Ministry of Health & Family Welfare
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A REPORT ON MONITORING OF IMPORTANT COMPONENTS OF NHM PROGRAMME IMPLEMENTATION IN VIDISHA DISTRICT, MADHYA PRADESH

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LIST OF ABBREVIATIONS

ANC	Ante Natal Care	F- IMNCI	Facility base IMNCI
ANM	Auxiliary Nurse Midwife	GOI	Government of India
ASHA	Accredited Social Health Activist	HIV	Human Immunodeficiency Virus
AYUSH	Ayurveda, Yoga& Naturopathy, Unani, Siddha and Homeopathy	HMIS	Health Management Information System
BB	Blood Bank	ICDS	Integrated Child Development Services
BMOC	Basic Emergency Obstetric Care	ICTC	Integrated Counseling and Testing Centre
BCC	Behaviour Change Communication	IEC	Information Education &Communication
BCG	Bacillus Calmette Guerin	IFA	Iron & Folic Acid
BPL	Below Poverty Line	IMNCI	Integrated Management of Neonatal and Childhood Illness
BSU	Blood Storage Unit	IPD	Indoor-Patients Department
CDO	Computer Data Entry Operator	IPHS	Indian Public Health Standards
CDMO	Chief District Medical Officer	IUCD	Intra Uterine Contraceptive Device
CGHS	Central Government Health Services	JSY	Janani SurakshaYojna
EMOC	Emergency Obstetric Care	JSSK	JananiShisuSurakshaKaryakram
ESIC	Employee State Insurance Corporation	LHV	Lady Health Visitor
EVA	Equine Viral Arthritis	MCH	Maternal and Child Health
DGD	Delhi Government Dispensary	MCTS	Mother and Child Tracking System
DOTS	Directly Observed Treatment Strategy	MH	Maternity Home
DPMU	District Program Management Unit	MIS	Management Information System
DPT	Diphtheria, Pertussis (whooping cough), Tetanus	MO	Medical Officer
OBG	Obstetrics Gynecology	MTP	Medical Termination of Pregnancy
PHN	Public Health Nurse	NBCC	New Born Care Corner
PIP	Programme Implementation Plan	NBSU	New Born Special Unit
PPIUCD	Post- Partum IUCD	NHM	National Health Mission
PNC	Post Natal Care	NGO	Non-Government Organization
RCH	Reproductive & Child Health	NRHM	National Rural Health Mission
RKS	RogiKalyanSamiti	NUHM	National Urban Health Mission
RTI/STI	Reproductive tract infection/Sexually transmitted infection	NSSK	NavjatShishuSurkshaKaryakram
SBA	Skilled Birth Attendant (Special training course is available for SBA).	NSV	Non Scalpel Vasectomy
TT	Tetanus Toxoid	VHND	Village Health and Nutrition Day

EXECUTIVE SUMMARY

The NHM envisages achievement of universal access to equitable, affordable & quality healthcare services that are accountable and responsive to people's needs. One of the salient factors that measure the progress of NHM remains the Monitoring and Evaluation activities undertaken by The Ministry of Health and Family Welfare on a continuous basis. It is expected that a timely and systematic assessment of the key components of NHM can be critical for further planning and resource allocation for any areas. In this regard, the Ministry of Health and Family Welfare has assigned Population Research Centres (PRC) the task of quality monitoring of essential components of State Programme Implementation Plan.

This report hence focuses on the monitoring of essential components of NHM in Vidisha district for the year 2020-21. The evaluation was carried out in the month of September, 2021 and thus captures the status of NHM activities in the said district of Madhya Pradesh. The report highlights key observations made during the team's visit to various health facilities of the district and also brings forth essential inputs provided by the key personnel of NHM.

The following public health care facilities were visited by the PRC-IEG Team: DH Vidisha, CHC Nateran, PHC Karaiya Khera, CHC Gyaraspur, PHC Gulabganj, and HWC AndiyaKala. Structured checklists were used to collect information on human resources, infrastructure, funds utilization, training, health care services including drugs and equipment, family planning, disease control programmes and other programmes under the umbrella of NHM.

Interactions with district and block level health administrators including the Chief Medical Officer (CMO) and the nodal programme officers, the Block Medical Officer-in-Charge (MOIC), facility (MOs, CHO, ANMs, etc) and community level health care providers (ASHAs, Anganwadi workers etc) and other supporting staff were conducted to understand the strengths and weakness of the facilities in service provisioning.

The report therefore summarises the status of Public Health Care in Vidisha, Madhya Pradesh during the financial year 2020-21 with regards to NHM and its components. Listed below are the key challenges being faced by the district with respect to health service delivery.

KEY CHALLENGES

Maternal Health

- In the last financial year, maximum 8-10 sterilization were done for male in the whole district but in the current there is no NSV.
- In the district, Maternal and Child death review are sanctioned in the district PIP. A total of 36 maternal deaths and 399 still births were reported in the last financial year 2020-21.

- Despite the improvement, multiple challenges remain around maternal and neonatal care. These include timely treatment during pregnancy to identify and treat causes of maternal deaths like post-partum haemorrhage, sepsis, hypertensive disorders, etc. The key challenges in addressing neonatal deaths remain the treatment of premature pregnancies, infections like pneumonia and septicaemia, and asphyxia. Many lives can be saved if these issues are identified early and treated appropriately.
- The interventions in RMNCHA+ should be focused on programmes in the district and the respective blocks and their facilities, providing training to accredited social health activists (ASHAs) and auxiliary nurse midwives (ANMs) in identifying and treating high-risk pregnancies, as well as identifying and resolving infrastructural gaps in the facilities. These interventions focus on using technology to do these tasks at scale, while also monitoring and evaluating the activities and outputs to improve programmatic performance.
- JSY portal has some technical problem and that is the major reason of lack of payment status at the very initial stage i.e., from the field and also incomplete entries are being done by ASHAs. Beneficiaries who didn't have MPID are not eligible for the incentives and the maximum numbers of beneficiaries were not having their respective IDs. Besides this, illiteracy is too visible amongst the ASHAs, so it is hard for them to convey the correct information to the patient.
- ASHAs and ANMs are less active in the block and less number of registrations have been recorded for ANC by ASHAs for 1st trimester. There are several ASHAs which do not stay in the village resulting to which there is no such mechanism to remove such ASHAs. ASHA monitoring in the block is nil.
- The ASHAs are coming from the nearby state headquarters and do not stay in the village. This has an impact on their services deliveries. The phone SIM given to ASHAs is often found to be with the husband or their father-in-law.

Family Planning

- The district is an aspirational district due to which it is very difficult for the community members to understand about family planning methods and also to use temporary methods such as CONDOMs etc.
- The location of the health is in the state list rather than the concurrent list that possesses major problems for service delivery. This is also compounded by the fact that the National Rural Health Mission funding is from the center while the implementation is by the state governments. Healthcare delivery cannot be improved to provide a heartwarming service without the removal of these obstacles.
- Ineffective counselling is being done by ASHA and lack of trust on the life as people does believe that if 1 or 2 children die due to any disease or for any reason at least they would have few other left who will look after their family. Another issue is demand for the male child.

Adolescent Health

- The inadequate adolescent friendly services were amplified by inflexible health facility regulation such as; the insistence that partners of pregnant women accompany them to the health facility when accessing maternal services, and attend health facilities in appropriate maternity wear. Health workers often gave priority to women who were escorted by their partners and in some cases, adolescent mothers were not attended because they did not go with their partners for antenatal services since their partners had denied responsibility for the pregnancy.

Human Resources for Health

- Doctors must be part of planning process of infrastructure as the time of making layout so that work can be done accordingly.
- There is an acute shortage of specialists in the districts. Shortage of LT/LA was also reported in the district resulting to which the beneficiaries have to avail the services from private facilities due to crunch of technicians.
- The diverse and difficult conditions of medical practices across the state give an authority of relevant factors of strengthening for health professionals. So, there is need for differential payments or some additional incentives to healthcare staffs working in remote areas and difficult.
- Chief Health Officers of all the HWCs have been deployed in the COVID-19 duty since they have been posted due to which they were unable to complete the target.
- The data entry operators are also over-burdened with COVID-19 data feeding. Shortage of data entry operators caused problems in reporting and piling up of work load on the data entry operator.
- Converting of Health and Wellness Centres in replacement of sub centres across the country, is alarmingly, wherein the vision documents talks about the upgradation of sub centres but Madhya Pradesh, in Vidisha district the health department is trying to convert PHCs in health & wellness centres. Due to this step, the demand for two doctors at Primary health centre will be in grey area.
- An estimate of the similarities of data between states and within region and social groups suggests clearly noticeable change in the national rural health mission quality of training, usage of funds and improvement in the healthcare delivery. Regions with good health indices have shown marked improvement, while those with existing poor indices have recorded a much lesser change. This is a true, despite a greater NRHM focus on inputs to poor performing states.

AYUSH

- The annual demands of the AYUSH medicines were not given from the very long time and as such the supply is also not coming at the district. However, AYUSH OPD is being reported

regularly in the HMIS portal as this is not showing the true picture. Although, as per the district officials AYUSH doctor can prescribe some allopathic medicines and they are currently prescribing the same.

- Despite crunch of staff, all the district officials are quite efficient and giving their double efforts to shape the health system of the district in a better way. The entire district administration is quite supportive and full co-operation is maintained.
- ANMOL Tablet is functional in the district but ANMs are not happy with tablet because from the past 3-4 years they are using the same tablet. Also the Application is so complicated for ANMs that they are unable to handle it. The ANMs have submitted back the tablets to the State. No data entry report is been done at the ANMOL Tablet. Now the tablets are getting old and require to get it repaired. Also the data entry operation is not willing to do entry in the portal because of its portal issue and internet problems. One month backlog is there.

INTRODUCTION

1.1 Background

The National Health Mission (NHM), which is our flagship health systems reform programme, provides a robust platform for implementation of a range of interventions focused on primary and secondary health care in rural and urban areas. NHM's efforts in strengthening health systems in States by allocating additional financial resources, flexibility in design and implementation, ensured sharper focus on particularly marginalized and vulnerable populations and enabled us to achieve impressive improvements in several key indicators of RMNCH+A and communicable diseases. NUHM seeks to improve the health status of urban population particularly urban poor and other vulnerable sections by facilitating their access to quality primary healthcare.

The broad national parameters and priorities, states would have the flexibility to plan and implement state specific action plans. The state PIP would spell out the key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes. The State PIPs would be an aggregate of the district health action plans, and include activities to be carried out at the state level. The state PIP will also include all the individual district plans. This has several advantages: one, it will strengthen local planning at the district level, two, it would ensure approval of adequate resources for high priority district action plans, and three, enable communication of approvals to the districts at the same time as to the state.

PRC Delhi Team visited the district office of Vidisha to interact with CM&HO, DPM and other nodal officers of the district. A brief profile oh health scenario of the district has been discussed intensively and officers were questioned on broader areas under NHM like Family Planning, Immunization, Training Status, Awareness Program etc. and also on the gaps in infrastructure and human resources and a brief discussion on the loopholes of the programme and their major recommendations to improve the overall efficiency of the scheme.

Specific goals for the states will be based on existing levels, capacity, and context. State specific innovations would be encouraged. Process and outcome indicators will be developed to reflect equity, quality, efficiency, and responsiveness. Targets for communicable and non-communicable diseases will be set at state level based on local epidemiological patterns and taking into account the financing available for each of these conditions.

1.2 Objectives of the Monitoring

I. To assess the current condition of physical infrastructure of availability in the selected health facilities CHCs, PHCs, HWC of the district.
II. To examine the status and the availability and efficiency of human resource required for better service at the selected health facilities.
III. To understand the gap between Demand and supply of health service delivery under NHM programme.
IV. To assesses functionality of equipment, supply and essential drugs, essential consumables etc.at the selected facilities.
V. To review the status of implementation and performance of different scheme under NHM such as maternal health, child health, family planning, JSSK, RBSK, ARSH, etc.
VI. To analyses other important components namely service delivery, record maintenance, Biomedical Waste Management, referral transports system, IEC material, disease control programme etc.
VII. To assess the availability of finance for the NHM activities in the district.

1.3 Methodology

The report is based on Primary data collected from health facility visits as well secondary data collected from DPM and CMHO office as well as information collected from HMIS Web Portal for Vidisha District. Structure interview schedules were used for nodal officers and health facilities. The Team interacted with key programme officials at District Programme Management Unit (DPMU) office of Vidisha District and examined the status of the key activities. Apart from rigorous interactions with the District Programme Manager, the Team visited at District Hospital, CHC, PHC and HWC to interact with Block Medical Officer-in-Charge, medical officers, staff, ASHAs, ANMs and beneficiaries in the district.

The attempt was to find solutions and support the health functionaries in identifying gaps and sensitizing them about the same and then to find areas where action can be taken within their designated capacities.

The assessment is based on observations made and information collected during the round table meeting with CMHO, DPM and other Nodal officers and NHM staff also visits to health facilities and beneficiary interactions. Interviews with the beneficiaries who were present during visits to health facilities were also conducted to obtain information from the beneficiaries' perspective about the functioning of National Health Mission.The field visits to health facilities in the district were planned and implemented with the consultation with NHM officials. The main motive of the team was to have a fruitful interaction with officials such as CM&HO, DPM and block development officer, to identify the major problems faced by them and recommendations on their

part to improve the overall efficacy of the NHM program. Health facilities from all the three levels (at district, block and village level) were selected for supportive supervision after consultations with the CMO and the DPM.

Prior to the assessment of health facilities, a meeting with key personnel of NHM, Vidisha was held. The interactions gave an enriching insight into the health situation of the district, key challenges that lay ahead, and a prospective way forward. The DPM further elaborated the plan of visit to the health facilities.

Table 1 reports the list of institutions and facilities visited in the Vidisha districts. The Team interacted with key programme officials at the office of the CMHO, the DPM and discussed the status of the key activities. Apart from detailed interactions with the District Nodal Officers and DPMU staff, the Team visited selected health facilities in the districts. The health care facilities visited to accomplish the objective of the visits are enlisted in the table below:

Table 1: List of institutions and facilities visited by the PRC-IEG Team, Vidisha 2020-21

Institution and Facilities	Nodal Officers
Office of the Chief Medical Officer	CMHO, Dr. A.P. Singh
District Programme Management Unit	DPM, Dr. Ashutosh
District Hospital, Vidisha	R.M.O, Dr Sanjay Khere
Urban Community Health Centre, Nateran	M.O, Dr. Neetu Singh Rai
Rural Community Health Centre, Gyaraspur	M.O. Dr Abbas
Urban Primary Health Centre, Kanaiya Khere	MO, Dr. D.K. Singh
Rural Primary Health Centre, Gulabganj	MOI, Dr. Bibhuti Srivastava
Health and Wellness Centre, AndiyaKala	CHO, Dr. Shivani

2. AN OVERVIEW OF KEY DEMOGRAPHIC AND HEALTH INDICATORS: VIDISHA DISTRICT, MADHYA PRADESH

2.1. Demographic Profile

The District derives its Name from the Head Quarters town of Vidisha. Vidisha Situated in the fork of the Betwa and Bes rivers, Vidisha, 10 km from Sanchi, occupies an important place amongst the ancient cities in India. In the 6th and 5th centuries BC, it rose to become an important trade centre and a bustling city under the Sungas, Nagas, Satvahanas and Guptas. The Emperor Ashoka was governor of Vidisha, and it finds mention in Kalidasa's immortal Meghdoot. The District Head Quarters town as it stands today is different from the old town of Vidisha or Besnagar. Till 1956, its name was Bhilsa. After that it was renamed as Vidisha for its close proximity to that glorious city of great antiquity.

In Madhya Pradesh, there are 333 blocks and 54903 villages. Out of which 7 blocks and 1626 villages are in Vidisha district. As per Census 2011, Madhya Pradesh has population of 7.27 Crores. Total population of Madhya Pradesh as per 2011 census is 72,626,809 of which male and female are 37,612,306 and 35,014,503 respectively. In 2011, Vidisha had population of 1,458,875 of which male and female were 769,568 and 689307 respectively (Table 2).

