
    - State should follow Comprehensive Abortion Guidelines (will soon be disseminated by GoI) to operationalise its facilities for MTP services and to train MOs in same. MVA guidelines for training PHC MOs already exist.
    - Trainings should be conducted as per GoI norms.
    - Nurses and ANMs should be trained to provide assistance to the certified MTP provider and also counselling services to clients. It may be noted that nurses and ANMs are currently NOT permitted to be trained as primary service provider for MTP under the MTP Act and Rules.
    - D & C is not a recommended method for MTP.
    - State should also plan for training of MOs in Medical Abortion Services.
    - State is also requested to plan for training of MOs in 2nd trimester abortion services (currently approved methods), as these services should be made available at District Hs and FRUs. Also strengthening of facilities should be done for same.
    - Training institutes should be strengthened as per the GoI protocols. Funds for centre strengthening can be kept under Training head.
    - State should ensure that MOs are posted at Facilities which have been operationalised for MTP services.
    - Funds should be kept for monitoring of the training and post training follow up.

7. **RTI/STI Training:**
    - State should plan to operationalise health facilities for RTI/STI services.
    - State is requested to plan for RTI/STI training, as per GoI norms.
    - Funds for the operationalisation and monitoring of RTI/STI services should be kept.
    - Training of sub district level health functionaries posted at FRUs/CHCs and PHCs may be done by utilizing the training resources (faculty, training material) of the NACP (through SACS). This is an agreed action under the convergence framework.

C. Quality Assurance:

- State is requested to enlarge the scope of QA cells for RCH services including FP services.
- QA cell should be established both at the level of State and District for all MCH activities at State and District Level.
- TORs of the QA cell communicated to the State should be followed.

- QA cell should ensure quality and monitoring of all MCH activities which should also include monitoring of the training.
- Budget has to be indicated for monitoring activities by QA Cell under MH or M & E.
- State is accrediting its health facilities under NABH and NABL but before going for such expensive accreditations, it may evaluate the quality of services offered through its own mechanism of QA Cell.

D. Miscellaneous:

- Specific plan for thosedistrictsclassified as poor performing in the NRHMshouldhaveaseparatepriority plan.
- State may define difficult, most difficult and inaccessible areasas per geographical location or in terms of difficulty to find HR for these areas.
- State should take measure to ensure continuity of contractual appointments and take steps to regularize them.
- Additional allowances should be for regular staff, so as to promote them to work in rural/hard areas.
- Incentives for specialist and MOs for difficult areas and on performance basis should be defined clearly and tabulated. Hard to reach areas/ the places where specialist/MOs do not join can be identified and defined for difficult area allowance and should be restricted to a reasonable amount which can vary as per the cadre.
- Incentives on ‘per case basis’should be avoided, however the same can be given to a group of service providers i.e. doctor, staff nurses etc. if a particular protocol of the service is maintained for e.g. conducting normal delivery should be linked with 48 hrs stay, EBF and provision of PNC protocols to both the mother and child. Such incentives can be restricted to Rs 200/-.
- It is suggested that all incentive schemes, giving the details may be tabulated and may please be indicated and given comprehensively.
- **TBA/Dai should not be promoted as primary provider for deliveries but can be utilized for community based services.** However the services of Dais should be well defined to avoid conflict of interest between link workers. Some of the suggested roles for TBAs are: birth preparedness, birth companion, assistance to ANM in A/N, I/Nand P/N Care, home-based new born care, arrange referral transport/escort the pregnant woman to the institution for delivery, as a depot holder for contraceptives, DOTs Provider, report births and deaths of neonates,infants and mothers. However, please ensure that TBAs should be utilized only where there is no ASHA, otherwise there will be conflict of interest.
- Any incentives for Dais need approval so kindly indicate the details.
- Unit cost of the Blood camp should be indicated and such camps should be linked with blood banks and NACO.
- The accreditation guidelines for any of the RCH services should synchronize with GoI guidelines on accrediting private health facilities.
- The focus of such accreditation scheme should be at sub-district level.
- Budget for different strategies like incentives/bed nets/supplementary food/IEC etc should be under respective heads.

- New constructions are not permitted under RCH. So funds for new SCs construction should be reflected under NRHM and ID division.
- State needs to look into the quality of the service provided by the NGOs running APHCs. Cost effectiveness of these outsourced PHCs needs to be evaluated before scaling up.
- PPP for health facilities be preferably allotted on competitive bidding and service quality should be monitored closely.
- PPP for skill based training should be encouraged as per GoI guidelines. Close monitoring in such cases should be undertaken to ensure skill practice by the trainees at such facilities.

E. Additionalities under NRHM:

- Remuneration to contractual staff should be as per RCH/NRHM norms.
- Activities under NRHM need approval from NRHM Division.
- ASHA incentive for any scheme should be budgeted under Training/NRHM and too many fragmentations should be avoided.
- Hiring of additional staff should be avoided on generic basis beyond the approved norms and should be linked with case load and quality of service delivery.

F. Budget:

- Budgeting should be as per GoI criteria and norms, and should not be duplicated.
- RCH Drugs/Any other drugs should be budgeted under State head or under NRHM except for those states whose procurement procedures are in accordance with World Bank Guidelines.
- Budget head under each activity for previous years should include both allocation and expenditure.
- JSY deliveries should be co-linked with service provision and facility upgradation and budgeted accordingly.
- Adequate funds for monitoring of MH activities including trainings should be kept.
- Final costing should be as per the competitive bidding and following procurement procedure.
- Sub-heads related to monitoring visits and should form part of comprehensive monitoring.
- Funds from Untied grant to VHSCs should be budgeted under NRHM.
- Rent for SC should be under Infrastructure.
- Funding for BCC/IEC components should be the part of comprehensive BCC/IEC strategy.