Table 2: Key Demographic Indicators: Vidisha District & Madhya Pradesh

Indicators	Madhya Pradesh (State)	Vidisha (District)
Number of blocks	333	7
Number of villages	54903	1626
Actual Population	72626809	1458875
Urban population	20069405	339618
Rural population	52557404	11119257
Male	37612306	769568
Female	35014503	689307
Population Growth Rate (%)	18.4	20.1
Density/km2	236	198
Child Population (0-6 age)	10809395	235391
Area (sq. km)	308252	7371
Literates	42851169	862918
Male Literates	25174328	512344
Female Literates	17676841	350574
Sex Ratio (per/1000)	931	896
Child Sex Ratio (0-6 age)	918	926

Source: Census of India, 2011

Population living in urban areas is 20,069,405 and population of rural areas of Madhya Pradesh state was 52,557,404. In total 339,618 people lives in urban areas and are 1119257 in rural areas of Vidisha district of Madhya Pradesh. The total population growth of Madhya Pradesh in this decade was 18.4 percent and in Vidisha was 20.09 percent. Density of Madhya Pradesh is 236 per sq. km and in Vidisha is 198 per sq. km. In actual numbers, total literates in Madhya Pradesh stands at 42,851,169 of which males were 25,174,328 and females were 17,676,841. In total, 862,918 people were literate of which males and females were 512344 and 350,574 respectively in Vidisha district. Sex Ratio in Madhya Pradesh is 931 i.e. for each 1000 male, which is below national average of 940 as per census 2011.For child (0-6) sex ratio is 918 girls per 1000 boys. Sex Ratio in Vidisha, it stood at 896 per 1000 male. The average national sex ratio in India is 940 as per latest reports of Census 2011 Directorate. In 2011 census, child sex ratio is 926 girls per 1000 boys.

Figure 1: Outline map of Vidisha district in Madhya Pradesh

Source: CMHO Office

2.2 Key Health Issues in the Vidisha District- Case Study

Exact rates of morbidity or affliction of diseases are difficult to estimate. Information on morbidity rates for diseases handled through vertical programmes of Government of India is available through their management information systems (MISs). Some of these diseases are malaria, tuberculosis, leprosy and blindness.

Maternal Death Review (MDR) as a strategy has been spelt out clearly in the RCH – II National Programme Implementation Plan. It is an important strategy to improve the quality of obstetric care and reduce maternal mortality and morbidity. The importance of MDR lies in the fact that it provides detailed information on various factors at facility, district, community, regional and national level that are needed to be addressed to reduce maternal deaths. Analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service. There were 36 maternal deaths in the Vidisha. The reason been MDR has been conducted as an established intervention for the district took look after the issues.

The status of infant (children up to the age of one year) and child mortality (upto age group of 5 years) is considered to be indicators for the assessment of the state of basic health care, quality and reach of health delivery, general environment for health and facilities of crucial health determinants such as nutrition, sanitation, safe drinking water etc. It also helps as good determinants of the performance of development initiatives that focus on poverty, backwardness, gender equity and empowerment.

Infants and children up to age of five years die prematurely due to diseases such as measles, diphtheria, tetanus, diarrhoea, pneumonia etc. due to combination of factors including poor nutrition for their mother while pregnant, lack of haemoglobin in their bodies, poor sanitation and health care conditions at birth, poor care during delivery, overall unhygienic conditions, poor level of awareness, unclean environment, poor health delivery system; and environment from which respiratory and water-borne diseases could be contacted etc. These are preventable through simple vaccination, nutritious diet and health care provisions and measures.

Government of India has decided to take up Community based maternal death review (CBMDR) and the Facility based maternal death review (FBMDR) which help in identifying the gaps in the existing health care delivery systems, prioritize and plan for intervention strategies and to reconfigure health services.

The mortality indicator of the district is evident that the highest numbers of cases in the district were in case of still birth; however there has been an increase in the number of cases of still birth from 392 in 2019-2020 to 399 in 2020-2021. Similarly, there is a decrease in maternal death cases from 39 in 2019-2020 to 36 maternal deaths in 2020-2021. But for child death there is a hike, 596 in 2019-2020 to 637 child deaths in the last financial year. There has been one death due to Malaria. No deaths were reported due to sterilization procedure.

Table 3 depicts the estimated indicators of the Vidisha district. The numbers of estimated deliveries were reported 26358 followed by C-section deliveries 2581 and live births were 26745. The total numbers of eligible couples in the last financial year were report 76293. Target for public and

private sector TB notification were 4300 and no leprosy cases in the district. Estimated numbers of cataract surgeries to be conducted in the Vidisha district were 11400.

Table 3: Estimated indicators of the Vidisha District, 2020-21

Estimated Indicators	Numbers
Estimated number of deliveries	26358
Estimated number of C-section	2581
Estimated numbers of live births	26745
Estimated number of eligible couples	76293
Estimated number of leprosy cases	0
Target for public and private sector TB notification for the current year	4300
Estimated number of cataract surgeries to be conducted	11400

Source: CMHO, Vidisha 2020-21

2.3 Progress on Health Indicators by Vidisha district

The Health services in Vidisha District are available at reasonable cost and Ambulance service is also available for any emergency as Vidisha is an aspirational district. Department of Health and Family Welfare, Government of Madhya Pradesh, is playing a vital role in improving the health status & quality of living of the People of Madhya Pradesh. With the objective of providing health services in Urban and Remote areas, the department provides medical services in the state of Madhya Pradesh. For monitoring medical related activities in Vidisha at district level Chief Medical & Health Officer (CMHO) is responsible for all the works related to this department. Local Medical Institutions At the local governance level, there are CHCs and PHCs to assist the citizens. CHC stands for Community Health Centre, PHC stands for Primary Health Centre.

2.4 Health Care Service Delivery Indicators of Vidisha District

Maternal Health is an important aspect for the development of any country in terms of increasing equity & reducing poverty. The survival and well-being of mothers is not only important in their own right but are also central to solving large broader, economic, social and developmental challenges. Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period.

Quality of ante-natal care, care during labor and post-natal care remain key pillars for addressing maternal mortality. Maternal nutrition during pregnancy is also a key element of ante-natal care that needs to be addressed if the maternal mortality and morbidity is to be addressed.

Table 4 presents the health profile of Vidisha district for the year 2020-2021. It highlights the performance of major service delivery indicators and the subsequent health outcomes in terms of the quantifiable goals of NHM. It analyses the input, output and outcomes of the public health delivery system in Vidisha with respect to various domains such as Maternal Health, Delivery

Care, Child Health, Immunisation Coverage, Family Planning, Facility Service Delivery and Mortality Indicators. In Vidisha district 71.1 percent of the women register for ANC in the first trimester while less than half of women (77 percent) who register for ANC received 4 or more checkups. Early registration of pregnancy allows for adequate care during the cycle. IFA supplementation was given to 113.5 percent of all women who registered for ANC.

Table 4: Health Care Service Delivery Indicators of Vidisha District, Madhya Pradesh, 2020-2021

Health and Health Care Service Delivery Indicators	HMIS (2020-2021)	
	Madhya Pradesh	Vidisha
Maternal Health		
% 1st Trimester registration to Total ANC Registrations	71.8	71.1
% Pregnant Women received 4 or more ANC checkups to Total Registration	80.6	77.0
% Pregnant women given 180 IFA to Total ANC Registrations	96.7	113.5
Institutional Deliveries and Home Deliveries		
Number of Home Deliveries	59360	1377
% SBA attended Home Deliveries to Total Reported Home Deliveries	14.6	9.7
% of Institutional Deliveries to Total Reported Deliveries	95.7	94.0
% Institutional Deliveries to total ANC Registrations	68.9	59.0
% Women discharge in less than 48hours of delivery to Total Reported Deliveries at Public Institutions	11.9	2.8
% C-section Deliveries (Public + Private) to reported Institutional (Public+ Private) Deliveries	11.4	10.1
Post Natal Care		
% Women getting 1st Post-Partum Check-up between 48 hours and 14 days to Total Reported Deliveries	13.7	12.7
% Newborn breast fed within 1 hour of birth to Total Live Birth	91.8	94.7
% Newborn weighed at Birth to Live Birth	96.4	98.5
Child Immunization		
Number of Fully Immunized children (9-11 months)	1737729	39835
% of children received measles to full immunization	0.05	0
% of children received BCG to full immunization	76.9	64.9
Family Planning		
Total Sterilization conducted	317272	4853
% Male Sterilization (Vasectomies) to Total sterilization	0.9	0.1
% Female Sterilization (Tubectomies) to Total sterilization	99.1	100.1
Mortality Indicators		
Maternal Death	2722	38
Child Death	4109	156
Infant Death	27669	198
Still Birth	24453	399
Other Services		
IPD	3747157	78782
OPD (AYUSH + Allopathic)	52710661	1054184
% IPD to OPD	7.1	7.5

Source: HMIS Standard Reports, 2020-21

Delivery Care is important component of Infant health. The numbers of total home deliveries in Madhya Pradesh are 59360, out of which 1377 home deliveries were in Vidisha district. Of the total home deliveries in Vidisha, 31.8 percent were SBA attended. Government of India

recognizes an SBA as someone who can handle common obstetric and neonatal emergencies. Thus presence of SBA in cases home delivery is essential to combat maternal death. Of all women who registered for ANC, only 61.4 percent went for institutional delivery and 10.3 percent women discharge in less than 48hours of delivery to total reported deliveries at public institutions.

For C-section deliveries, 10.3 percent of all institutional deliveries were C-section deliveries. With regards to Post Natal Care, 16.1 percent women getting 1stpost-partum check-up between 48 hours and 14 days to total reported deliveries. Only 90 percent of newborns were breast fed within 1 hour of delivery while 96.4 percent of newborns were weighed at birth.

Child Mortality is a threat facing India since decades. The Reproductive and Child Health programme (RCH) II under the National Rural Health Mission (NRHM) comprehensively integrates interventions that improve child health and addresses factors contributing to Infant under five mortality rates. With regards to the service delivery for Child Health, Vidisha observes 39835 full immunisation coverage rates and full coverage of BCG is 65.

Unmet need for family planning is a significant factor that contributes to population growth. Family planning services work in accordance to lower the unmet need. Female sterilisation as a method of permanent family planning dominates the statistics with 100 percent of all sterilisation conducted in 2020-2021 in Vidisha being Tubectomies.

To improve the health care delivery, increase in the OPD and IPD services through better facilitation and coordination of public health systems has been a contribution of NHM. The OPD patient load is as high as 1054184 number of OPD patients in 2020-2021 as against 78782 IPD patients. In Vidisha district, there were 38 maternal deaths, 156 child deaths, 198 infant deaths and still birth is 399. There is not a single death due to sterilization in Vidisha district of Madhya Pradesh.

3. PUBLIC HEALTH PLANNING AND IMPLEMENTATION OF NATIONAL PROGRAMME

3.1 District Action Plan

3.1.1 State Resource Envelope and District Allocations

For the financial year (FY) 2020-21, against a resource envelope of 3173.20 Crore (calculated assuming state share of 40%), Madhya Pradesh received administrative approval for an amount of Rs. 4417.49 Crore. The resource envelope for FY 2020-21 consists of union government's support of Rs. 1235.71 Crore for flexible pool allocation including cash and kind, Rs. 264.40 Crore for incentive pool based on last year's performance and Rs. 403.81 Crore for infrastructure maintenance. The total support from Government of India is Rs. 1903.92 Crore whereas the state share of 40% works out to be Rs. 1269.28 Crore.

Table 5: Details of Resource Envelope, Vidisha District, 2020-21

Particulars	Rs. in Crore
1. GoI Support (Flexible Pool allocation including Cash and Kind)	1235.71
2. GoI Support for Incentive Pool based on the last year's performance (assuming no incentive/ reduction on account of performance)	264.40
3. GoI Support (under Infrastructure Maintenance)	403.81
Total GoI support	1903.92
State Share (40%)	1269.28
Total Resource Envelope	3173.20

Source: Record of Proceedings (NHM Madhya Pradesh 2020-21), MoHFW

It may be noted that the Madhya Pradesh received approvals of Rs. 4417.25 Crore for NHM. The state has received the full proposed amount of Rs.1903 Crore for infrastructure maintenance during 2020-21. Similarly, the state also proposed and received immunization kind grants of 122.36 Crore.

The breakup of the total resource envelope shows that Rs. 399.22 Crore is allocated for RCH Flexible Pool (including RI, IPPI, NIDDCP), Rs. 866.40 is allocated for Health System Strengthening (HSS) under NHM. Thus the GOI contribution toward total NRHM-RCH Flexible Pool works out to be Rs. 1285.26. The GOI contribution toward NUHM Flexible Pool, NDCP Flexible Pool and NCD Flexible Pool is Rs. 64.25 Crore, Rs. 99.87 Crore and Rs. 50.36 Crore, respectively. Within NDCP Flexible Pool bulk of the resources are allocated for RNTCP activities. Finally, over Rs. 403.81crore of the GOI contribution under the total resource envelope is allocated toward infrastructure maintenance (including Direction and Administration).

Table 6: Breakup of resource envelope, NHM FY 2020-21, Madhya Pradesh

S.No.	Particulars	Amount (GoI Share)	Percent (GOI Share)	State share

1	RCH Flexible Pool (including RI, IPPI, NIDDCP)	399.22	12.6%	
(i)	RCH Flexible Pool (including RI, IPPI, NIDDCP) Cash Grant Support	276.68	-	
(ii)	RCH Flexible Pool (Kind Grant Support under Immunization) as per FY 2019-20	122.36	-	
2	Health System Strengthening (HSS) under NRHM	866.40	27.3%	
(i)	Other Health system Strengthening covered under NRHM	727.88	-	
(ii)	Comprehensive Primary Health Care under HSS	103.47	-	
(iii)	Additional ASHA Benefit Package including support to ASHA facilitators	55.06	-	
	Total NRHM-RCH Flexible Pool	1285.62	-	
3	NUHM Flexible Pool	64.25	2.0%	
(i)	Other Health System Strengthening covered under NUHM	46.75	-	1269.28
(ii)	Comprehensive Primary Health Care under NUHM	17.50	-	
4	NDCP Flexible Pool (RNTCP, NVHCP, NVBDCP, NLEP, IDSP)	99.87	3.1%	
(i)	NVBDCP (Cash & Kind)	13.21	-	
(ii)	RNTCP (Cash &Kind)	75.15	-	
(iii)	NVHCP (Cash &Kind)	7.12	-	
(iv)	NLEP	1.98	-	
(v)	IDSP	2.41	-	
5	NCD Flexible Pool (NPCB, NMHP, HCE, NTCP, NPCDCS)	50.36	1.6%	
6	Infrastructure Maintenance (including Direction and Administration)	403.81	12.7%	
	Total Resource Envelope	1903.92	100%	1269.28
	Grand Total Resource Envelope (Central Allocation + State Share)	3173.20		

Source: Record of Proceedings (NHM Madhya Pradesh 2020-21), MoHFW

3.1.2 Budget Utilization

NHM consists of the following six major financing components: The RCH Flexipool to fund maternal and child health, family planning, and the Janani Suraksha Yojana (JSY). This now also includes the erstwhile 'Immunisation' Flexipool for financing routine immunisation and pulse polio immunisation, as well as the National Iodine Deficiency Disorders Control Programme (NIDDCP). The Health Strengthening System(HSS)/NRHM Mission Flexipool (MFP)which finances untied funds, annual maintenance grants, and Hospital Strengthening. The NUHM Flexipool addresses the healthcare needs of the urban poor with a special focus on vulnerable sections. The Communicable Diseases (CD) Flexipool for financing the National Disease Control Programme (NDCP) is an important component for the Vidisha district. This includes programmes such as the Revised National Tuberculosis Control Programme (RNTCP), National Vector Borne Disease Control Programme (NVBDCP), Integrated Disease Surveillance Programme (IDSP), and National Leprosy Eradication Programme (NLEP). The Non-Communicable Diseases(NCD) Flexipool for financing programmes such as the National Programme for Control of Blindness (NPCB), National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), National Tobacco Control Programme (NTCP), National Programme for the Healthcare of the Elderly (NPHCE) and, National Mental Health Programme (NMHP). Lastly, the Direction and Administration funds (formerly known as Infrastructure Maintenance) which are allotted across various programmatic divisions of NHM in the district to overlook the performance and over all development of the State.

Budget utilisation under NHM is to operationalise an effective and accountable financial management system for budgeting, monitoring and utilisation of funds at central, state, district and block level. The detail of the budget utilisation is given in table 7 as per the Financial Management Report (FMR).

Maximum budget for untied funds and programme management has been utilized. The highest under-utilization rates are for infrastructure, IEC-BCC, and IT Initiatives for Service Delivery. For these, more than 50 percent sanctioned budget lies unutilized. One of the major reasons cited for underutilization during the meeting with district officials was the delay in receipt of funds. It was also reported that the untimely disbursal of funds fails to cover the pre sanctioned loans due to audit loops, owing to which 100% utilisation has not been possible. The fund sanctioned to the district is always less, what the district demands. As per the given records it can be observed that, the maximum number of utilizations as per the FMR is in Human resources followed by Community Intervention, Service Delivery: Community Based and Printing in which health facilities is monitored. No budget is utilized for Referral Transport and Review, Research and Surveillance. The fund utilized under NUHM is 60 percent.

Table 7: Financial Management Report, Vidisha District, 2020-21

Indicator	Budget Released (in lakhs)	Budget utilized (in lakhs)	Reason for low utilization (if less than 60%)
1. FMR 1: Service Delivery: Facility Based	11207203	5925918	52.88
2. FMR 2: Service Delivery: Community Based	3417794	3032869	88.74
3. FMR 3: Community Intervention	7815403	7014113	89.75
4. FMR 4: Untied grants	60000	N.A	0.0
5. FMR 5: Infrastructure	2290000	26275	1.15
6. FMR 6: Procurement	21476584	15784396.06	73.50
7. FMR 7: Referral Transport	0	0	0
8. FMR 8: Human Resource (Service Delivery)	55953793	50689835	90.59
9. FMR 9: Training	11285942	8427668.18	74.67
10. FMR 10: Review, Research and Surveillance	0	0	0
11. FMR 11: IEC-BCC	2768544	684289	24.72
12. FMR 12: Printing	3943244	3475428	88.14
13. FMR 13: Quality	8294800	6415062	77.34
14. FMR 14: Drug Warehouse & Logistic	547960	434327.20	79.26
15. FMR 15: PPP	37550000	30766000	81.93
16. FMR 16: Programme Management	24251981	19373844.46	79.89
17. FMR 17: IT Initiatives for Service Delivery	2209354	485091	21.96
18. FMR 18: Innovations	83089	68007	81.85

Source: CMHO, Vidisha 2020-21

Moreover, if we observe programme wise which is depicted in the figures 2 shown, out of the RCH and Health Systems Flexi Pool in which 100% utilization of PC-PNDT. Funds for ASHA (94%) have been utilised, as all the payments and incentives have been given on time. Funds utilised for Programme management (92%)followed by HR (82%), PPP (81%), Immunization (78%), Blood Services and Disorder (76%), Comprehensive Primary Health care (CPHC) (71%), Family Planning (69%), Quality Assurance(68%), RBSK (64%), Maternal Health (61%), Child Health (60.5%), United Fund (53%), RKSK/Adolescent Health (53%), Infrastructure (45%) and PC-PNDT (28%). No fund received under, MMU, Referral Transport, Procurement, and NIDDCP in Vidisha district.

Figure 2: Utilization of Funds Programme Wise, Vidisha District, 2020-21

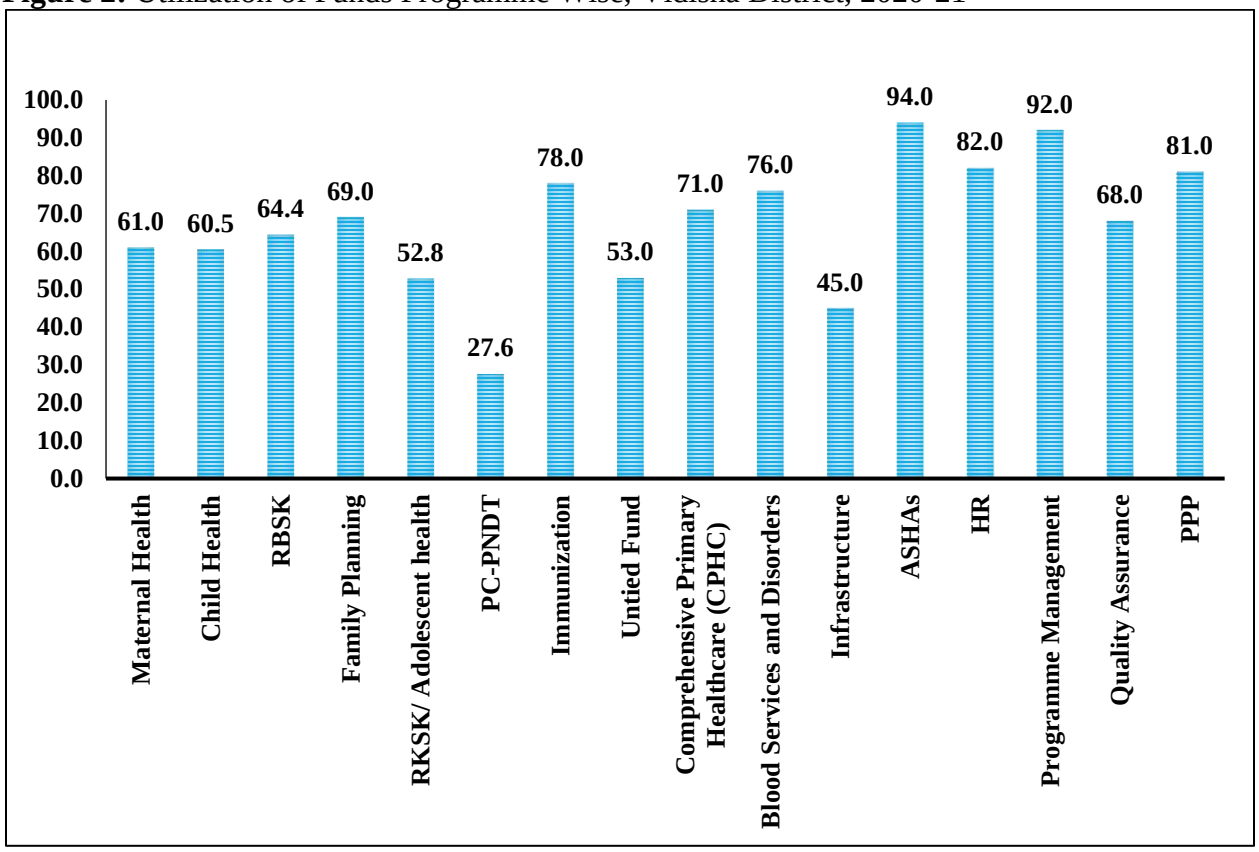


Figure 3 depict the fund utilisation under communicable disease in Vidisha. The communicable disease pool, the maximum number of utilization of funds is observed in the National Vector Borne Disease Control Programme (NVBDCP) at 98 percent. The reason being all the fund is being utilized in tackling the COVID-19 situation with full force. On the contrary, the least utilization is being in National TB Elimination Programme (NTEP) nearly 82 percent.

Figure 3: Fund Utilisation under Communicauncable Dieases, Vidisha district, 2020-21

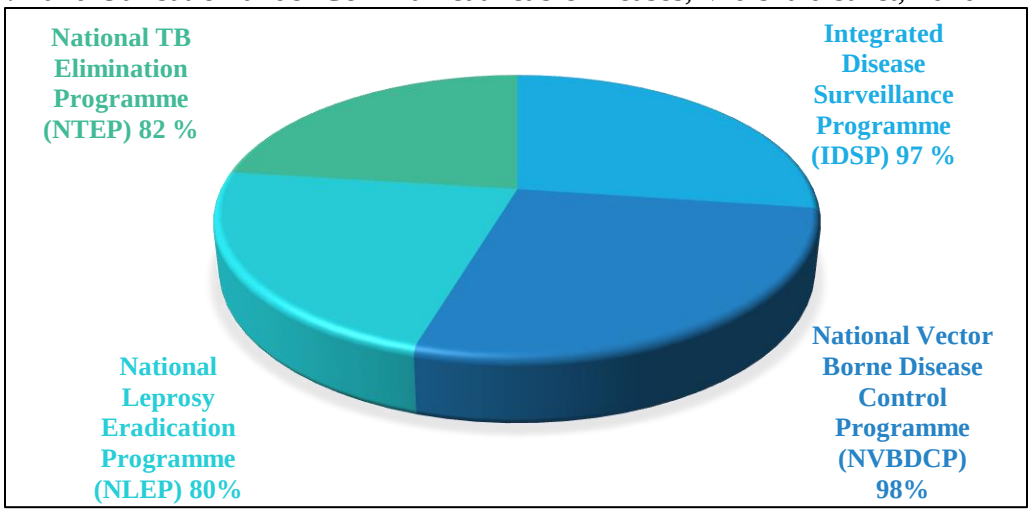
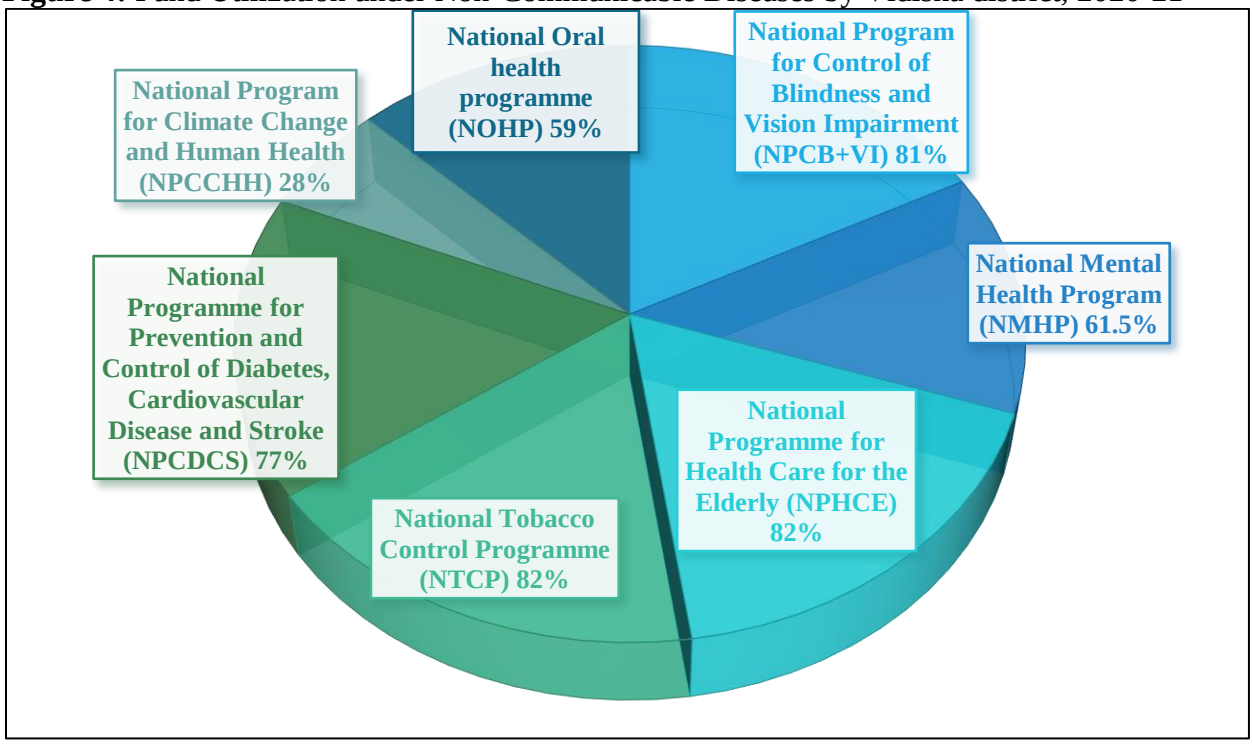


Figure 4 illustrates fund utilisation under non-communicable diseases in Vidisha district. The cases of non-communicable disease 100% utilization of fund under National Oral Health Program (NOHP). The funds utilized for National Programme for Prevention and Control of Diabetes, Cardiovascular Disease, and Stroke (NPCDCS) (89%) followed by National Mental Health Program (NMHP) (79%) and National Programme for Health care for the Elderly Care (NPHCE) (36%). There was no fund utilisation for National Tobacco Control Programme in the district.

Figure 4: Fund Utilization under Non-Communicable Diseases by Vidisha district, 2020-21



3.2 Status of Service Delivery

3.2.1 Health Infrastructure

Health infrastructure of a district has a significant role in ensuring effective provision of all the services to the beneficiaries. All public health services depend on the presence of basic infrastructure. Every public health program—such as immunizations, infectious disease monitoring, cancer and asthma prevention, maternal health—requires health professionals who are competent in cross-cutting and technical skills, up-to-date information systems, and public health organizations with the capacity to assess and respond to community health needs. Public health infrastructure has been referred to as the nerve centre of the public health system. Strengthening the Public Health Care Institutions and put in their best efforts to achieve high quality of health care across the district.

Under National Health Mission (NHM), financial support is provided to States to strengthen the public health system including upgradation of existing or construction of new infrastructure. Under NHM high focus states can spend up to 33% and other States up to 25% of their NHM funds on infrastructure. The populations Norms for setting up of public health facilities are as under:

- Sub Centre: 1 per 5,000 population in general areas and 1 per 3,000 population in difficult/tribal and hilly areas
- Primary Health Centre: 1 per 30,000 population in general areas and 1 per 20,000 population in difficult/tribal and hilly areas
- Community Health Centre: 1 per 1,20,000 population in general areas and 1 per 80,000 population in difficult/tribal and hilly areas.

A new norm has also been adopted for setting up a SHC based on 'time to care' within 30 minutes by walk from a habitation has been adopted for selected district of hilly and Desert areas. It has also been decided to strengthen Sub-Health Centres based on 'time to care' within minutes by walk from habitations has been adopted in selected districts of hilly States and desert areas as per the Rural Health Statistics (RHS) 2020, the status of public health facilities.

Infrastructure provides health system the foundation to deliver, evaluate and respond to community health needs. It is essential to effectively provide essential public health services. An adequate system is capable of providing preventive, diagnostic, and curative care, according to the requirements of the people being served. The Public Health Care Infrastructure under NHM includes Sub Health Centres at the most peripheral level, Primary Health Centres to provide an integrated curative and preventive health care, and Community Health Centres which serve as a referral centre for PHCs and also provides facilities for obstetric care and specialist consultations.

Table 8 presents the details of Health Infrastructure in Vidisha. With regards to Public health infrastructure, there is 1 District Hospital, 2 sub District Hospital, 7 Community Health Centres (CHCs), 23 Primary Health Centres (PHCs), 4 Urban Primary Health Centres (PHCs), and 206 Sub Centres(SCs) in Vidisha. In addition, 1 blood storage unit, 3 Tuberculosis units and 1 CBNAAT Site are functioning in the district. The total numbers of UPHC's present in the district are 4 and no UCHC's are available. One Special New-Born Care Unit (SNCU) and 5 Nutrition Rehabilitation Centres are present at the DWH. In the district, there are 15 designated microscopy Centre (DMC) are fully operational. Moreover, there are 2 first referral units (FRUs), 1 blood bank, and 2 blood storage units. Almost all the 21 Urban Primary Health Centres have been transformed into HWCs. Furthermore, out of 206 SC's, only 72 SCs have been converted into HWC's the proportion is less. In addition, the number of functional NCD clinic is found to be at the DH only 1 and CHC level 7 clinics. The total number of institutions providing comprehensive abortion care services (CAC) is reported to be at 14 facilities. Only 1 facility are providing 1st trimester services i.e., at DH, District Combined Hospital (DCH) and PHC. No facility is providing both 1st and 2nd trimester services in the district. However, it must be noted that the district doesn't have District Early Intervention Centre (DEIC).