Status of Facility Operationalisation *

S. No.	Facility	Total No.Planned till 2012 (cumulative)	Total No operationalised till2010 (till Dec. 2010 cumulative)	Target for 2010-11	Achievement in 2010-11 (till December, 2010)	Target for 2011-12
1.	FRUs					
2.	24x7 PHCs					

*Must fulfil GoI minimum criteria,including availability of Blood Storage centres (for FRUs)

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

Status of MCH Centres Operationalisation *

S. No.	Facility	Total identified	Total No operationalised tillDecember 2010 (cumulative)	Target for 2011-12
1.	MCH Centre Level III			
2.	MCH Centre Level II			
3.	MCH Centre Level I			

*Must fulfil GoI minimum criteria,including availability of Blood Storage centres (for FRUs)

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

Performance based incentives

Name of the Scheme/A ctivity	Type of worker	Type of work being incentivised	Level of Facility (CHCs/ PHCs/ Sub-Centres	Amount of Incentive	Performance Expected	No of workers given incentive	Quantifiable Output

Status of Anaesthesia Training

No of Medical Collegesconducting LSAS Training	No of District Hospitalsconducting LSAS Training	Total No of MBBS Doctors to be trainedin LSAS till 2012 (cumulative)	Total No of MBBS Doctors trained in LSAS till2010 (till Dec. 2010 cumulative)	Noof trained MOs posted at FRUtill December 2010 (cumulative)	Target for2010-11	Nos. trained in 2010-11 (till December 2010)	Target for 2011-12
States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total							

Status of EmOC Training

No of Medical Collegesconducting EMOC Training	No of District Hospitalsconducting EMOC Training	Total No of MBBS Doctors to be trainedin EMOC till 2012 (cumulative)	Total No of MBBS Doctors trained in EMOC till2010 (till Dec. 2010 cumulative)	Noof trained MOs posted at FRUtill December 2010 (cumulative)	Target for2010-11	Nos. trained in 2010-11 (till December 2010)	Target for 2011-12
States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total							

Status of SBA Training

No of districtscon ducting SBA Training	No. of Institutions (including District Hospitals)conduct ing SBA training in the state	No. Of districthospitals/train ing institutespracticing SBA ProtocolsparticularlyP artograph	No of Master Trainers trained (Both State and Districts)	No. of SNs/ANMs/LHVs to be trained till 2012 (cumulative)	Total No of SNs/ANMs/LHVs trained till2010 (till Dec. 2010 cumulative	Target for2010-11	Total No of SNs/ANMs/LHVs trained in 2010-11 (till Dec. 2010)	Target for 2011-12

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

Status of MTP Training

No. of Govt. health facilities conducting MTPs	No. of Private Health Facilities accredited for conducting MTPs	No of doctors planned to be trained in MA/ MVA/EVA till 2012	Total No of doctors trained till2010 (till Dec. 2010 cumulative	Targets for 2010-11 (No. of doctors planned to be trained in 10-11)	No. of doctors trained in 2010-11 (till December 2010)	No. of 24x7 PHCsproviding at least 1st Trimester, Safe Abortion Services	No. of DH/FRUs Providing Comprehensive Safe Abortion services

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

Allocation and Expenditure under MH and JSY

Budget Allocatedunder MH(excluding JSY) 2010-11	Budget Utilized under MH in 2010-11 (excluding JSY) Till December, 2010	Budget Allocatedunder JSY 2010-11	Budget Utilized under JSY in 2010-11 (Till December, 2010)

Annex 8b

CHILD HEALTH PROGRAMME IMPLEMENTATION FORMAT FOR THE YEAR 2011-12

STATE

1.IMR (SRS 2008)	
2.Goal: Overall NRHM 2012	
3.Goal: Annual 2011-2012	

2.SITUATION ANALYSIS:

2.1 Mortality Indicators	**NFHS 2**	**NFHS 3**	**SRS 2007**	**SRS 2008**	**Trend Analysis**
Neo Natal Mortality Rate					
Infant Mortality Rate					
Under Five Mortality					

PROCESS INDICATORS

2.2ANAEMIA	NFHS 2	NFHS 3	Coverage Evaluation Survey (CES) 2009	Trend Analysis
% of children (under 5 years) of age with anaemia				

2.3INFANT & YOUNG CHILD FEEDING	NFHS 2	NFHS 3	DLHS 2	DLHS 3	Coverage Evaluation Survey (CES) 2009	Trend Analysis
Children under 3 years breastfed within one hour of birth						
Children age 6 months and above exclusively breastfed						
Childrenage 6 - 24 months received solid/semisolid foods and are still breast fed						

DIARRHOEA & ARI	NFHS 2	NFHS 3	DLHS 2	DLHS 3	Coverage Evaluation Survey (CES) 2009	Trend Analysis
Children with Diarrhoea in the last 2 weeks who received ORS						
Children with Diarrhoea in the last 2 weeks who were given treatment at facilities.						
Children with ARI or fever in the last 2 weeks who were given treatment at facilities.						

TRAINING UNDER CHILD HEALTH

4.1 Progress till date- no. of trainings conducted/ health persons trained / districts covered	**Planned For 2010-11**	**Held/Trained (til Nov / Dec 2010)**
• IMNCI - No. of trainings - No. of persons trained - No. of Districts implementing • Pre- Service IMNCI - No. of trainings - No. of persons trained - No. of Districts implementing • F-IMNCI - No. of trainings - No. of persons trained - No. of Districts implemented • NavjaatShishuSurakshaKaryakram (NSSK) - No. of trainings - No. of persons trained - No. of Districts implemented • Any other		

KEY CHILD HEALTH PERFORMANCE INDICATORS

Progress onCH interventions	**Planned For 2010-11**	**Held/Trained (til Nov / Dec 2010)**
• IYCF - No. of Newborn breastfed within one hour - No. of children 6 months and above exclusive breastfed • Mgmt of Acute Respiratory Infection - No. of children below (5 years) with ARI screened/detected - No. of children (below 5 years) with ARI treated at facilities.		

Progress onCH interventions	Planned For 2010-11	Held/Trained (til Nov / Dec 2010)
• Mgmt of Diarrhoea - No. of children below 5 years with Diarrhoea in the last 2 weeks who received ORS and Zinc. - No. of children with Diarrhoea in the last 2 weeks who were given treatment at facilities. • Iron Folic Acid supplementation - No. of children below 5 years provided IFA Syrup/Tablet • Vit A supplementation - No. of children below 5 years provided Vitamin A Syrup • Mgmt of Malnutrition / Severe Acute Malnutrition - No. of children with SAM detected - No. of children referred to NRC/facilities for Mgmt.		
Key Programme indicators ■ Home visits for newborn by IMNCI trained person ■ No. of newborn children visited on 1st Day/ 3rd Day/ 7th Day. ■ Number of Low Birth Weight babies visited on 14th, 21st& 28th day. ■ No. of Sick Children Screened/detected & managed at home. ■ No. of Sick Newborn & Children treated at facilities for Sepsis, Asphyxia, Severe dehydration, Pneumonia etc. ■ No. of NSSK trained person conducting deliveries at facilities.		