Table 8: Facility Details, Vidisha District, 2020-21

Facility Details	Sanctioned/ Planned	Operational
1. District Hospitals	1	1
2. Sub District Hospital	2	2
3. Community Health Centers (CHC)	7	7
4. Primary Health Centers (PHC)	23	23
5. Sub Centers (SC)	206	206
6. Urban Primary Health Centers (U-PHC)	4	4
7. Urban Community Health Centers (U-CHC)	0	0
8. Special Newborn Care Units (SNCU)	1	1
9. Nutritional Rehabilitation Centres (NRC)	5	5
10. District Early intervention Center (DEIC)	1	0
11. First Referral Units (FRU)	3	2
12. Blood Bank	1	1
13. Blood Storage Unit (BSU)	3	2
14. No. of PHC converted to HWC	21	21
15. No. of U-PHC converted to HWC	4	4
16. Number of Sub Centre converted to HWC	72	72
17. Designated Microscopy Center (DMC)	15	15
18. Tuberculosis Units (TUs)	7	7
19. CBNAAT/TruNat Sites	0/1	0/1
20. Drug Resistant TB Centres	1	0
21. Functional Non-Communicable Diseases (NCD) clinic		
• At DH		
• At SDH	1	1
• At CHC	0	0
	7	7
22. Institutions providing Comprehensive Abortion Care (CAC) services		
• Total no. of facilities	14	14
• Providing 1st trimester services	Yes	Yes
• Providing both 1st & 2nd trimester services	No	No

Source: CMHO, Vidisha 2020-21

Table 9 represents the details on referral transport services in Vidisha District. Health infrastructure also includes the transport facilities provided by the district for safe and timely movement of patients. These include ambulances or any other form/mode of transport used to commute by the people of the community. Vidisha District had 11 Basic Life Support (BLS) ambulances and 1 advance life support ambulances. And the ambulance were having GPS fitted and handled through centralized call centre. The district received average number of calls and trips per day were 5 and the average kilometres travelled per ambulance were 500 per day. The numbers of transport vehicle 102 on road were 19. The average numbers of trips per ambulance were 6 per day and average kilometre travelled per ambulance were 400-500km per day.

Table 9: Details on Referral Transport service provision in Vidisha District, 2020-21

Vehicle for Referral Transport	
No. of Basic Life Support (BLS) (on the road) and their distribution	11
No. of Advanced Life Support (ALS) (on the road) and their distribution	1

Operational agency (State/ NGO/ PPP)	0
If the ambulances are GPS fitted and handled through centralized call centre	YES
Average number of calls received per day	5
Average number of trips per ambulance per day	5
Average km travelled per ambulance per day	500
No. of transport vehicle/102 vehicle (on the road)	19
If the vehicles are GPS fitted and handled through centralized call centre	Yes
Average number of trips per ambulance per day	6
Average km travelled per ambulance per day	400-500

Source: CMHO, Vidisha 2020-21

3.2.2 Human Resource

The component of Human Resources under NHM is to ensure availability of adequate manpower at the public health facilities in the rural and remote areas of the district. Human Resources are largely based on the requirements. The component/scheme of Human Resources under NHM includes different interventions to ensure recruitment, deployment, continued capacity building and functioning of adequate health care man power. Interventions for increasing the generation of health Human Resources to meet the demands in the public sector like Contractual appointment of HR for service delivery including Doctors, Consultant, Staff nurses, Lab technicians, ANMs, other paramedical staff and support staff for filling short term gaps at public facilities. Provision of incentives for ensuring service delivery in rural and remote areas, Multi-skilling and skill up-gradation of existing staff such as doctors and staff nurses to overcome the shortage of specialists and skilled manpower interventions for effective management of existing HR, including measures for quality assurance, Measures for assessing the competencies of service delivery staff including nurses, ANM and Lab Technicians etc.

The number of health workers available in a district is a key indicator of that district's capacity to provide delivery and intervention. Table 10 provides the Human Resource Availability in Vidisha District. In the district at present 278 ANMs, 71 MPW (Male), 267 Staff Nurse, 28 Lab Technician, 28 pharmacist, 63 MO, 5 OBGY, 3 Paediatrician, 17 Radiographer, 115 CHO/MLHP and only 1 surgeon, radiologist, and other specialist. In the district, there is no dental clinical, dental hygienist, Dentist, OT technician CSSD technician, anaesthetist, AYUSH MO and AYUSH Pharmacist.

Table 10: Human Resource of Vidisha District, 2020-21

Staff details at public facility (Regular+ NHM+ other sources)	Sanctioned	In-place
ANM	377	278
MPW (Male)	152	71
Staff Nurse	308	267

Lab technician	31	28
Pharmacist (Allopathic)	43	28
MO (MBBS)	103	63
OBGY	05	05
Pediatrician	10	03
Anesthetist	07	0
Surgeon	11	01
Radiologists	03	01
Other Specialists	09	01
Dentists/ Dental Surgeon/ Dental MO	01	0
Dental technician	0	0
Dental Hygienist	0	0
Radiographer/ X-ray technician	17	17
CHO/ MLHP	181	115
AYUSH MO (RBSK)	02	-

Source: CMHO, Vidisha 2020-21

3.2.3 Status of Training

ASHA is volunteer health activists in the communities, who is creating awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing public health services. She is a promoter of good health practices. ASHA will be entitled for Performance Based Incentives fixed by the NRHM State HQ for prefixed activities only. The performance based incentives required to be given on monthly basis to ASHA. The roles and responsibilities of an ASHA include the functions of a healthcare facilitator, a service provider and a health activist. Broadly, her functions involve providing preventive, promotive and basic curative care in a role complementary to other health functionaries; educating and mobilizing communities particularly those belonging to marginalized communities, for adopting behaviours related to better health and create awareness on social determinants, enhancing better utilization of health services; participation in health campaigns and enabling people to claim health entitlements. She is also providing a minimum package of curative care as appropriate and feasible for that level and making timely referrals for further treatment.

ASHA (Accredited Social Health Activist) is health activists in the communities who creates awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. They act as a 'bridge' between the rural people and health service outlets and would play a central role, in achieving national health and population policy goals. The effectiveness of ASHA worker largely depends on the training and support from both the health system and the community.

Table 11 describes the number of ASHA's and their training status in Vidisha district. In the district the number of ASHAs were1634 and requirement as per population by the district was reported to be 2000 ASHA workers and 1634 were selected. 163 ASHA workers are covering more than 1500 population in rural area and no coverage of 3000 urban population. Number of villages and the slum area with no ASHA is 57.

ASHAs are the foremost health workers in the field. Our Honourable Prime Minister had set forth social security benefits for ASHAs and ASHA facilitator as to double the incentives for routine activities. Those who meet the said criteria are to be enrolled in these schemes implemented by GoI namely, the Pradhan Mantri Jeevan JyotiBima Yojana (PMJJBY) and Pradhan Mantri Suraksha Bima Yojana (PMSBY). The status of social benefits scheme for ASHAs ans ASHA Facilitators were 721. The maximum numbers of ASHAs and ASHA facilitator have been given the benefit of PMJJBY with 438 and 78 workers followed by 283 ASHAs and 32 ASHAs facilitator in PMSBY. The numbers of ASHA enrolled for Pradhan Mantri Shram Yogi Maandhan Yojana (PMSYMY) were 390 and 86 workers.

Table 11: Number of ASHA's and its Training Status, Vidisha District, 2020-21

ASHA's Status	Number
Number of ASHAs	1634
• Required as per population	2000
• Selected	1634
• No. of ASHAs covering more than 1500 (rural)/ 3000 (urban) population	163/0
• No. of villages/ slum areas with no ASHA	57
Status of social benefit scheme for ASHAs and ASHA Facilitators (if available)	721
• No. of ASHAs enrolled for Pradhan Mantri Jeevan JyotiBima Yojana (PMJJBY)	438
• No. of ASHA Facilitator enrolled for Pradhan Mantri Jeevan JyotiBima Yojana (PMJJBY)	78
• No. of ASHAs enrolled for Pradhan Mantri Suraksha Bima Yojana (PMSBY)	283
• No. of ASHA Facilitators enrolled for Pradhan Mantri Suraksha Bima Yojana (PMSBY)	32
• No. of ASHAs enrolled for Pradhan MantriShram Yogi Maandhan Yojana (PMSYMY)	390
• No. of ASHA Facilitators enrolled for Pradhan MantriShram Yogi Maandhan Yojana (PMSYMY)	86

Source: CMHO, Vidisha 2020-21

Table 12 depicts RBSK team status and its transport facilities availability in the district. The total number of RBSK team sanctioned in the district were 16 but due to the COVID 19 pandemic all the teams were indulged into monitoring to the Corona patients. Only 3 full team with all HR in place in the district. The availability of vehicles for RBSK teams was 16 and the numbers of teams per block were 16. In the district, there were no blocks which were left out by the RBSK team to monitor. In the Vidisha district, there were 3blocks were single HR team were posted. The average numbers of children screened per day per team by RBSK were 110.

Table 12: RBSK Team Status and Transport Facilities in Vidisha, 2020-21

RBSK Status	Numbers
Total no. of RBSK teams sanctioned	16
No. of teams with all HR in-place (full-team)	03
No. of vehicles (on the road) for RBSK team	16
No. of Teams per Block	16
No. of block/s without dedicated teams	0
Average no of children screened per day per team	110
Number of children born in delivery points screened for defects at birth	520

Source: CMHO, Vidisha 2020-21

Although in the beginning of the COVID 19 pandemic the RBSK team screening after a lot but later on the team achieved its targets. Numbers of children born at the delivery points screened for defects at birth were 520.

Table 13: Availability of Free Drugs and Diagnostics Services, Vidisha District, 2020-21

Indicators	Remarks
Implementation of Free drugs services (if it is free for all)	Yes
Implementation of diagnostic services (if it is free for all)	Yes
Status of delivery points	
• No. of SCs conducting >3 deliveries/month	0
• No. of 24X7 PHCs conducting > 10 deliveries /month	07
• No. of CHCs conducting > 20 deliveries /month	06
• No. of DH/ District Women and child hospital conducting > 50 deliveries /month	1
• No. of DH/ District Women and child hospital conducting C-section	1
• No. of Medical colleges conducting > 50 deliveries per month	0
• No. of Medical colleges conducting C-section	0
Number of institutes with ultrasound facilities (Public+Private)	19
• Of these, how many are registered under PCPNDT act	6
Details of Pradhan MantriSurakshitMatritvaAbhiyan PMSMA activities performed	0

Source: CMHO, Vidisha 2020-21

Table 13 represents availability of free drugs and diagnostics services in Vidisha District. It was observed that implementation of free drugs and diagnostics were there in all the facilities visited and the number of notified lab test in the district. There were 15 delivery points in Vidisha. In the district in HWC no deliveries were operational. All the 7 PHC, 1 CHC and 1 DH were having delivery points and were functional properly. In the Vidisha District, 19 ultrasounds test are available at the facilities. Numbers of cases registered under PCTNDT in the district were 6.

4. IMPLEMENTATION OF NATIONAL PROGRAMME

There are several National Health Programmes such as the National Vector Borne Diseases Control, Leprosy Eradication, TB Control, Blindness Control and Iodine Deficiency Disorder Control Programmes have come under the umbrella of National Health Mission.

4.1 Reproductive, Maternal, New-born, Child and Adolescent Health (RMNC+A)

Improving the maternal and child health and their survival are central to the achievement of national health goals under the National Health Mission (NHM). SDG Goal 3 also includes the focus on reducing maternal, newborn and child mortality. In the past years, innovative strategies evolved under the national programme to deliver evidence-based interventions to various population groups. Maternal Health is an important aspect for the development of any country in terms of increasing equity & reducing poverty. The survival and well-being of mothers is not only important in their own right but are also central to solving large broader, economic, social and developmental challenges. Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. The

RMNCH+A strategy aim to reduce child and maternal mortality through strengthening of health care delivery system.

4.1.1 Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NHM). It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. The scheme is under implementation in the district. The scheme has been effective in increasing institutional deliveries over a period of time. The scheme incentivizes both mother and ASHA.

Janani Suraksha Yojana is one of the key maternal health strategies under NHM. JSY, a demand promotion scheme was launched in April 2005 with the objective of reducing Maternal and Infant Mortality. This is a conditional cash transfer scheme for pregnant women coming into the institutional fold for delivery. It has been lauded as a successful scheme bringing about a surge in institutional deliveries since its launch. Cash assistance of INR 1400 is provided to mothers who deliver in institutional facilities.

In the Vidisha district, the health officials have made admirable determination in promoting institutional deliveries by equipping facilities at all levels to handle deliveries. While meeting with officials (CMHO) they said that they had proper records for ASHA payments of their incentives and there is no pending record.

4.1.2 Janani Shishu Suraksha Karyakaram (JSSK)

To complement JSY, Government of India launched Janani Shishu Suraksha Karyakram (JSSK) to eliminate out of pocket expenditure for pregnant women and sick newborn and infants on drugs, diet, diagnostics, user charges, referral transport, etc. The scheme entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section.

Out of pocket expenditure on diagnostics and transport was reported and observed in the district. JSSK beneficiaries were observed to be spending on pick-up transportation/ ambulance due to the far reach or extremely scattered peripheral location of beneficiaries in the district. However, beneficiaries were aware of the drop-back from facility to the home. No beneficiary in the facilities visited reported spending on drugs. It is an initiative with a hope that states would come forward and ensure that benefits under JSSK would reach every needy pregnant woman coming to government institutional facility. All the States and UTs have initiated implementation of the scheme.

JSSK has been implemented and is functional in Vidisha District. Beneficiaries are being provided free of cost consultation, drugs and referral transport. However, with respect to diet, only the one's delivering at CHC level is being given food. For the deliveries taking place at sub centres and PHCs, there is no provision of free diet. A recommendation was made to provide nutritious dry food packets containing milk, fruits etc. to mothers with costs equivalent to diet cost under JSSK.

4.1.3 Maternal Death Review (MDR)

Maternal Death Review (MDR) as a strategy has been spelt out clearly in the RCH –II National Programme Implementation Plan document. The importance of MDR lies in the fact that it provides detailed information on various factors at facility, district, community, regional and national level that are needed to be addressed to reduce maternal deaths. Analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service.

In Vidisha district, it was observed that 36 Maternal deaths in the year 2020-21. However, it was reported that MDR is properly functional in the district. It is not listed in the district health action plan and fund is received funds on the time. In the district, 36 maternal deaths occurred due to Haemorrhage refers to excessive loss of blood during the delivery which could have been avoided if the High-Risk Pregnancies are monitored better. Another cause of maternal death is during the commute from the home to hospital, which has been aimed to improve through JSSK but the scheme needs to be implemented effectively. The deaths at home could have been avoided if the pregnant would have reached an institution with proper supervision to deliver. Also some death deaths were occurred due breathlessness at the time of COVID 19 and there were many mothers in the district who were anaemic.

4.1.4 The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

The programme has been launched by the Ministry of Health & Family Welfare (MoHFW), Government of India with aim to provide assured, comprehensive and quality antenatal care, free of cost, universally to all pregnant women on the 9th of every month. PMSMA guarantees a minimum package of antenatal care services to women in their 2nd / 3rd trimesters of pregnancy at designated government health facilities. PMSMA guarantees a minimum package of antenatal care services to women in their 2nd / 3rd trimesters of pregnancy at designated government health facilities. The programme follows a systematic approach for engagement with private sector which includes motivating private practitioners to volunteer for the campaign developing strategies for generating awareness and appealing to the private sector to participate in the Abhiyan at government health facilities.

The programme is running in the district. ANC checkups are being provided on 9th of every month. Mothers who are found to be severely anaemic during the checkups are given Injectable iron supplements (iron sucrose). Also the district has initiated to provide milk and bananas to such mothers, instructing them to take similar nutritious diet on daily basis. Also, an elaborate ANC record card is provided to every mother wherein records are being maintained.

4.1.5 Home Based New Born Care (HBNC)

Under National Rural Health Mission, Home Based New Born Care is being implemented since 2011 for reduction of neonatal mortality in rural areas. The guidelines on Home Based Newborn Care were revised in 2014. Home Based Newborn Care scheme for reduction of neonatal mortality, has incentivized Accredited Social Health Activist (ASHA) for making visits to all newborns and their mothers according to specified schedule up to 42 days of life. The incentive amounts to a total of Rs. 250 for six visits in case of institutional delivery and seven visits in case of home delivery, subject to the following recording of weight of the newborn in Mother Child Protection (MCP) card, ensuring BCG, 1st dose of OPV and DPT vaccination, both the mother and the newborn are safe till 42 days of the delivery, and registration of birth has been done.

This will be confirmed through recording in MCP cards & ASHA visit form. Special training is being provided to ASHA on Module 6 & 7 in this regards and a kit consisting of required equipment and medicine is also being provided. HBNC is functioning in Vidisha District. In the year 2020-21 (table 14), a total of 1634 kits were available with ASHAs. Number of new-borns visited in the same year are 1948.

Table 14: Status of Home Based Newborn Care (HBNC) in Vidisha, 2020-21

Home Based Newborn Care (HBNC)	Numbers
Availability of HBNC kit with ASHAs	1634
Newborns visited under HBNC	1948
Availability of drug kit with ASHAs	1634

Source: CMHO, Vidisha 2020-21

4.1.6 Rashtriya Bal Swasthya Karyakram (RBSK)

National Health Mission has ensured significant progress in reducing child mortality. However, a dire need prevails to improve survival outcome which would be reached by early detection and management of childhood conditions in a comprehensive manner.

Rashtriya Bal Suraksha Karyakram (RBSK) is an important initiative aiming at early identification and early intervention for children from birth to 18 years to cover 4 ‘D’s viz. Defects at birth, Deficiencies, Diseases, Development delays including disability. Child Health Screening and

Early Intervention Services under RBSK envisages to cover 30 selected health conditions for Screening, early detection and free management.

The programme is functional in the district but due to COVID no screening has been performed at schools in the last financial year because of the COVID pandemic. The number of children born in delivery points screened for defects at birth is 520. The teams that have been constituted for RBSK have been diverted to perform COVID immunization activities.

4.1.7 Family Planning (FP)

Family planning provides a choice & freedom to Women for deciding their Family size number of children and determines the spacing of pregnancies. A woman's freedom to choose "When to become pregnant" has a direct impact on her health and well-being as well as the neonate. This could be achieved only by providing basket of choices for contraceptive methods. Family planning and its various methods allow the couples to determine their favourable family size and the spacing they want between pregnancies. Needless to say, that family planning is enabling women to choose the number of children they want to raise without letting it take a toll on their physical health. Various family planning methods and techniques exist. Family planning is also important from the perspective of an increasing population.

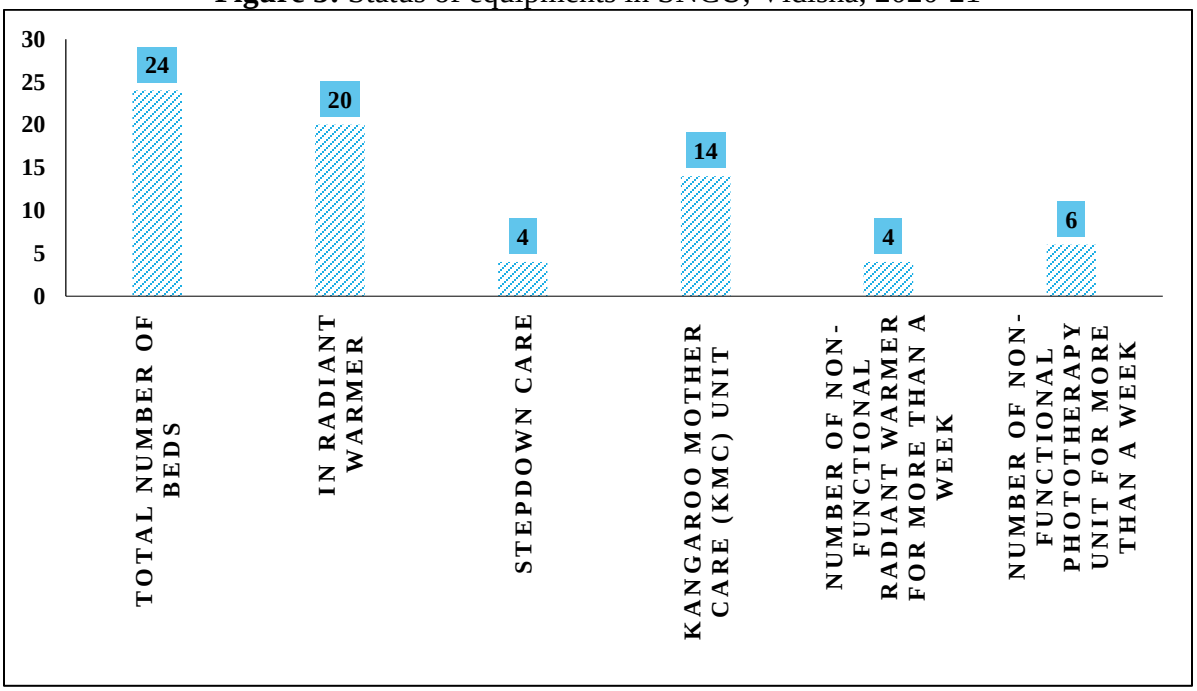
By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortions. Activities under family planning are functioning in the district. Female sterilization is noted to be the dominate method under permanent sterilization. PPIUCD, Antara and Chaya are being promoted at all facilities. Other prevalent methods like condoms were distributed by ASHAs and also available at the facilities visited.

4.1.8 Special Newborn Care Unit (SNCU)

Special Newborn Care Units (SNCUs) have been established at district hospitals which provide care for sick newborns, that is, all type of neonatal care except assisted ventilation and major surgeries. It is a separate unit in close proximity to the labour room with 12 or more beds, and managed by adequately trained doctors, staff nurses and support staff to provide 24x7 services. This report provides a comprehensive overview of the progress made by the country in terms of establishment and functionality of SNCUs during the two year period from April 2011 to March 2013. It describes the progress in the operational status, bed strength, human resource availability, and service utilization of the units.

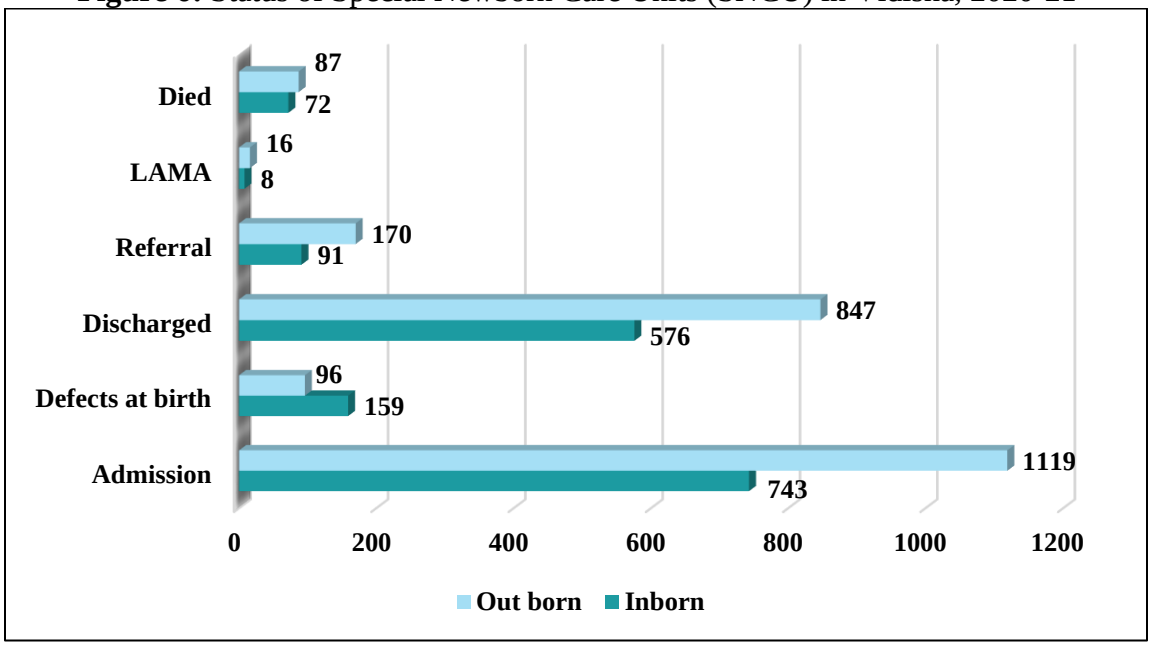
The figure 5 illustrates the status of equipments in SNCU in Vidisha district of Madhya Pradesh. In the district, total number of beds available in the SNCU is 20, number of radiant warmer is 16, number of Kangaroo Mother Care (KMC) unit is 15 and number of step-down care is 4. In the district only one radiant warmer who is not functional for more than a week and there is no phototherapy unit in the district.

Figure 5: Status of equipments in SNCU, Vidisha, 2020-21



The figure 6 depicts the status of Special Newborn Care Units (SNCU) in Vidisha.In the district the number of Inborn and Outborn admission is 743 and 1119. The number of defect at birth in inborn admitted in the facility is 159 and for outborn is 96. The children are discharged from the city were 576 (in born) and 847 (outborn). The number of children referred in the SNCU is 91 inborn and 170 outborn. The number of children had LAMA 8 were inborn and 16 were outborn. The numbers of children died in SNCU 72 were inborn and 87 were outborn.

Figure 6: Status of Special Newborn Care Units (SNCU) in Vidisha, 2020-21

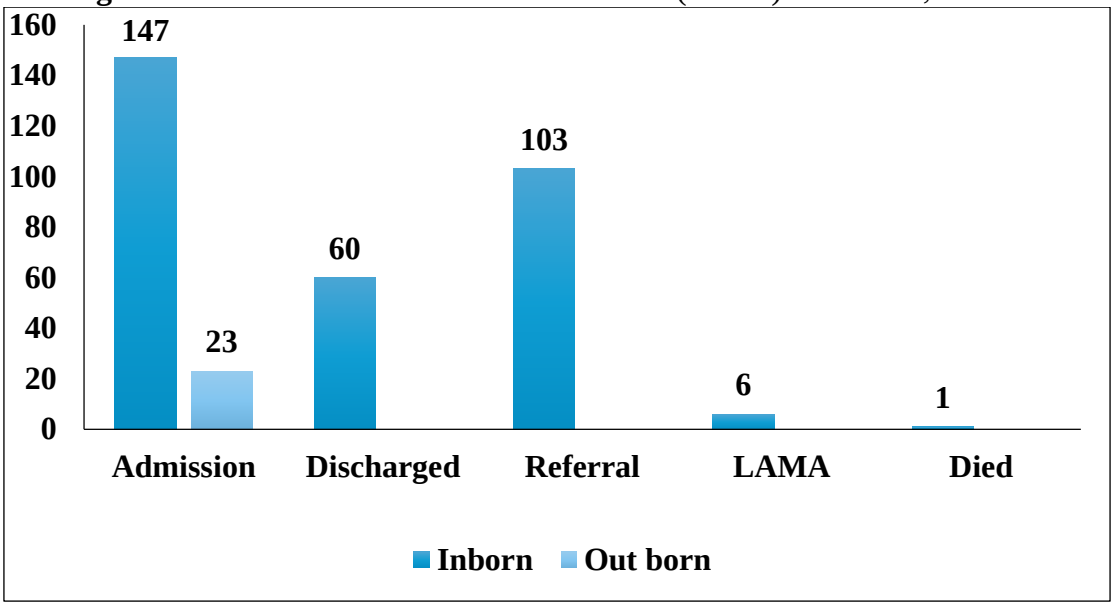


4.1.9 Newborn Stabilization Unit (NBSU)

Newborn Stabilization Units (NBSU) are an important part of the facility based newborn care. They have been established at the sub district level (First Referral Unit/Community Health Centre) in order to provide facility based newborn care to babies delivered at the same health facility and to sick and small babies delivered at other health facilities closer to FRU/CHC. The advantage of a functional NBSU is that it adds to the total bed capacity available in the district for newborn care, while making provision for newborn care closer to home for many sick and small babies. Current data shows that the mortality is higher in babies referred from home/other health facilities (out born), as compared to the facility born babies (inborn). This could be due to the fact that currently newborns are referred to Special Newborn Care Unit (SNCU), without adequate pre referral management. This gap can be addressed at an optimally functioning NBSU. NBSUs have an important role of stabilizing these sick & small newborns before they reach SNCU and managing not so seriously sick newborns so that the limited SNCU beds are utilized for those who need advanced care. To fulfill your role as quality service provider for newborn care in the FRU/CHC, this course will help you in acquiring essential knowledge and skills for optimal management of newborns presenting at NBSU.

The figure 7 depicts the status of Newborn Stabilization Units (NBSU) in Vidisha.In the district the number of Inborn and Outborn admission is 147 and 23. The children are discharged were 60. The number of children referred in the NBSU is 103. The number of children had LAMA were 6. The numbers of children died in SNCU were only 1.

Figure7: Status of Newborn Stabilization Unit (NBSU) in Vidisha, 2020-21



4.1.10 Nutrition Rehabilitation Centre (NRC)

Nutrition Rehabilitation Center (NRC) is a in a health facility where children with Severe Acute Malnutrition (SAM) are admitted and managed. A steady linkage with ICDS identifies and refers severely malnourished children in the community using MUAC tape. Children are admitted in NRC as per the defined admission criteria adopted in line with IAP 2006 and new WHO 2009 recommendations and provided with medical and nutritional therapeutic care.

Malnutrition, as a major public health and nutrition challenge faced by many developing countries, stands as a consequence of several key social and economic factors such as lack of education, inadequate health care services and ill-informed cultural behaviors. Underpinning all these is the fact that poverty, by and large, is the principal cause of poor feeding habits. In order to holistically address the issues surrounding malnutrition, a comprehensive understanding of the multidimensional complexities at play in society is crucial.

Child under nutrition encompasses stunting (chronic malnutrition), wasting (acute malnutrition) and deficiencies of micronutrients (essential vitamins and minerals). It significantly contributes to under5 mortality as undernourished children have increased susceptibility to infections and hence frequent episodes of diarrhoea, acute respiratory infections, malaria and measles. It also leads to growth retardation and impaired psychosocial and cognitive development. This has impact on education attainment. The degree of cognitive impairment is directly related to the severity of stunting and iron deficiency anaemia. Screening for Malnutrition is done in the community as well as by Health Staff by measuring weight and height in a given population. Management of these severely malnourished children does not require sophisticated facilities & equipments or highly qualified personnel. It does require that each child be treated with proper care & affection, and that each phase of treatment be carried out properly by approximately trained and dedicated health personnel. When this is done, the risk of death can be substantially reduced and the opportunity for full recovery greatly improved.

Once discharged from the NRC, the child continues to be in the Nutrition Rehabilitation program till she/he attains the defined discharge criteria from the program. In addition to curative care special focus is given on timely, adequate and appropriate feeding for children; and on improving the skills of mothers and caregivers on complete age appropriate caring and feeding practices. In addition, efforts are made to build the capacity of mothers/caregivers through counseling and support to identify the nutrition and health problems in their child.

Table 15: Status of Nutrition Rehabilitation Center (NRC) in Vidisha, 2020-21

Nutrition Rehabilitation Centers (NRC)	Numbers

Admission	
○ Bilateral pitting oedema	123
○ MUAC<115 mm	30
○ <'-3SD WFH	314
○ with Diarrhea	34
○ ARI/Pneumonia	64
○ TB	05
○ Fever	130
○ Nutrition related disorder	24
○ Others	92
Referred by	
○ Frontline worker	272
○ Self	57
○ Pediatric ward/ emergency	152
Discharged	346
Referral/ Medical transfer	20
LAMA	23
Died	0

Source: CMHO, Vidisha 2020-21

The table 15 represent the Status of Nutrition Rehabilitation Center (NRC) in Vidisha. It was observed that in NRC children got admitted in which 123 were Bilateral pitting oedema, 30 were from MUAC<115 mm, 314 were from<'-3SD WFH, 34 were from Diarrhea, 5 were from TB, 130 were from Fever, 24 were from Nutrition related disorder and 92 were from others. The numbers of children referred by frontline worker were 272, 57 by selfand152 by Pediatric ward/ emergency. The children are discharged were 346. The number of children referred/ Medical transfer in the NRC is 20. 23numbers of children were having LAMA. No children died in NRC.

4.2 Disease Control Programme

4.2.1 Integrated Disease Surveillance Programme (ISDP)

The key objective of the programme is to strengthen/maintain decentralized laboratory based IT enabled disease surveillance system for epidemic prone diseases to monitor disease trends and to detect and respond to outbreaks in early rising phase through trained Rapid Response Team (RRTs). In the Vidisha district, there is a rapid response team working very efficiently and monitoring after all the diseases.

4.2.2 National Vector Borne Disease Control Programme (NVBDCP)

It is an umbrella programme for prevention and control of malaria and other vector borne diseases viz., Lymphatic Filariasis, Kala-azar, Japanese Encephalitis, Chikungunya and Dengue with special focus on the vulnerable groups of the society. Under the programme, it is ensured that the disadvantaged and marginalized sections benefit from the delivery of services so that the desired National Health Policy and Rural Health Mission goals are achieved.