5.Establishmentof newborn and child care facilities at Maternal and Child Health (MCH) Centres		
Level III MCH Centre	• Special Newborn Care Units (SNCU) at district hospitals	
Level II MCH Centre	• Newborn and child Stabilization Units at FRUs	
Level I MCH Centre	• Newborn Care Corner at 24x7 PHCs	
	• Nutritional Rehabilitation centres	

6.Any other activities under Child Health which have been reflected in PIP	
■ ■ ■	
7.IEC/BCC ■ Provision for IEC materialplanned ➢ New born Care - Early initiation of Breastfeeding. - Protection from infection - Protection from Hypothermia ➢ Recognition of Danger signs ■ BCC ■ Other Activities	

8.Supplies & Stock position	**Received Quantity**	**Utilization**	**Balance in stock**
■ ORS ■ Zinc ■ Antibiotics (Cotrimoxazole) ■ Vitamin A ■ Iron & Folic Acid ■ Albendazole Tablet			

Planning for the year 2011-12	**1st Qtr** Target	**2nd Qtr** Target	**3rd Qtr** Target	**4th Qtr** Target	**Total** Target
9.IMNCI ■ Number of districts planned for IMNCI implementation. ■ Number of IMNCI training planned. ■ Number of persons planned to be trained 10.F-IMNCI ■ Number of districts facilities planned for implementing F- IMNCI ■ Number of persons (MO/SN) planned to be trained					

Planning for the year 2011-12		**1st Qtr** Target	**2nd Qtr** Target	**3rd Qtr** Target	**4th Qtr** Target	**Total** Target
11.NavjaatShishuSurakshaKaryakram (NSSK) ■ Number of districts facilities planned forimplementing NSSK ■ Number of persons (MO/SN) planned to be trained in NSSK 12.Pre- Service IMNCI Training ■ Number of medical colleges/ nursing colleges planned for implementing Pre-Service IMNCI ■ Number of medical/nursing studentsplanned to be trained						
13.Establishmentof newborn and child care facilities at Maternal and Child Health (MCH) Centres						
Level III MCH Centre	• Special Newborn Care Units (SNCU) at district hospitals					
Level II MCH Centre	• Newborn and child Stabilization Units at FRUs					
Level I MCH Centre	• Newborn Care Corner at 24x7 PHCs					
	• Nutritional Rehabilitation centres					

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

14.Community based initiatives ■ Organization of VHNDs	
15.School Health Scheme ■ Number of children screened for illness. ■ Number of children provided IFA Tablet. ■ Number of children provided Albendazole Tablets.	
15.Budget • Budget allotted(2010-11) • Budget utilized(Dec 2010)	
16.Budget proposed for Child Health for the year 2011 – 12	

Annex 8c

IMMUNISATION PLANNING FORMAT

Situation analysis of the State Immunization Program

(The States/UTs should provide a brief write-up covering all the following issues)

1. Current scenario of implementation of immunization program
   i.) State level coverage as per District Level Household Survey-3, Coverage Evaluation Survey 2009 & Reported coverage for 2009-10, 2010-11 till Dec'10.
   ii.) District wise coverage levels of all antigens for 2009-10, 2010-11 till Dec'10 (including Hepatitis B & JE wherever applicable).
   iii.) Reasons for Shortfall in coverage
   iv.) Reporting and incidence of VPDs for 2010-11 till Dec'10.
   v.) Reporting and Response to Outbreaks and AEFIs for, 2009-10 till Dec'10.
2. Strategies for further improving Routine Immunization
   i.) What is the target of immunization coverage for this year?
   ii.) To improve the accessibility of routine immunization services (*reflected by BCG and DPT-1 coverage);* identify the districts with poor access and reasons thereof.
   iii.) To reduce dropouts (reflected *by DPT3 coverage*); reasons for dropout and specify steps taken for this.
   iv.) To create community demand for routine immunization*;(write specific steps taken)*
   v.) Any other innovation started for strengthening of routine immunization in the state.
3. Status of microplanning- Number of districts where RI micro-plans have been updated in 2010-11. *(Provide details in the format enclosed)*
4. What are the roles & responsibilities pertaining to immunization of 1st ANM, 2nd ANM, and HW(Male) ?
5. What is the mechanism of coordination & convergence between AWW and ASHA?
6. Alternate Vaccine Delivery System- what system is in place, whether it is working and what are issues faced?
7. Supervision and Monitoring-Status of Routine Immunization cell, Supportive Supervision Structure in field, Review meetings and data analysis and action taken at all levels etc)
8. Status of RIMS implementation for monitoring (details of districts uploading data regularly, issues with other districts and proposed support required)
9. Co-ordination with Partners (ICDS, Public Private Partnerships, Other agencies)
10. Component-wise receipt & expenditure of funds received from 2009-10 onwards (format attached).
11. Status of Cold Chain Equipment-
    i.) ILRs, DF, Voltage stabilizers
       a) Plan for replacement of all condemned or non service able equipment which is beyond repair.
       b) Expansion: - Need based depending on the setting up of New PHC/ cold chain points
       c) All CFC equipments supplied till 1992 has been replaced with Non CFC equipment. The expansion plan should include replacement of remaining CFC equipments supplied during the period of 93-98

ii.) Cold boxes, Vaccine carriers - replacement plan for expansion or replacement of condemn equipment.

iii.) Insulated/Non Insulated vaccine van: Plan for supply of insulated vaccine vans against condemned vehicles and expansion plan for supply of vaccine van for newly created district.

iv.) Mechanism for cold chain maintenance and repairs- HR structure, AMC(if any) etc.

12. Status of implementation of Procurement Management Information System (ProMIS)
13. IEC plan for strengthening UIP; however the budget for IEC is to be provisioned under RCH.
14. Infrastructural and manpower requirements that are essential for implementation of UIP but not admissible under Part C (Immunization) may be provisioned under the NRHM/RCH heads. (eg; Refrigerator mechanics, renovation of stores etc.) This should include district level need for godown for vaccine/logistics.
15. Additional support required to improve Routine Immunization; for any state specific need please provide a separate write-up on objective, strategy, expected output and budgetary basis for the activities.

A. Basic information of the State/UT related to Immunization Programme

Position	Name & Designation	Contact No./Email
State Immunization Officer		
State Cold Chain Officer		
State Level Data Assistant		
District Immunization Officers (DIO)	No. of Districts…………	No. of DIOs in position………

What are the systems of ensuring stability of tenure for these key officers?