The micro and macro plan for NVBDCP have been reported to be available at the district level. The annual blood examination rate for the diseases has been 6 percent test conducted for last year due to lab technicians and lab assistants been shifted to COVID duties. There is no distribution of LLIN and Indoor Residual Spray (IRS) in the district. The method which is used for Anti-larval is house to house larva survey, temiphose and oil feeling. In the district contingency plan for epidemic is prepared but weekly, day report of all health facility epidemiologist and entomological situation is monitored as medicine is provided to all depo holder in each villages monitored by ISDP day.

4.2.3 National Leprosy Eradication Programme (NLEP)

It is a chronic infectious disease caused by Mycobacterium leprae. It usually affects the skin and peripheral nerves, but has a wide range of clinical manifestations. The National Leprosy Eradication Programme is a centrally sponsored Health Scheme of the Ministry of Health and Family Welfare, Govt. of India. The NLEP's mission is to provide quality leprosy services free of cost to all sections of the population, with easy accessibility, through the integrated healthcare system, including care for disability after cure of the disease. NLEP is functioning in the district.

4.2.4 The National Tuberculosis Elimination Program (NTEP)

Tuberculosis (TB) is an infectious disease caused by Mycobacterium Tuberculosis bacteria. It spreads through air when a person suffering from tuberculosis cough, sneeze or spit. TB remains to be major public health problem in India. TB control efforts are initiated countrywide since 1962 with inception of National TB Control Programme. It aims at diagnosing and caring for TB cases both in the public as well as in the private sector. The Drug sensitive is treated using Fixed Drugs Combinations through Directly Observed Treatment (DOTS) strategy.

NTEP is functional in the district. A total of 2650 target TB notification was 2546 achieved in 2020-21. There are 1774 eligible TB patients with UDST testing and out of which 1774 were HIV positive. Drugs for both, drug sensitive and drug resistance TB have been reported to be available. The number of patients notified from public sector is 2227, out of these 89 percent have been successfully cured. The number of MDR TB patients is 37 and the initiation for the treatment among MDR TB patients were 37. The number notified from private sector is 308, out of these 62

percent have been successfully cured. A total of 2753 beneficiaries have been paid under Nikshay Poshan Yojana.

4.2.5 Comprehensive Primary Health Care (CPHC)

Over the years, the emergence of Universal Health Coverage has arisen as a key objective for assuring accessible, affordable, and quality health care services. One such target is being achieved through the recently launched programme that is the Ayushman Bharat-Health and Wellness Centres (HWCs). The prime aim of HWCs is to provide all the health care services under one umbrella by covering majority of the population.

The Ministry of Health and Family Welfare (MoHFW) has rolled-out the programme with a view to furnish wide and expanded range of services through Comprehensive Primary Health Care (CPHC) and cater the needs specifically at the peripheral level.

As with the rapid urbanization and change in the lifestyles the epidemiology pattern of diseases is increasing day by day with non-communicable diseases being highly prevalent throughout the country. Hence, with the help of Ayushman Bharat-Health and Wellness Centres, it would play a key role in reducing the burden of Non-Communicable Diseases (NCDs) and would tackle the burden of the disease through primordial and primary prevention.

With regards to the allotment and functional HWCs across various tiers it is quite visible from the figure that after 2018-19 no such HWCs has been functional since the allotment. Almost all the HWCs have been transformed in the year 2018-19. However, out of the 21 PHC's, all the 21 PHC's have been converted into HWCs in 2020-21and all the 72 SC have been converted into HWCs.

As per the plan 275042 individuals have been enumerated of which 261355 enumerations have been completed. Till now, 166175 CBAC forms have been completed but some are still pending as majority of the CHOs have been deployed in the COVID-19 duty due to which they are unable to update the portal and fill the CBAC forms on time (table 16).

Out of 78 SC-HWC's, 78 SC-HWCs have started their NCD screening. Out of the planned individuals who are screened through CBAC forms the majority of the cases were observed for hypertension, diabetes andbreast cancer. A total of 69 HWCs are providing tele-consultation services and 116 HWCs organizes wellness activities are being performed such as yoga etc.

In the district for universal health screening, 534112 were targeted population. In the Vidisha district, 165991 number of Community Based Assessment Checklist form had been filled till date. The number of patients screened, diagnosed and treated for Hypertension were 5619, diabetes were 1925, oral cancer were 5and 8 for cervical cancer.

Table 16: Status of Comprehensive Primary Health Care, Vidisha, 2020-21

Indicator	Planned	Completed
Number of individuals enumerated	275042	261355
Number of CBAC forms filled	-	166175
Number of HWCs started NCD screening	78	78
Number of individuals screened for:	5619	
a. Hypertension	1925	-
b. Diabetes	05	-
c. Oral Cancer	0	-
d. Breast Cancer	08	-
e. Cervical Cancer	-	-
Number of HWCs providing Tele-consultation services	116	69
Number of HWCs organizing wellness activities	116	116

Source: CMHO, Vidisha 2020-21

5. SERVICE AVAILABILITY AT HEALTH FACILITIES- FACILITY WISE OBSERVATION

The observations made by the monitoring team during the visit to various health facilities in Vidisha are listed below. The points summarize the broad status of the health facilities with regards to infrastructure, service delivery, manpower, drugs and equipment, etc.

5.1 DISTRICT HOSIPTAL, VIDISHA

- The monitoring team visited district hospital of Vidisha- District Hospital. The facility has an average OPD load of 500-600 patients per day and 25-30 deliveries per day.
- The facility was 350 bedded Hospital and out of that 10 beds were in the ICU.
- The district hospital building is new but due to crunch of staff the building and its infrastructure is not well maintained.

Figure 2: District Hospital, Vidisha

- Maternity ward has all the equipments have being working. Due to over load of OPD in the hospital which create a major issue, which is the crunch of HR in the facility but they manage to work.
- The facility has 24 by 7 running water and availability of drinking water all the time. Clean and functional toilets separate for male and female.
- The facilities were having geriatric and disability friendly ramp and sufficient arrangement of OPD waiting area for the patients.
- Availability of all the drugs and proper storeroom with rack and well maintained data for the expiry medicine.
- All the services were available in the hospital for the beneficiaries like JSSY, PSY, NCD, Trauma, Aayushman, RMNCHA, E- Sanjivani, ANMOL, E- Hospital, E- RaktKosh, Lab, CT-Scan, Dialysis, SNCU, Vaccination, etc.
- All the specialized services were available in addition General OP, ANC, Delivery, Immunization, FP, and Laboratory services like medicine, O&G, Pediatric, General Surgery, Anesthesiology, Ophthalmology, Dental, Imaging Services (X-Ray), USG, DEIC, NRC, MNCU, NICU, PICU, Labour Room Complex, ICU, Dialysis Unit and Emergency Care.

- The facility having telemedicine services for NCD.
- The operation theatre is available in the hospital with all the services like single general OT, electric OT-Major general, electric OT-Major ortho, obstetrics & Gynecology OT, Ophthalmology/ENT OT and Emergency OT.
- In the hospital blood bank were functioning properly and availability of all the blood group and at the time of requirement free blood is given to BPL patients. The number of units of blood currently available in the facility is 80 units and the number of blood transfusions done in last month is 556.

Figure 3: Beneficiaries interaction, DH

- The laundry service is available at the facility. Proper cleanliness in the hospital and also bed sheet was cleaned. In the facility, they were having proper machines for washing.
- Lot of Issues related to portal as JSY portal has some technical problem and that is the major reason of lack of payment starts at the very initial stage i.e., from the field and also incomplete entries done by ASHAs. Beneficiaries who didn't have MPID are not eligible for the incentives and the maximum number of beneficiaries were not having the IDs.
- Many of the ANMs were not aware of proper functioning of ANMOL tablet. In the last 2 years, 3-4 versions have been changed in the ANMOL tablet, due to lack of knowledge and understanding they were unable to operate it.A single wrong entry in the tablet will generate back lock for the payments of ASHAs and beneficiaries both.
- The labour room was clean, with shoe covers, slippers masks and head cover are readily available outside.
- At the time of monitoring, the facility have all the supply of Emergency contraceptive pills, sugar testing kits and pregnancy testing kits and maintained proper records for the follow up.
- In the district hospital previous year there were 2 maternal deaths and in the current year it is 7. Similarly, if we see number of child death reported in the facility in the previous year was 166 and in the current year it is 102.
- Consumables like gloves were observed to be re-used which can foster various infections.
- Record maintenance at the facility was efficient and all registers pertaining to OPD, IPD etc. were well maintained and updated.
- In the district hospital 48 in house test is conducted and 102 outsourced like CBC, LFT, RFT, PT, APTT, Liquid Profile and Thyroid.

- The availability of X-Ray machine with proper AERB certified. Also availability of sufficient amount of testing kits and rapid diagnostic kits.
- In the district hospital 131-255 patients in the year 2019-20 were admitted for dialysis and 101-105 patients admitted in the year 2020-21.

Figure 4: In-House Kitchen, JSSK Beneficiares & NRC, DH

- Availability of In-House Kitchen in the district hospital and providing food to the beneficiaries of NRC and their attendant (Figure 4). Also JSSK diet is available and surprise tasting of the food by the doctors.
- Interval audit is done by the hospital management in every department.
- 24 bedded SNCU in the district hospital.
- Services delivery in the post-natal wards was fully efficient. All beneficiaries were provided with diet services free of charge and were asked to stay for more than 48 hours post-delivery. On interaction with the beneficiaries, they cited that no cost was borne by them for the diet, drugs, or diagnostics and timely doctor rounds were observed. They were fully satisfied with the services being rendered at the facility.
- The beneficiary interaction surfaced that no cost was borne by them for the delivery and timely doctor rounds were observed.
- There is a huge OPD in the hospital, to manage the people there is a required of security guard.
- In the DH the availability of service delivery, as the facility is designated as FRU, whether C-section are performed. The number of normal deliveries performed in last month is 472 and for C-section are 153.
- In the facility 1767 number of newborns immunized with birth dose at the facility in the last 3 months.

- The number of sterilization done in the last one month is 38. Proper family planning is been done at the facility. Also AFHC counselling being provided at the facility.
- DEIC is fully functional with all the required staff at the facility and also they have counsellors on the field.
- In the district hospital, availability of 2 own ambulance and 2 contractual ambulances are there in the DH.
- The data entry is done in ANMOL tablet wee NCD related information is uploaded like patient screened and diagnostic. The ANMs do the entries in the portal. The doctor and CHO organized the camp and again reporting is done. Entries also done in RCH portal information related to ANC, Child Immunization and Family Planning.
- The district hospital has sufficient staff (table 17). It was observed, that while monitoring at the facility there was proper work going in the hospital.

Table 17: Details of HR available in the District Hospital, Vidisha, 2020-21

Human Resource		Sanctioned	Contractual
MO (MBBS)		24	
Specialists	Medicine	04	
	ObGy	04	
	Pediatrician	07	
	Anesthetist	02	
	Surgeon	02	
	Ophthalmologist	02	
	Orthopedic	02	
	Radiologist	02	
	Pathologist	02	
	Others	01	
Dentist		02	
Staff Nurses/ GNMs		163	16
LTs		10	01
Pharmacist		06	01
EmOC trained doctor		04	

Source: District Hospital, Vidisha 2020-21

5.2 COMMUNITY HEALTH CENTRE, NATERAN

- The Community Health Centre Nateran is a 30 bedded facility and per day OPD is 100-200 and 100 deliveries taken place per month. It is an L2 facility.
- The maximum number of patients coming to the facility were for hypertension, diabetes and women for iron sucrose.
- Currently the major OPD as the beneficiary is coming for viral fever, cold and cough and fungal infection.

Figure 5: CHC, Nateran

- In the Nateran blocks maximum numbers of pregnant women were facing a major issue of iron deficiency. As it's an aspirational district, so is very difficult for ASHAs, ANMs and the MOI to counsel the beneficiary and convince them about the family size and use protection.
- For family planning LTT is done but seasonal. 30 percent PPIUCD is given at the time of deliveries.
- All essential drugs and supplies were available and proper registered is maintained at the time of supply. Also there is no storage issue for keeping the medicines.
- There is no pharmist, no dresser in the facility. Only 1 gynecologist and 1 ward boy at the facility.
- In the CHC maximum number of women found to be anemic during their ANC check-up. Most preferred contraceptive is ANTARA.
- Bio-medical waste management as the van came to the facility at very alternative days.
- AYUSH is functional at the facility and all the required drugs is also available.
- In CHC Nateran, PMSMA services are also provided on 9th of every month.
- Number of TB screening OPD at the facility is 25-30 patients per month.
- No guard is available at night in the facility.
- There was proper waiting area and sitting arrangement was also ample for the public.
- Tele-medicine consultation service is also available and an average of 1-2 cases arrive per day.
- In the last financial year there is no training provided in the facility.
- No maternal and child deaths have been reported at the facility in both the years i.e., 2019-20 and 2020-21.
- CHC were having cold chain and records were properly maintained.
- Many of the beneficiaries come by their own vehicle as they don't use ambulance. Although they have full information about JSY services at the time of the 1st ANC registration but they are using their own transport.

- All the united funds have been received and 100% fund being utilized by the facility.
- In the facility, all mothers were asked to stay for 48 hours after birth and provided diet free of cost. However JSY payments weren't made before discharged. Such payments were initiated through PFMS.
- All records were available, updated and correctly filled in line listing Performa. Also all IEC materials were correctly displayed.
- The IEC materials were not displayed effectively, as informing about all the new schemes and updated programs under NHM and all the registers were updated and well-maintained.
- The CHC having staff quarters for MO, staff nurse and was not properly maintained. The sewage water flow inside the quarters.
- There are several ASHAs which do not stay in the village. There is no mechanism to remove such ASHAs. ASHA monitoring in the block is nil. The Sarpanch has the power to appoint and remove ASHAs.
- The ASHAs are coming from the nearby state headquarters and do not stay in the village. This impact on their services deliveries. The phones SIM given to ASHAs are often found to be with the husband or their father-in-law.
- 24/7 running water, availability of complaint and suggestion box, electricity back up, functional and clean toilet for both male/ female and also washroom was attached to the labor room.
- There was lack of cleanliness in the new building of the CHC Nateran as there was lack of housekeeping staff who could maintain the facility cleanliness.
- Facility is conducting COVID vaccination campaign and beneficiaries have increased post second wave of the infection. COVID testing was simultaneously taking place in the facility at the time of visit.

5.3 URBAN PRIMARY HEALTH CENTRE, KARAIYA KHERA

- The health facility was easily accessible from the nearest road. UPHC Karaiya Khera is catering around 50 thousand population. It is a 2 bedded facility. The OPD load remains is 50-60 cases per day. It used to be approx. 100 before COVID.
- The facility has 24 by 7 running water and availability of drinking water all the time. Clean and functional toilets separate for male and female and availability of both suggestion/ complaint box.

Figure 6: UPHC, Karaiya Khera

- No staff quarters are available for any Medical Officers or Staff Nurses.
- No shortage of tablets was observed. The overall cleanliness at the facility was up to the mark.
- Record maintenance with regards OPD, IPD, ANC, PNC registers was proper and complete.
- The IEC material, Citizen Charter was also efficient displayed at the PHC with regards to visibility as well as coverage of schemes/programmes.
- The facility is managed by 1 MO (MBBS), 1MO (AYUSH), 1 ANM and 1 Pharmacist.
- The bio-medical waste is dispose by on call vehicle.
- Most of the patients come for fever, cough, cold and fungal infection. Most of the patients for skin infection because water infection and dusty area. There is no shortage of any drugs at the facility.
- The services provided here include OPD, testing, Routine Immunization, VHND and ANC. The entire 9 test are done at the facility. There is no LT at the facility.
- For Family planning Antara, Chaya and IUCD are promoted. Mostly female preferred Antara and condoms were also distributed to males. Family Planning counselling regularly done by ANM. The condom box was not available at the facility at the time of visit. The reason they told that children pick condoms from the basket.
- At the facility there is a sufficient supply of availability of testing kits and rapid diagnostic kits.