____

____

____

____

S.No	Beneficiaries	Target		
		2009-10	2010-11	2011-12
1.	Pregnant women			
2.	0 to 1 yr infants			
3.	1-2 yr			
4.	2-5 yr			
5.	5 yr			
6.	10 yr			
7.	16 yr			

The following information is to be filled based on the RI micro-plans. Please provide the details of held sessions for 2009-10 & 10-11, while for 2011-12 the number of planned sessions is to be provided:

S.No	Routine Immunization Sessions	2009-10	2010-11	2011-12
1.	Total Sessions planned			
2.	Total Sessions Held			
3.	No. of Outreach Sessions			
4.	No. of Fixed site sessions			
5.	No. of Sessions in Urban Areas			
6.	No. of Sessions in Rural Areas			
7.	No. of sessions in hard to reach areas			
8.	No. of session with hired vaccinators*			
9.	No. of hired vaccinators*			
10.	No. of villages where sessions are held monthly			
11.	No. of villages (smaller) where sessions are held on alternate months			
12.	No. of villages where sessions are held quarterly			

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

B. Existing Support to the States

Sl No	Item	Stock (functional) as on 31st Dec'10	Requirement			Remarks
			2009-10	2010-11	2011-12	
1	**Cold Chain Equipments** -					
a)	WIC					
b)	WIF					
c)	ILR					
d)	DF					
e)	Cold Boxes					
f)	Vaccine Carrier					
g)	Ice Pack					
h)	Vaccine Van					
2	**Vaccine stock and requirement (including 25% wastage and 25% buffer)**					
a)	TT					
b)	BCG					
c)	OPV					
d)	DPT*					
e)	Measles					
f)	Hep B					
g)	JE (Routine)					
3	**Syringes including wastage of 10% and 25 % buffer**					
a)	0.1 ml					
b)	0.5 ml					
c)	Reconstitution Syringes					
4	**Hub Cutters**					

**Note: DPT is to be given instead of DT at 5 yrs once the current stock of DT Vaccine is exhausted*

C. **Additional Support required by the State**

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
Mobility supportfor supervision	@Rs.50,000 per District for district level officers (this includes POL and maintenance) per year		No of sessions Supervised		No of sessions Supervised		No of sessions Supervised	
Supervisory visits by state and district level officers for monitoring and supervision of RI								
	By state level officers @ Rs.100,000 /year		No of districts visited for RI review		No of districts visited for RI review		No of districts visited for RI review	
Cold Chain maintenance	@ Rs 500 per PHC/CHC per year District Rs 10,000 per year		% Funds used		% Funds used		% Funds used	
Focus on slum & underserved areas in urban areas:	Hiring an ANM @Rs.300/session for four sessions/month/slum of 10000 population and Rs.200/- per month as contingency per slum of i.e. total expense of Rs. 1400/- per month per slum of 10000 population.		No of sessions with hired vaccinators		No of sessions with hired vaccinators		No of sessions with hired vaccinators	

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
Mobilization of children through ASHA/ mobilizers	@ Rs 150/session (for all states/UT.s)		No. of sessions with ASHA		No. of sessions with ASHA		No. of sessions with ASHA	
Alternative Vaccine Delivery:	Geographically hard to reach areas (eg. Session site>30 kms from vaccine delivery point, river crossing etc.) @ Rs 100 per RI session		No of sessions with AVD		No of sessions with AVD		No of sessions with AVD	
	NE States and Hilly terrains @100 per RI session							
	For RI session in other areas @ Rs.50 per session.							
Support for Computer Assistant for RI reporting (with annual increment of 10% w.e.f. from 2010-11)	State @Rs 12,000- 15,000 p.m.							
	Districts @ Rs 8000- 10,000 p.m		No of C.A. in position		No of C.A. in position		No of C.A. in position	
Printing and dissemination of immunization cards, tally sheets, monitoring forms, etc.	@ Rs 5 per beneficiary							

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
Review Meetings	Support for Quarterly State level Review Meetings of district officers @ Rs 1250/participant/day for 3 persons (CMO/DIO/Dist Cold Chain Officer)		No of meetings held		No of meetings held		No of meetings held	
	Quarterly Review & feedback meeting for exclusive for RI at district level with one Block MO.s, ICDS CDPO and other stakeholders@ Rs 100/- per participant for meeting expenses (lunch, organizational expenses)							
	Quarterly review meeting exclusive for RI at Block level @Rs 50/-pp as honorarium for ASHAs (travel) and Rs 25 per person at the disposal of MO-I/C for meeting expenses(refreshments, stationery and misc. expenses)							
Trainings			No of persons trained		No of persons trained		No of persons trained	

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
District level orientationtraining for 2 days**ANM, Multi Purpose Health Worker (Male), LHV, Health Assistant (Male / Female), Nurse Mid Wives, BEEs & other specialist (as per RCH norms)**	As per revised norms for trainings under RCH							
Three day training of **Medical Officers on RI** using revised MO training module	As per revised norms for trainings under RCH		No of persons trained		No of persons trained		No of persons trained	
One day refresher training of **District RI Computer Assistants** on RIMS/HMIS and Immunization formats under NRHM	As per revised norms for trainings under RCH							
One day **Cold Chain handlers training** for block level cold chain handlers by State and District Cold Chain Officers and DIO for a batch of 15-20 trainees and three trainers	As per revised norms for trainings under RCH		No of persons trained		No of persons trained		No of persons trained	

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
One day Training of **block level data handlers** by DIO and District Cold chain Officer to train about the reporting formats of Immunization and NRHM	As per revised norms for trainings under RCH		No of persons trained		No of persons trained		No of persons trained	
Microplanning								
To develop sub-center and PHC microplans using bottom up planning with participation of ANM, ASHA, AWW	@ Rs 100/- per subcentre (meeting at block level, logistic)				No.of Districts have updated microplans this year		No. of Districts have updated microplans this year	
	For consolidation of microplan at PHC/CHC level @ Rs 1000/- block & at district level @ Rs 2000/- per district							
POL for vaccine delivery from State to District and from district to PHC/CHCs	Rs100,000/ district/year		% Funds used		% Funds used		% Funds used	
Consumables for computer including provision for internet access for RIMS	@ 400/ - month/ district							
Injection Safety			% funds used		% Funds used		% Funds used	
Red/Black Plastic bags etc	@ Rs 2/bags/session							

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
Bleach/Hypochlorite solution	@ Rs 500 per PHC/CHC per year							
Twin bucket	@ Rs 400 per PHC/CHC per year							
Any State Specific Need with justification (Please provide a separate write-up on objective, strategy, expected output and outcomes, basis for cost estimates etc.)	10 % of total amount of approved PIP		% funds used		% Funds used		% Funds used	

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

District –wise Coverage reports *(in numbers)*

S. No	Name of District	Yearly Target (2010-11)		BCG Coverage (in Numbers)		OPV - 1st Dose Coverage (in Numbers)		OPV - 3rd Dose Coverage (in Numbers)		DPT - 1st Dose Coverage (in Numbers)		DPT - 3rd Dose Coverage (in Numbers)	
		Infants	Pregnant Women	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*
	TOTAL												

S. No	Name of District	Measles Coverage		TT2+Booster Coverage		Hep B - Birth Dose Coverage (Wherever applicable)		Hep B - 1st Dose Coverage (Wherever applicable)		Hep B - 3rd Dose Coverage (Wherever applicable)		JE-routine (Wherever applicable)	
		2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*
	TOTAL												

#Coverage for 2010-11 till Dec’10

District –wise VPD reports in 2010-11 (in numbers)

S. No	Name of the Districts	Diphtheria		Whooping Cough		Neonatal Tetanus		Tetanus(Other)		Measles		Polio		AES	
		Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
	TOTAL														

Annex 8d

FAMILY PLANNING GUIDELINES FOR 2011-12

The following are the important issues that states can consider while strategizing and formulating the **PIP (2010-12) for Family Planning**:

1. Regular fixed day static **(FDS)** services for FP round the year to be operationalised in addition to the periodic camps

2. Emphasis on **minilap**tubectomy services because of its logistical simplicity and requirement of only MBBS doctors and not post graduate gynaecologists/ surgeons.