- Tele-medicine consultation service is operation at the facility and is connected Jaipur Medical College (Figure 7).
- The facility has a fixed day for NCD clinic and in a week 6 days the clinic is being operated.
- A laptop has been provided to record NCDs, after screening and recording the daily OPDs. Screening of diabetes and hypertension is done with high risks found mostly in the age group falling above 45. The maximum number of confirmed cases for hypertension is 74 and confirmed cases for diabetes are 65.
- Yoga is done at the facility in every 10 days in a month and around 7-8 people come for the yoga exercise at the facility.
- It is a vaccination site for COVID. Community approach is being adopted. People being informed about the availability of vaccination.

Figure 7: Functioning of Tele-medicine, Karaiya Khera

- RBSK team is functioning at the Anganwadi centres daily. The children are called in batches of 10. On a day 50-60 consultation are running. 2-3 surgeries are done in the last months which were referred to the district hospital.
- RBSK team guiding the children as how to wash their hands, applying soap etc. taught them all the good practices.
- All the doctors from the facility were busy in COVID vaccination.
- Kayakalp assessment has been done and the facility is waiting for its result.
- In UPHC Karaiya Khera, there is not display of IEC material as all material was destroyed by the local people of the village.
- Karaiya Khera facility was very congested, as the infrastructure was not properly made.
- Family Planning counselling is done by the staff nurse at the facility. There is no availability of sterilization machine at the UPHC.
- Various In-house tests are being performed such as Hemoglobin, Blood sugar, Malaria, HIV, Urine Albmum, CBC, Sputum, COVID-19 RT-PCR tests.

5.4 COMMUNITY HEALTH CENTRE, GYARASPUR

- The Community Health Centre Gyaraspur is a 30 bedded facility, out of which 10 bedded for PNC.
- There are 22 sub-centres under CHC Gyaraspur and out of which only one sub-centre is having a delivery point. Also, 3 PHCs is under this CHC and all the 3 facility having delivery points.
- The CHC per day OPD is 50-100 and 20 deliveries per day.
- The maximum numbers of patients coming to the facility were for hypertension, diabetes and women for iron sucrose.

- Currently the major OPD as the beneficiary is coming for viral fever, cold and cough and fungal infection.
- X-ray is available 24/7 at the facility.
- There is a separate registration counters for OPD and NCD at the facility.
- The children those who are admitted in the NRC in the beginning their weight is measured as they are malnourished and after that their proper records and fills are maintained and proper follow up of the children be done. After the discharged a proper case study is made. It's an achieved for CHC Gyaraspur that 4 children admitted in the bad condition but they managed to survive and now presently they are healthy (Figure 9).

Figure 9: Journey of Malnourished Children admitted to CHC

- Ineffective counselling done by ASHA and lack of awareness in the family as they are not education enough to understand about the family planning process.
- The facility is Kayakalp awarded with 83 score.
- The routine vaccination is available on Tuesday and Friday at the CHC.
- Eye-clinic is also available at the facility and for cataract they refer the beneficiary to district hospital.
- ARSH clinic is functional and counselling is done by the MO.
- Till now 90 percent of the PPIUCD is done at the delivery.
- CHC Gyaraspur has only 1 ambulance 108 in the block. There is a network issue in the area which create problem at the time of calling the ambulance. The major reason of Home deliveries at this block is the network.

- Seasonal OT is done at the winters for LTT.
- In the facility, all mothers were asked to stay for 48 hours after birth and provided diet free of cost. However JSY payments weren't made before discharged. Such payments were initiated through PFMS.
- CHC Gyaraspur is having in house kitchen and all provisions under JSSK including diet is provided timely.
- CHC were having cold chain and records were properly maintained.
- Many of the beneficiaries come by their own vehicle as they don't use ambulance. Although they have full information about JSY services at the time of the 1st ANC registration but they are using their own transport.
- Within 30 minutes the breastfeed is done on the table of delivery at the facility.
- All essential drugs and supplies were available and proper registered is maintained at the time of supply. Also there is no storage issue for keeping the medicines.
- In the year2019-20 there is one maternal deaths at the facility and in the year 2020-21 there is 4 maternal deaths. For child death in the year 2019-20 there is 44 death and in the 2020-21 there is 16 deaths because of Dehydration and Pneumonia.
- Regular VHND Programme is rural areas for those people who were unable to reach the facility. Every Wednesday ASHAs monitor specifically to pregnant and high risk pregnancies to guide them, where to go for delivery.
- In the facility the 5 shortage of priority drugs for EDL in the last 30 days are Paracetamol, Dicyclomine, Azithromycine and Ibupara medicines.
- NRC is available at the facility with proper diet given to the children and their mother.
- Bio-medical waste management as the van came to the facility at very alternative days.
- 83 percent of the united fund have been utilized by the facility.
- AYUSH is functional at the facility and all the required drugs is also available.
- In the facility, all mothers were asked to stay for 48 hours after birth and provided diet free of cost. However JSY payments weren't made before discharged. Such payments were initiated through PFMS.
- CHC having all the equipment's, sufficient essential drugs and its supplies was on time. Overall the CHC were very actively performing activity and were doing their jobs enthusiastically.
- All records were available, updated and correctly filled in line listing Performa. Also all IEC materials were correctly displayed.
- The IEC materials were displayed effectively informing about all the new schemes and updated programs under NHM and all the registers were updated and well-maintained.
- There was proper waiting area and sitting arrangement was also ample for the public.
- Tele-medicine consultation service is also available and an average of 1-2 cases arrives per day.

- CHC Gyaraspur is having 24/7 running water, availability of complaint and suggestion box, electricity back up, functional and clean toilet for both male/ female and also washroom was attached to the labor room. CHC having staff quarters for MO, staff nurse and was not properly maintained.
- The block has majority of the cases of diabetes (230) than hypertension (164) when screened. The confirmed number of cases of hypertension is 28 and that of diabetes are 8.
- CHC Gyaraspur having well maintained herbal garden in which different kinds of herbs and flowers were planted. NRC is operational at the facility. Children are being given proper diet as prescribed by the doctor and also as per the required of each child food is provided, their weight is measured every day. The doctor and the staff nurse make a proper record and a well maintained fill of the each child. How to wash their hands and to stay hygiene also taught to the attendant who is staying with children. A separate registration counter and toilets for both male and female at the facility. 23 types of services are available at CHC Gyaraspur. In the Labour room they have a music system in which at the time of delivery they play "Gayatri Mantra" so that the mother get the positive power and strength. CHC Gyaraspur did another self-initiative as they printed Biochemistry Report in which the mother whole medical dials are available. The facility having proper place to wash their hands. The facility having proper IEC material for Family Planning in which they are guiding the important information to the people (Figure 10).

Figure 10: Best Services Available, CHC Gyaraspur

5.5 PRIMARY HEALTH CENTRE, GULABGANJ

- The Primary Health Centre Gulabganj distance from district headquarter is 30 km. The health facility was easily accessible from the nearest road. It is 10 bedded facility out of which 6 beds for PNC.
- The facility catered around 30 thousand population and covered 48 villages.
- Under PHC Gulabganj 5 sub-centres come under it and out of which in 3 have CHO's and one is converted into HWC.

Figure 11: PHC, Gulabganj

- Staff quarters are available for Medical Officers and Staff Nurses and are in manageable condition.
- No shortage of tablets was observed. The overall cleanliness at the facility was up to the mark.
- Record maintenance with regards OPD, IPD, ANC, PNC registers was proper and complete.
- There was electricity power backup; 24/7 running water, clean toilet separate for male/ female, functional and clean labor room with attached washroom and availability of both suggestion/ complaint box.
- The IEC material, Citizen Charter was also efficient displayed at the PHC with regards to visibility as well as coverage of schemes/programmes.
- Adolescent Friendly Health Clinic (AFHC) is also available at the facility. Adolescent girls come for the problem of hygiene, RTI/STI, menstrual disorder etc.
- The OPD load remains is 30-60 cases per day. The maximum numbers of patients come for cough, cold and fever. The facility is managed by 1 MO (MBBS), 1 MO (AYUSH), 2 Staff nurses, 2 ANM and 1 pharmacist.
- The services provided here include OPD, testing, Routine Immunization, ANC, PNC and delivery. Delivery rate is high with 100 deliveries per month.
- In PHC Gulabganj, JSY a payment is not on time as the beneficiaries don't have their documents and at time there is a network issue. The diet under JSSK scheme is being provided as the facility having out-housed kitchen.
- The bio-medical waste is dispose of in pits. No van comes to collect the biomedical waste.
- Referral register is properly updated. No data entry operator at the facility. Medicines reaching their expiry dates are sent to facilities where they have drug shortages for optimum utilization.
- A laptop has been provided to record NCDs, after screening and recording the daily OPDs. The maximum number of cases that were screening are of hypertension i.e., 450 followed by diabetes with 230 cases, 22 for oral cancer, 46 for breast cancer and 20 for cervical cancer. The confirmed after screening for hypertension were 100 and for diabetes were 12.

- PHC Gulabganj received 87500rs united fund in the last financial year and all the fund has been utilized in hospital management, water supply management, bed repairing, drainage repairing, drinking water repairing etc.
- Once in the last 3 month RKS meeting is held in the facility.
- VHND is also organized and at the time of COVID pandemic RI was functioning properly in the block.
- For NCD screening facility organizing the camp at the outreach community and the patients come for follow up and being monitored. All 30 plus age group patients are being monitored for hypertension and diabetes.
- In the facility the doctor is trained for BeMOC.
- For family planning ANTARA is mot preferable by the beneficiaries. Condom box was also available at the facility.
- Weekly in 3 days telemedicine is operational at the facility. They connect to AIIMS Bhopal and the query regarding pediatric, gynae.
- Crunch of staff at the facility as there is no data entry operator.
- There are 4 ASHAs working under PHC Gulabganj. All the ASHAs were well aware of their incentives and the entire programme and the responsibilities being given to them.

Figure 12: Interaction with ASHAs, Beneficiaries and Services Availability, PHC Gulabganj

5.6 HEALTH WELLNESS CENTRE, ANDIYAKALA

- HWC AndiyaKala building is handed over last year. 35-40 daily patient come OPD. They come mostly having problem of cough and cold.
- Telemedicine is also available at the facility. It connects to District Hospital Vidisha. Monday and Wednesday is for NCD OPD and Tuesday for children.
- Wifi equipment for internet is been provided at the facility. But still there is low connectivity for internet.
- Record maintenance was found to be up to the mark in the facility.

Figure 13: HWC, AndiyaKala

- Equipments in the SC were functional and well maintained. Supply of essential contraceptives was also observed. Availability of all the drugs and their supply.
- All the procured IEC material was properly displayed.
- No issues were reported with regards to the procurement of untied funds.
- There was complain/suggestion box in the sub centre.
- The maximum number of patients comes for the OPD were hypertension, body ache and the 30 years old plus age group people come for their checkup.
- The facilities have water and electricity connection, proper branding is done at the facility.
- Every Saturday Yoga session is being held at the facility and the person from the nearby village come and attends the session.
- The CHOs have a functional tablet for data feeding in the HWC portal.
- All the essential instruments were available at the facility such as thermometer, BP instrument, contraceptives and glucometer.
- There are total 98 EDL drugs are available at the facility.
- The 5 priority drugs shortage at the facility for EDL are paracetamol, Injection Iron Sucrose, Injection Adrenaline, Tablet cetirizine and IV NS 100ml.
- All the drugs are available for hypertension and diabetes like tablet Amlodipine 5mg, tablet Losartan 40mg and tablet Metformin 500mg.
- Regular counselling for family planning by ASHAs and ANMs.
- The report number of individuals screened for whom CBAC form has been filled in the last six month for the score with below 4 are 1300 and 4 and above score are 1204.
- The status of the TB in the HWC area is number of presumptive patients identified in 2019-20 is 6 and in 2020-21 is 5 and the patients that were referred for testing 2019-20 were 2 and 2020-21 is 1. The number of patients diagnosed out of the presumptive patients referred 2019-20 was 4 and 2020-21 is 3.

5.7 COMMUNITY INTERACTION

The team visited AndiyaKala Village for gathering community perception on provision of health services. Villagers were gathered at the Health and Wellness Centre AndiyaKala and the team interacted with villagers both individually as well as in groups.

- With regard to health seeking behaviour, it was reported that along with the existing public facilities, there is no private clinics in the surrounding area and people are satisfied with the facilities. People are very happy with work of ASHAs and ANM and easily share their problem with them. ASHAs are formed to serve as a significant communication mechanism connecting the wide-ranging healthcare system to the rural areas. The contribution of ASHAs towards the attainment of female sterilization showcases their fruitful work done in these areas, and their performance levels have been ever increasing with time.

Figure 14: Community Interaction, AndiyaKala

- The village people were satisfied with the work of ASHAs and Anganwadi workers, as Anganwadi worker probably know the whole of the village because she goes to homes to meet people and talk to women. Same is the case with ASHA; she also go to houses, meet people, counsel, and converse with them on their problems. Both the Anganwadi and ASHA workers hold a position of respect in the village. They inspire confidence amongst the ones they live in, which means that people will listen to them. Furthermore, discussion with the village people, they said that both the workers create awareness amongst themselves by gathering and discussing their problems and discussion on various useful topics. They bring the natives of the villages close and therefore form a strong network of people, which can assist in accomplishing the rural campaigns effectively.

- However, for Antenatal Care, majority of women resort to public health facilities. These are driven by ASHAs and availability of female ANM at public facilities. Health interventions designed to reduce the risk of ill-health and promote feelings of well-being in a community must consider many social and environmental factors. These factors will vary in importance between communities, because of differences in the current services, facilities, priorities and needs of the communities, and because communities change over time. If health interventions are needed in several areas, they may need to be prioritized before they are implemented. Several programmes, such as primary health care or the Basic Development Needs programme,

address the factors that influence the health and well-being of communities. Advice on these programmes is available from a number of sources.

- ANMs and ASHAs work at all levels of rural families as well as their communities. They advise parents about the nutrition they give to their children; they also guide pregnant women about self-love and care along with nutrition-based suggestions. They advise couples about family planning and healthy living. This assistance makes them very closely involved in the household of the people. Healthy communication levels and a close relationship is the first step in enhancing rural campaigns. These groups and volunteers can help in promoting rural campaigns as they know better about the working style and psychology of the people aimed for local campaigns.

- They already have an established network of local professionals, familiar people, and they meet up regularly. The ANMs and ASHAs have a strong bond with the locals and therefore have a considerable number of people who listen to their pieces of advice and instructions. They have spoken to families and have been an integral part of many family groups. The extra monetary contribution will help them grow their centers better and therefore is the right drive for them to work harder for a rural campaign. ANMs don't just know one family; they know multiple families who make the outreach even bigger and better.

- Personal hygiene is essential both for improving health and for sustaining the benefits of interventions. For example, if injuries and minor cuts are not kept clean, they may become infected and lead to further health problems. And even though water supplies and sanitation facilities may be constructed in a community, unless people use these facilities properly and wash their hands after defecation, store water safely, bathe, and clean clothes and utensils properly, diseases caused by poor water and sanitation may still exist.

- All people suffer from disease at some point in their lives and may need to seek medical advice and treatment. Small children in particular may be prone to illnesses that require treatment and there are several infectious diseases for which immunization is recommended as ASHA and ANM daily went for the field visit. In all cases, the health outcomes are profoundly affected by whether health care facilities are available to the people.

- None of the villagers in the gathered group reported to have incurred any out of pocket expenditure in the public health facilities. Ambulance service was being utilized by people in the district especially by pregnant women.

- To improve the health of people in a community a number of problems may need to be resolved. While it is better to address these problems in an integrated way, it may be necessary to establish priorities and deal with the most pressing issues immediately. This situation could arise, communities or service providers have limited resources and can tackle only a few problems at a time.

- When asked about lifestyle and living conditions in the village, it was reported that the village environment clean and to reduce health risks, solid waste should be disposed of properly in the community. Untreated refuse is unsightly and smelly and degrades both the quality of the environment and the quality of life in the community. It also provides a breeding ground for disease vectors, such as mosquitoes, flies and rats. The waste is not properly disposed of, animals can bring it close to the home and children can come into contact with disease vectors. The community, solid waste disposal programmes require action at both household and community levels - if only a few households dispose of waste properly, the village environment may remain dirty and contaminated. It was advised to the Community members should decide how important solid waste management is and determine the best ways to achieve waste-management goals.