3. Plan for **Post Partum Family Planning Services including Sterilisation (PPS)** for utilizing the opportunity of increased institutional deliveries and subsequent hospital stay of 48 hours.

4. A clear plan for scaling up **NSV services** to be reflected.

5. Plan for **accreditation of more private/ NGO** facilities to increase the provider base for family planning services under PPP.

6. A rational **human resource development** plan for minilap, NSV and IUD 380A be chalked up to empower the facilities (DH, CHC, PHC) with at least one provider each for each of the services and Sub Centres with ANMs trained in IUD insertion

7. Plan for developing/designating **Regional/district clinical training centres** for training service providers in male and female sterilization services (may refer to "Government Of India GuidelinesFor Clinical Skill Building Trainings in Male And Female Sterilisation Services")

8. Plan for **community based family planning services** (including counselling, contraceptive distribution, referral services) utilizing ASHAs,AWW,ANM at VHNDs and VHSCs.

9. **Demand generation** activities in the form of display of posters, billboards and other audio and video materials in the various facilities be planned and budgeted

10. Plan for **contraceptive updates** for MOs, SNs, LHVs, ANMs be drawn up

11. States may also consider planning for recruiting **Family Planning Counsellors** at the district hospitals/CHCs.

12. **District level action plans** for FP be drawn up by the CMOs for achieving the ELAs

13. The states may also include any **state specific schemes/innovative schemes** within the family planning strategy and include details of the same within the PIP

	STRATEGY / ACTIVITY	Planned	Achieved	WORK PLAN	SCHEDULED/ Trg. LOAD	BUDGET (In lakhs)
		2010-11		2011-12		
1	**FAMILY PLANNING MANAGEMENT**					
1.1	Review meetings on Family Planning performance and initiatives at the state and district level (periodic)					
1.2	Monitoring and supervisory visits to districts/ facilities					
1.3	Orientation workshops on technical manuals of FP viz. standards, QA, FDS approach, SOP for camps, Insurance etc.					
2	**TERMINAL/LIMITING METHODS (Providing sterilisation services in districts)**					
2.1	Plan for facilities providing FEMALE sterilisation services on fixed days at health facilities in districts					
2.2	Plan for facilities providing NSV services on fixed days at health facilities in districts					
2.3	Number ofFEMALE Sterilisation camps in districts.					
2.4	Number of NSV camps in districts.					
2.5	Compensation for sterilisation (female)					
2.6	Compensation for sterilisation NSV (male)					
2.7	Mobility support to surgeon’s team					
2.8	Accreditation of private centres/NGOs for sterilization services					
2.9	Planfor post partum sterilisation					
3	**SPACING METHOD (Providingof IUD services by districts)**					
3.1	Plan for providingIUD services at health facilities in districts					
3.2	No. ofIUD camps in districts					
3.3	Compensation for IUD					
3.4	Compensation to ASHA for ensuring retention of IUD by clients					
4	**SOCIAL MARKETING OF CONTRACEPTIVES**					
4.1	Setting up CBD Outlets					
5	**FAMILY PLANNING TRAINING**					
5.1	**Laparoscopic Sterilisation Training**					
5.1.1	TOT on laparoscopic sterilisation					
5.1.2	Laparoscopic sterilisation training for service providers (gynaecologists /surgeons)					

	STRATEGY / ACTIVITY	Planned	Achieved	WORK PLAN	SCHEDULED/ Trg. LOAD	BUDGET (In lakhs)
		2010-11		2011-12		
5.2	**Minilap Training for MOs/ MBBS**					
5.2.1	TOT on Minilap					
5.2.2	Minilap training for service providers (medical officers)					
5.3	**Non-Scalpel Vasectomy (NSV) Training**					
5.3.1	TOT on NSV					
5.3.2	NSV training for medical officers					
5.4	**IUD Insertion training**					
5.4.1	TOT for IUD insertion					
5.4.2	Training of Medical officers in IUD insertion					
5.4.3	Training of staff nurses in IUD insertion					
5.4.4	Training of ANMs / LHVs in IUD insertion					
5.5	No. of **Contraceptive Update trainings** forhealth providers in the districts					
5.7	**Other FP trainings (please specify)**					
6	**BCC/IEC activities/campaigns/melas for family planning e.g. Funds earmarked for district and block level activities during 'World Population Day' celebration week**					
7	**PROCUREMENT of DRUGS/MATERIALS**					
7.1	NSV Kits					
7.2	IUD insertion Kits					
7.3	Minilap Set					
7.4	Procurement/ repair of laparoscopes					
7.5	Procurement of drugs & supplies for FP					
8	**Innovatory schemes for promoting FP at state or district level**					
9	**Performance based rewards to institutions and providers for FP performance at state and district level**					

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

Annex 8e

ARSH GUIDELINES AND FORMATS FOR PIPS 2011-12

Adolescents constitute a vulnerable and large (22%) segment of the population in need of focused attention. Adolescent Reproductive & Sexual Health (ARSH) has been identified as one of the four strategies under RCH-II and implementing context – sensitive ARSH interventions is now over four years old. While preparing for the PIP 2011–12 states are requested to make a holistic plan for ARSH interventions. This may include the following:

1. List of districts where ARSH program has already been rolled out.
2. List of districts where the state plans to roll out ARSH program 2011-12.
3. Parameters on the basis of which the state has decided to identify these districts.
4. Plan of the state to address the ARSH needs of school/college/non-school going children.
5. Is there any existing community based ARSH programme which has increased facility utilization? Please provide details.
6. IEC activities under taken on ARSH issues in the state.
7. Innovations by the state if any.

   Please also provide details of the ARSH program as per the formats in Annexure II

The districts to be selected for implementation of ARSH strategy in 2011-12 could be selected based on following DLHS-3 indicators:

1. Sex Ratio in age 10-19 years
2. Female literacy rate in 10-19 years
3. Mean age at marriage of women in district
4. Rate of deliveries in 15-19 years age group.
5. Women (age 15-19) who heard of HIV/AIDS

See Annexure I for details.

As part of the scheme for promotion of menstrual hygiene, adolescent girls in the age group of 10-19 years in rural areas will be provided with packs of sanitary napkins at subsides rates. The distribution/ sale of napkins will be through the ASHA or any other community worker. The procurement of sanitary napkins will be from SHGs in the local area. The state will take the initiative to identify strong women SHGs already producing sanitary napkins, or strengthen existing or new SHGs to take on this activity and ensure availability of sanitary napkins. The states could include the following in the state RCH II PIP:

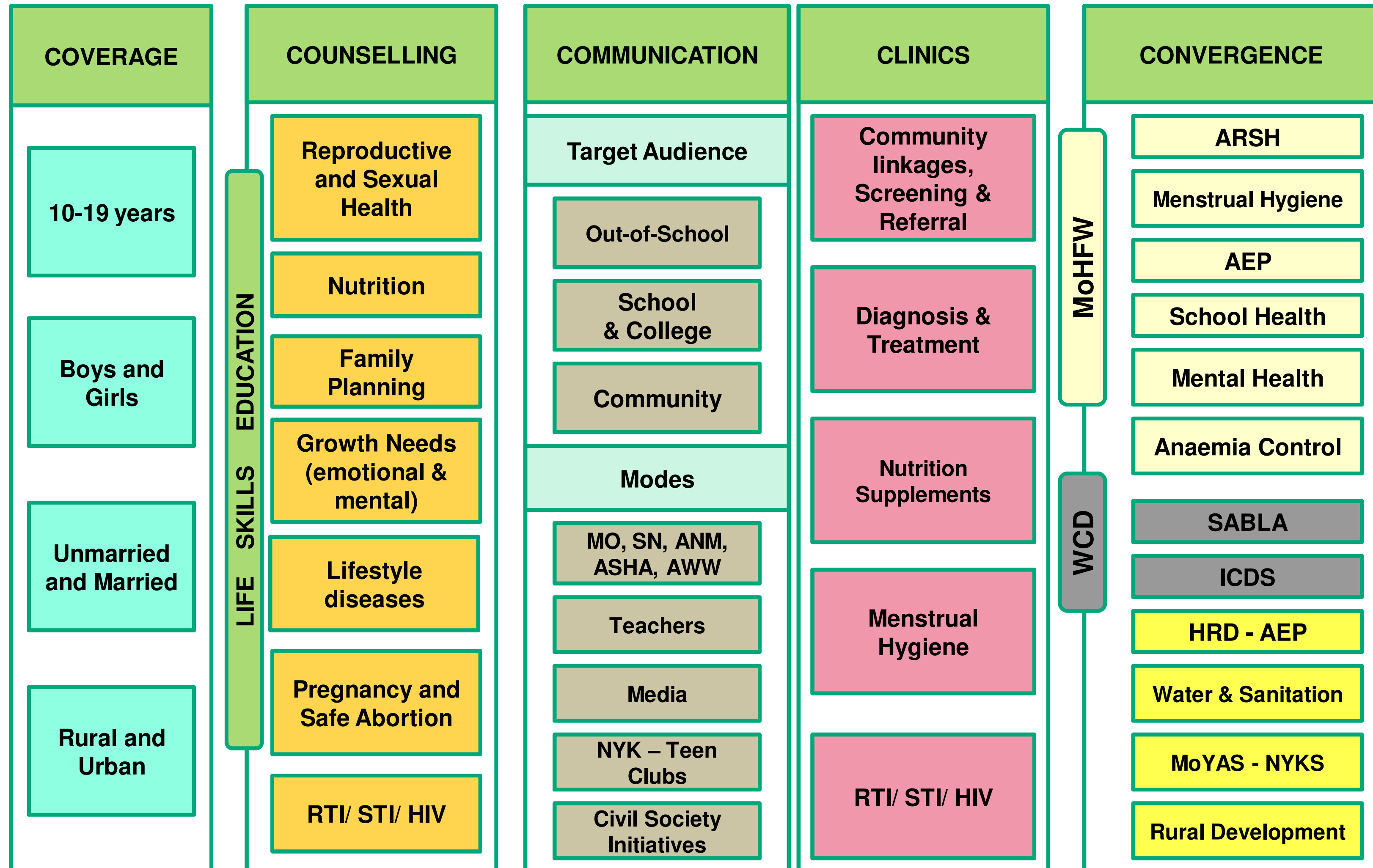
1. Calculation of monthly and annual requirement of sanitary napkin packs (each pack containing 6 napkins) for adolescent girls
2. Cascading training of nodal officers, ANMs and ASHAs on menstrual hygiene

3. Training of SHGs to take on production of sanitary napkins
4. Setting-up and functioning of state and district committees
5. Setting-up a state recourse centre to provide technical support to the SHGs in the state
6. Identify support agencies like NGOs at the division/ district level to provide supportive supervision to the SHGs for the production of sanitary napkins
7. Convergence with Department of Women and Child Development, Rural Development, School education and Drinking Water Supply for effective implementation of the scheme
8. No of girls provided with packs of sanitary napkins each month
9. No of monthly meetings held by ANM with adolescent girls at the village level

Refer Annexure II for details.

STATES ARE ENCOURAGED TO MAKE ADOLESCENT HEALTH STRATEGIES CONVERGENT. A SUGGESTED FRAMEWORK IS PROVIDED IN EXHIBIT 1 BELOW.

EXHIBIT 1: FRAMEWORK FOR ADOLESCENT HEALTH



Annexure-I

Check-list for ARSH activities

S. No.	Activity	Status as on 01.04.2010	Planned for 2010-11	Achievement against plan till 31.12.2010	Planning for 2011-12	Remarks
1.	1-day State Orientation Workshop for ARSH					
2.	State level Training of Trainers (3 days)					
3.	Printing of Training Modules					
4.	IEC for ARSH					
5.	Helpline for ARSH					
6.	Convergence with other programmes / departments (WCD, SACS, MoYAS, HRD)					
7.	Other activities (pls specify)					

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

ARSH Training

Name of district	Training Status as on 01.04.2010		Training Planned for 2010-11		Achievement against plan till 31.12.2010		Planning for 2011-12	
	MO	ANM/LHV	MO	ANM/LHV	MO	ANM/LHV	MO	ANM/LHV

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

AFHS clinics

Total District Hospital:
District hospital with AFHS clinic:
Planned AFHS clinic in DH in 2011-12:

Name of district	Total PHC	PHC with AFHS clinic as on 01.04.10	AFHS clinics planned in 2010	Achievements till 31.12.2010	AFHS clinics planned for 2011-12

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

Any other AFHS clinic at CHC/SDH

Utilization of Adolescent services in AFHS clinics

Name of district	Number of AFHS clinics	Adolescent attending AFHS clinics	RTI/ STI/ HIV cases	Anaemia/ Under nutrition	Pregnancy / MTP	Condom/ OCP/ ECP	Counselling provided	Mental disorders/ sexual abuse

Innovation / Programmes by State

Annexure II

Monitoring formats for scheme for promotion of menstrual hygiene at state and district level

1. State level Formats:

1a. State level Format: (data to be collected on an Annual basis)

Name of district	Total number of rural girls	Total number of villages	Number of girls to be reached	Number of SN packs required	Sourcing agency	Quality Assurance agency	Storage available or hired	Transport available or hired
Total								

1b. State level Format: (data to be consolidated on a Monthly basis from the district records i.e. 2b)

Name of District	Number of girls reached per month	Number of SN packs sold/ distributed	Number of monthly meeting held	Amount of Incentive paid to ASHA		Amount of funds recouped to the DHS	Rental cost for storage arrangements if any.	Costs of transportation
				Sale of napkins	Sunday meetings			
Total								

2. District level Formats:

2a. Data to be collected on an annual basis

- Number of girls to be reached
- Number of SN packs required
- Transport systems to enable reach of SN to the blocks
- Storage arrangements if required
- Annual audit of accounts at district and block
- Training:TOT held for trainers

2b. Data to be collected on a monthly basis at district level

Name of Block	Number of girls reached per month	Total number of villages in block	Number of SN packs sold/ distributed	Number of monthly meetings held	Amount of Incentive paid to ASHA		Amount of funds recouped to the DHS	Rental cost for storage arrangements if any.	Costs of transportation
					Sale of napkins	Sunday meetings			
Total									

3. Block level Formats:

3a. Data to be collected on an annual basis

- Number of girls to be reached
- Number of SN packs required
- Number of SN packs procured from SHG last year
- Transport systems to enable reach of SN to the Sub Centre
- Storage arrangements
- Training:
  - Training of ASHA
  - Orientation of VHSC
  - Orientation of ANM

Name of block	Total number of ASHA	Target for training ASHA in2011-12	Achievements in training 2011-12	Total number of ANM	ANM oriented in 2011-12	Total number of VHSC oriented
-	-	-	-	-	-	-
-	-	-	-	-	-	-

3b1. Data to be collected on a monthly basis at block level

Name of Sub Centre	Number of girls reached per month	Number of SN packs Received	Number of SN packs Distributed	Balance Packs	Amount of Incentive paid to ASHA	Amount of funds recouped to SC	Rental cost for storage arrangements, if any.	Costs of transportation
Total								

3b.2

Name of subcentre	Total number of ASHA	Amount of Incentive paid to ASHA for SN packs	Amount of Incentive paid to ASHA for meeting	Average attendance in monthly meeting
Total				

4. Monthly Monitoring format/Register for Sub Centre

a. Rental cost for storage arrangements (e.g. SC, rented godown)
b. Costs of transportation

Name of Village	Name of ASHA	Number of girls reached per month	Number of SN packs Recd from block	Number of SN packs sold	Balance SN packs	Amount of Incentive paid to ASHA		Amount of funds recouped to SC
						Sale of napkins	Sunday meetings	
Total								

5. The ASHA will maintain a tracking register (Format A) of the adolescent girls in her village and submit a monthly report to the ANM in the Format B.

Format A

	Jan		Feb		Mar		Apr	
Name of Girl	number of SN packs sold	Sunday mtg. attendance	number of SN packs sold	Sunday mtg. attendance	number of SN packs sold	Sunday mtg. attendance	number of SN packs sold	Sunday mtg. attendance
Total								

Format B – Monthly Report

1. Name of ASHA:
2. Name of village:
3. Stock of SN packs at the beginning of the month:
4. Stock of SN packs at the end of the month:
5. Cost of transporting from SC to village:

S. No.	Total # of girls	Sunday meetings heldand attendance by category					Number of SN packs sold	Amount of incentive earned
		Date	#. of girls	# of VHSC members	ANM	AWW		

ANNEX 8f

URBAN HEALTH PROGRAMME

S.No.	Name of cities identified for implementing UHPs. In the State PIPs. Under Urban RCH, so far	Major urban health strategies/activities carried out under Urban RCH so far, city-wise	Urban health strategies/activities as proposed now in the State PIP under Urban RCH, city-wise	Brief on activities being supported by external agencies

Information in respect of Special Schemes (for each city)

Name of city –

Sl. No.	Govt. Health Facilities – under Grant-in-aid from GOI	Controlling agency (SG/LB/VO/Ors.)	Status (Functional/closed)	Brief summary of activities being carried out
	No. of Health Posts			
	Type A			
	Type B			
	Type C			
	Type D			
	No. of Urban Family Welfare Centres			
	Type I			
	Type II			
	Type III			

Annex 8g

CHECKLIST FOR INCLUSION OF SOCIAL AND GENDER EQUITY

State Level

I.	**Strengthened Institutional Mechanismsfor Social and Gender Equity**
	Is there a designated government official to oversee inclusion of social and gender equity at the state level? Are there a technical consultant/ institution to mainstream gender and equity?
	What are the identifiedkey entry points to ensure social inclusionandgender- specific strategies, capacity building, BCC, MIS
	What are the mechanisms to capture and monitor programme reach to socially excluded groups
III	**Improved Health Financing**
	What istheallocation of funds for- specific strategies to reach vulnerablegroups, emergency transport, emergency obstetric care,MTP services, maternal complications
	Are there guidelines and plans for the use of un-tied funds at the village level and sub-centre level and adequately disseminated across the different districts?
III	**Training**
	Is there asystematictraining andcapacity buildingstrategy and plandeveloped on gender andsocial inclusion in relation to -ANM, ASHA, SBA, MIS, BCC person. Are they shared across the districts?
	Do training plans include a focus on provision of MTP, management of RTI/STI, insertion of IUDs, vasectomies?
1V	**Policies, Guidelines, Human ResourcePolicies**
	For effective out reach work by women service providers isthere an anti sexual harassment policyandcell at the state level
	For effect reach to socially disadvantaged groups are policies for staffing of service delivery units representative of excluded groups e.g. SC, ST being implemented?
	Are there sufficient women doctors, at least one in every PHC?
V	**Facilities for Women Health Care Providersunder NRHM**
	Are there plans to improve safety of housing for all ANMs/ LHVs/ Front-line workers?
	Are there plans to improve field level functioning of ANMs/ Frontline workers e.g. provision of mobile phones, provision of vehicles for easy transport

District Level

I	**Strengthened Institutional Mechanismsfor Social and Gender Equity**
	The keyentry points identifiedfor addressing social inclusionandgender equity-a nodal gender and equityperson, plans to trainANMs,ASHS,district level functionaries,use of MIS, BCC
	Has the plan been built on systematic mapping of underserved districts and vulnerable social groups[2], including (but not limited to) the Tribal areas.
II	**Improved Services forDisadvantaged Social Groups and Women as Clients**
	Are specific strategies or mechanisms proposed to reach at a scale including budget allocations for 1) Under Served Districts 2. Social Group -ANC, PNC,Nutrition and Health, Ambulance and Transport Facilities,Trained medical staff,hospitals,safe community friendly alternative systems
	Are there strategies specified to ensure quality of services from a woman's perspective (e.g. through expansion of district Quality of Care Protocols, district teams). Are issues such as adequate, clean and separate toilets for women, privacy with the help of screens/ partitions, sufficient water, clean linen etc included as an aspect of quality?
	Is there a plan for adolescent friendly health services - anemia treatment, delay marriages, delay pregnancy, etc(inclusion of adolescent boys/girls, married and unmarried, out-of-school and in-school for SRH education and service provision).
	Are there strategies for development of capacity to provide counseling services at appropriate levels (e.g. for Family Planning, HIV prevention and testing, STI -partner managementand Gender Based Violence) and integrate these in health services
III	**Improved Health Financing**
	Is there sufficient allocation of funds for emergency transport, emergency obstetric care,MTP services, maternal complications
	Is there adequate allocation offunds for health delivery strategymade for women and BPL, SC, ST, migrants, urban poor, minorities and locally vulnerable groups
IV	**Training**
	Do training plans include a focus on provision of MTP, management of RTI/STI, insertion of IUDs, vasectomies?
VI	**Improved Community Involvement -RCH - NRHM**
	Are there plans and funds for communication, networking and BCC activities through community and women's groups for improved RCH outcomes (e.g. involvement of community volunteers, health messages through SHGs, strengthening of MahilaSwasthyaSanghs, health action groups and community health dialogues)
	Are there mechanism to ensure participation of socially marginalized groups and 50% women's participation in RKS and VHSCs
	Are there mechanisms to involve Panchayati Raj Institutions/Self Help Groups in needs assessment and planning**?**
VII	**Innovative approaches to make services and service environment client friendly**
	Are there provision for innovative approaches to making services client –centered (e.g. 24 hour help counters at district hospitals for assisted referrals, helplines for emergency transport)

[2] By vulnerable groups we mean SC, ST, minorities, urban Poor, women, adolescent girls and boys, occupation based groups, migrants, etc.

	Are putting up patients rights charters, rate charts, timings,in local languages at all health centres, putting up complaints boxes and credible grievance redressal system being practiced?
	Are plans forlinking hospitals with NGOs, Women's groups, help linestoaddressgenderbased violence
VIII	**Men as partners and clients**
	Are there innovative plans and allocation to improve provision of STI services to men(e.g. through BCC, male health workers, partner notification and treatment)
	Are their plans and allocations for BCC and MPW training to improve men's involvement in family planning includinguse of condoms and terminal methods
IX	**Women Health Care Providers**
	Are there mechanisms to report or address sexual harassment at work-place at the district level?
	Are field level functioning of ANMs/ Frontline workers e.g. provision of mobile phones, provision of vehicles for easy transport
X	**Better implementation of PCPNDT Act**
	Are there plan and allocations for better implementation of the PNDT act to stop sex-selection, specifically for -support cells at district providing monitoring or legalhelp - - capacity-building of Appropriate Authorities and other stakeholders including for monitoringvisits

ANNEX 9

IMMUNISATION BUDGET FORMAT

ANNEX 9

IMMUNISATION BUDGET FORMAT

Budget Head	Activity	Budget 2011-12 (Rs. Lakhs)				
		Q1	Q2	Q3	Q4	Annual total
C.1	**Vaccine Delivery**					
C.1.1	POL for vaccine delivery from state to District and PHC/CHCs					
C.1.2	Alternate Vaccine Delivery to Session sites					
C.1.3	Other activities					
	Sub-total Vaccine Delivery					
C.2	**Cold chain maintenance**					
C.2.1	POL of Generators for cold chain					
C.2.2	Maintenance of WIC and WIF					
C.2.3	Other activities					
	Sub-total cold chain maintenance					
C.3	**Outreach activities**					
C.3.1	Focus on urban slum & underserved areas					
C.3.2	Social Mobilization by ASHA /Link workers					
C.3.3	Alternative vaccinator hiring for urban RI					
C.3.4	Other activities					
	Sub-total Outreach activities					
C.4	**Other Programmatic interventions/special campaigns**					
C.4.1	Catch up Campaigns					
C.4.2	Other activities					
	Sub-total Other Programmatic Interventions					
C.5	**Human Resources**					
C.5.1	Computer Assistants support at State					
C.5.2	Computer Assistants support at district level					
C.5.3	Other activities (incentive etc.)					
	Sub-total Human Resources					
C.6	**Supervision and Monitoring**					
C.6.1	Mobility support for Supervision and Monitoring at districts and state level.					
C.6.2	Supportive supervision for top priority districts					
C.6.3	Quarterly review meeting at state level					
C.6.4	Quarterly review meeting at District level					

Budget Head	Activity	Budget 2011-12 (Rs. Lakhs)				
		Q1	Q2	Q3	Q4	Annual total
C.6.5	Quarterly review meeting at block level					
C.6.6	Printing and dissemination of immunization cards, tally sheets, charts, registers, receipt book, monitoring formats etc.					
C.6.7	AEFI investigation of district AEFI committee					
C.6.8	Other activities					
	Sub-total Supervision and Monitoring					
C.7	**Training**					
C.7.1	District level Orientation for 2 days ANMs, MPHW,LHV					
C.7.2	Three days training of Mos on RI					
C.7.3	One day refresher training of district computer Assistant on RIMS/HIMS					
C.7.4	One day cold chain handlers trainings					
C.7.5	One day training of block level date handlers					
C.7.6	To develop micro plan at sub-centre level					
C.7.7	For consolidation of micro plan at block level					
C.7.8	Other activities					
	Sub-total Training					
C.8	**Procurement**					
C.8.1	Consumables for computer including provision for internet access					
C.8.2	Red/Black bags, twin bucket, bleach/hypochlorite solution					
C.8.3	Other activities					
	Sub-total Procurement					
	Grand Total Immunization					

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total