- The ANMs, Anganwadi and ASHA are firmly rooted in the social network of the local people and the villagers. Social networks and public relations are the backbones of every successful rural marketing campaign, and this network plays a crucial role in promoting rural campaigns too. Further, these workers have the advantage over specialists as they live in the same rural areas, which offer them insights into the locality and helps in identifying the root of issues and in solving them swiftly. Additionally, these are in constant need of monetary help, so if the motivation is high, they will perform better and be enthusiastic about rural campaigns. They also have superior social skills and can, therefore, more effortlessly interact with the local people. They are an integral part of a village's social set-up, and as locals, they know and are at ease with the local languages, approaches, and ways, familiar with the people, and are so highly trusted, which further promotes all categories of rural campaigns.

6. CONCLUSION AND RECOMMENDATION

6.1 CONCLUSION

Population Research Centre, Delhi has been assigned various states of the country by the Ministry of Health and Family Welfare for evaluation and monitoring of NHM Programme Implementation Plans (PIPs). The team is expected to carry out field visits for quality checks and improvements of the different components of NHM. This report explains the Monitoring and Evaluation findings of the Vidisha District of Madhya Pradesh. The team visited health facilities viz: District Hospital, Vidisha, CHC Nateran, UPHC Karaiya Khera, CHC Gyaraspur, PHC Gulabganj and HWC, AndiyaKala. Structured checklists were used to collect information on human resources, infrastructure, funds utilization, training, health care services including drugs and equipment, family planning, disease control programmes and other programmes under the umbrella of NHM. A summary of our findings in the district is presented below:

With regards to Public health infrastructure, there is 1 District Hospital, 2 sub District Hospital, 7 Community Health Centres (CHCs), 23 Primary Health Centres (PHCs), 4 Urban Primary Health Centres (PHCs), and 206 Sub Centres(SCs) in Vidisha. In addition, 1 blood storage unit, 3 Tuberculosis units and 1 CBNAAT Site are functioning in the district. The total numbers of UPHC's present in the district are 4 and no UCHC's are available. One Special New-Born Care Unit (SNCU) and 5 Nutrition Rehabilitation Centres are present at the DWH. In the district, there are 15 designated microscopy Center (DMC) are fully operational. Moreover, there are 2 first referral units (FRUs), 1 blood bank, and 2 blood storage unit. Almost all the 21 Urban Primary Health Centres have been transformed into HWCs. Furthermore, out of 206 SC's, only 72 SCs have been converted into HWC's the proportion is less. In addition, the number of functional NCD clinic is found to be at the DH only 1 and CHC level 7 clinics. The total number of institutions providing comprehensive abortion care services (CAC) is reported to be at 14 facilities. Only 1 facility are providing 1st trimester services i.e., at DH, District Combined Hospital (DCH) and PHC. No facility is providing both 1st and 2nd trimester services in the district. However, it must be noted that the district doesn't have District Early Intervention Centre (DEIC).

Meeting CMHO, DPM and all the respective nodal of the district there is a major crunch of staff in the district but they are still managing with the less staff. The district is lacking in child and ANC registrations field survey by ASHAs and ANM is lacking, as it's an aspiration district. Full immunization is very low if we compared with the last financial year because of COVID 19 all the teams, doctors, nurses were busy in COVID duty. Outreach areas are challenging as home deliveries are high in these areas and also due to less availability of 108 ambulances. In the district, there are 116 CHO appointment but only 50 CHOs have given letters for joining.
Presently, there are no COVID cases in the district and more than 65 percent done with their first dose and 20 percent with second dose. Vidisha ranked 7th position in Madhya Pradesh.
Maternal Death Review (MDR) as a strategy has been spelt out clearly in the RCH – II National Programme Implementation Plan. It is an important strategy to improve the quality of obstetric care and reduce maternal mortality and morbidity. The importance of MDR lies in the fact that it

provides detailed information on various factors at facility, district, community, regional and national level that are needed to be addressed to reduce maternal deaths. Analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service. There were 36 maternal deaths in the Vidisha. The reason been MDR has been conducted as an established intervention for the district took look after the issues.

The mortality indicator of the district is evident from the graph below that the highest numbers of cases in the district were in case of still birth; however there has been an increase in the number of cases of still birth from 392 in 2019-2020 to 399 in 2020-2021. The major reason for high still birth was prevalence of home deliveries in absence of SBA and missing or not undertaking ANC checkups as large number of tribal population in the district. But efforts were being made by the doctors, ANMs and ASHAs to convince their respective catchment population for institutional deliveries and undertaking complete ANC and PNC checkups. In the district, there is less first trimester registration in as women did not want to tell anyone that they are pregnant. The beneficiaries tell to ASHA or the ANM about their pregnancy when it cross to 4th month.There is a lack of monitoring and counselling regarding maternal death. The TFR of the district is very high which 3.4 and birth rate is 29.5 which is also very high.

In the last 2-3 years in the district, there is more institutional districts are taking place. 22-23 sub centres have now become the delivery points. In the district total 48 delivery points and all the CHOs have been trained for deliveries at district level and CHC level. There are total 118 CHOs in the district and the sanctioned post is 180.

Trainings of health personnel like medical officers, staff nurses, ANMs, ASHAs and others act as an essential ground for providing quality healthcare services. The lack of training of human resources was evident in the district for instance ANMs were lacking training in HMIS, immunisation and others. The JSY payments were being often delayed as beneficiaries did not have their own account and as per new rules, payments have to be transferred only in beneficiaries account and not in any family member's account. Verification of the beneficiary was also a problem as they were generally not equipped with identification documents like Aadhaar card and others. Under JSSK, the beneficiaries were receiving free diet and free medicines.
Updating the data is the major problem occurring in the district as SAMAGRA ID is not updated. E-Vith software has several issues related to data. Funds are sufficient but payments get delayed due to registration and entry. ANMs are not aware of the importance of data entry software. Here is no sector meeting has been organized by the district. Monitoring and motivation must be provided to ASHAs and ANMs, also to develop call centres for monitoring ANMs movement in the field so that they will sincerely focus on ANC check.

The sub-center infrastructure was too inadequate to provide any family welfare services. Three of

the sub-centers studied had structures made of mud and thatch with no electricity and water supply. They lacked even basic facilities like adequate space, examination table, BP apparatus, weighing machine for adults and children. Due to lack of proper residential facilities at the sub-centers, the ANMs spent more hours commuting, leaving them with only two or three hours for work, during which they could contact hardly seven to eight clients. Their visits to the outreach areas, especially the remote villages, were irregular and infrequent.

ASHA is volunteer health activists in the communities, who is creating awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing public health services. She is a promoter of good health practices. ASHA will be entitled for Performance Based Incentives fixed by the NRHM State HQ for prefixed activities only. The performance based incentives required to be given on monthly basis to ASHA. The roles and responsibilities of an ASHA include the functions of a healthcare facilitator, a service provider and a health activist. Broadly, her functions involve providing preventive, promotive and basic curative care in a role complementary to other health functionaries; educating and mobilizing communities particularly those belonging to marginalized communities, for adopting behaviours related to better health and create awareness on social determinants, enhancing better utilization of health services; participation in health campaigns and enabling people to claim health entitlements. She is also providing a minimum package of curative care as appropriate and feasible for that level and making timely referrals for further treatment.

It is important to note that the IECs were displayed in all facilities for timings of the facility, drug list, immunization, eye donation, JSY, JSSK and many others. Colourful charts representing facility's monthly performance for immunisation and IUCD insertions were also displayed at some facilities.

Government quarters allotted to them are uninhabitable and they have to reside in distant towns. They cannot make adequate home visits to remote villages, and provide services, due to lack of transport facility, difficult terrain, poor condition of the roads, and inundation of the roads due to heavy rains. The sub-centers lack most of the essential equipment and medicines, which hinders provision of even the most basic health services and in turn reduces their credibility among their clients and villagers.

6.2 RECOMMENDATIONS

- Improve logistic support and ensure strict supportive supervision of paramedical staff.
- Sterilization camps should be conducted only at health facilities that have all the necessary logistic support.

- Health workers should be provided with transport facilities to reach the inaccessible villages; improve residence facilities of ANMs to ensure that they reside in their area of work.
- Roads and transport facilities should be improved to enhance the villagers' access to these facilities.
- Recommendation register for each facility may be provided; this would be a very helpful tool for the improvement and betterment of the district, ensuring continuity for the process of the district.
- Detailed agenda notes to be prepared and circulated to the members well in advance, at least 2 days before the DHS meeting. DPM should collate all the materials for agenda and should alone be responsible for writing and getting the minutes signed, not others to take over this role.
- Meetings should be organized to follow up the previous action taken report on decisions. One time approval of district action plan to be taken at the beginning of the financial year and then implemented. Training in office procedure needed for better and faster implementation. Strengthening Health and Wellness Centre through an untied fund to enable local planning and action and more multi-purpose workers (MPWs). Preparation and implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition. Integrating vertical health and family welfare programmes at national, State, district, and block levels. Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- National level meetings of SPMs and State level meetings of DPMs needed for the improvements in systems for increasing effectiveness of the meetings. There is need for linking up the training institutes and monitoring of the quality. Comprehensive Continued Medical Education & training plan should be developed and have public health training institute in the state.
- Better utilization of specialists, power to post doctors and other staff may be given to districts and proper display of essential drug stock on the walls.
- Helpline for post-SBA training ANM/MOs as a handholding and the expansion of Community monitoring from pilot districts to rest of the state in a planned manner with budgetary allocation through NRHM PIP.
- ASHA support structure & ASHA resource center needs to be strengthened and ASHA selection and deployment needs to be looked into- norm of same village candidate and not related to any government post holders may be included.
- Strengthen community based nutrition and train ASHAs on nutrition and new born care. Emphasis on family planning, specially spacing methods, needs to be increased. IEC bureau infrastructure and staffing needs to be strengthened.
- Enhancement of Delegation of Financial and Administrative Powers to the Districts and lower institutions. And Public disclosure of RKS funds and institution of social audit mechanism. Bringing Untied Grant and Annual Maintenance Grant under the purview of RKS.
- There are delays in JSY payments as beneficiaries do not have their own account or there are

verification problems. Thus, some steps should be taken to solve the issue.

- A dire need exists to improve the staff quarters for the medical staff at the health facilities. It is especially important owing to the geographical distribution of the district and the commute issue after evening hours. Geographical reason is the major reason for the week health system in the district which must be monitored by the nodal officers daily.
- Formulation of transparent policies for deployment and career development of human resources for health. Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc. promoting non-profit sector particularly in underserved areas.
- Regulation of private sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost. Promotion of Public Private Partnerships for achieving public health goals. Mainstreaming AYUSH - revitalizing local health traditions. Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.
- There is need to pay urgent attention to reform towards not just the deployment but also and perhaps more importantly, the career development of human resources for health to keep them motivated to serve especially in difficult areas.
- The Rogi Kalyan Samiti model in M.P. needs to be modified in the light of the availability of untied funds under NRHM. There must be fixed standards for the quantum of user fees charged from patients as it seems to differ over a range in various health institutions. Overall dependence on user fees should be scaled down, given the situation of a significant section of marginal poor and persons who do not have BPL cards but have limited resources. In contrast to user fees, the role of NRHM untied funds needs to be increased. RKS generated funds should not be used in a major way to support routine expenses such as medicines and regular salaries.
- The dynamic role of SPMU at the state level and DPMs at the district level needs to be appreciated and supported, with further roles, responsibilities and resources.
- While compilation of PIPs at district and state levels is systematic, the involvement of people from the community and active civil society organizations in the process of developing local plans at village, block and district levels needs to be greatly strengthened.
- Positive innovations such as concurrent audit should be maintained and could be suggested for generalization in other states.

ANNEXURES

Schedule for PIP Monitoring

District Profile

Indicator	Remarks/ Observation			
1. Name of District				
2. Total number of Blocks				
3. Total number of Villages				
4. Total Population				
• Rural population				
• Urban population				
5. Literacy rate				
6. Sex Ratio				
7. Sex ratio at birth				
8. Population Density				
9. Estimated number of deliveries				
10. Estimated number of C-section				
11. Estimated numbers of live births				
12. Estimated number of eligible couples				
13. Estimated number of leprosy cases				
14. Target for public and private sector TB notification for the current year				
15. Estimated number of cataract surgeries to be conducted				
16. Mortality Indicators:	Previous year (2019-20)		Current FY (2020-21)	
	Estimated	Reported	Estimated	Reported
• Maternal Death				
• Child Death				
• Infant Death				
• Still birth	[redacted]		[redacted]	
• Deaths due to Malaria				
• Deaths due to sterilization procedure				
17. Facility Details	Sanctioned/ Planned		Operational	
23. District Hospitals				
24. Sub District Hospital				
25. Community Health Centers (CHC)				
26. Primary Health Centers (PHC)				
27. Sub Centers (SC)				
28. Urban Primary Health Centers (U-PHC)				
29. Urban Community Health Centers (U-CHC)				

30. Special Newborn Care Units (SNCU)		
31. Nutritional Rehabilitation Centres (NRC)		
32. District Early intervention Center (DEIC)		
33. First Referral Units (FRU)		
34. Blood Bank		
35. Blood Storage Unit (BSU)		
36. No. of PHC converted to HWC		
37. No. of U-PHC converted to HWC		
38. Number of Sub Centre converted to HWC		
39. Designated Microscopy Center (DMC)		
40. Tuberculosis Units (TUs)		
41. CBNAAT/TruNat Sites		
42. Drug Resistant TB Centres		
43. Functional Non-Communicable Diseases (NCD) clinic • At DH • At SDH • At CHC		
44. Institutions providing Comprehensive Abortion Care (CAC) services • Total no. of facilities • Providing 1st trimester services • Providing both 1st & 2nd trimester services		

Overview: DHAP

Indicator	Remarks/ Observation
1. Whether the district has prepared any District Programme Implementation Plan (PIP) for current year and has submitted it to the states (verify)	
2. Whether the District has received the approved District Health Action Plan (DHAP) from the state (verify).	If yes, date of release_____
3. Date of first release of fund against DHAP	
4. Infrastructure: Construction Status	
• Details of Construction pending for more than 2 years	
• Details of Construction completed but not handed over	

Service Availability

Indicator	Remarks/ Observation
1. Implementation of Free drugs services (if it is free for all)	

Indicator	Remarks/ Observation	
2. Implementation of diagnostic services (if it is free for all) • Number of lab tests notified		
3. Status of delivery points		
• No. of SCs conducting >3 deliveries/month		
• No. of 24X7 PHCs conducting > 10 deliveries /month		
• No. of CHCs conducting > 20 deliveries /month		
• No. of DH/ District Women and child hospital conducting > 50 deliveries /month		
• No. of DH/ District Women and child hospital conducting C-section		
• No. of Medical colleges conducting > 50 deliveries per month		
• No. of Medical colleges conducting C-section		
4. Number of institutes with ultrasound facilities (Public+Private)		
• Of these, how many are registered under PCPNDT act		
5. Details of Pradhan MantriSurakshitMatritvaAbhiyan PMSMA activities performed		
6. RBSK		
• Total no. of RBSK teams sanctioned		
• No. of teams with all HR in-place (full-team)		
• No. of vehicles (on the road) for RBSK team		
• No. of Teams per Block		
• No. of block/s without dedicated teams		
• Average no of children screened per day per team		
• Number of children born in delivery points screened for defects at birth		
7. Special Newborn Care Units (SNCU)		
• Total number of beds ○ In radiant warmer ○ Stepdown care ○ Kangaroo Mother Care (KMC) unit		
• Number of non-functional radiant warmer for more than a week		
• Number of non-functional phototherapy unit for more than a week		
	Inborn	Out born
• Admission		
• Defects at birth		
• Discharged		
• Referral		

Indicator	Remarks/ Observation	
• LAMA		
• Died		
8. Newborn Stabilization Unit (NBSU)		
	Inborn	Out born
• Admission		
• Discharged		
• Referral		
• LAMA		
• Died		
9. Nutrition Rehabilitation Centers (NRC)		
• Admission ○ Bilateral pitting oedema ○ MUAC<115 mm ○ <'-3SD WFH ○ with Diarrhea ○ ARI/ Pneumonia ○ TB ○ HIV ○ Fever ○ Nutrition related disorder ○ Others		
• Referred by ○ Frontline worker ○ Self ○ Ref from VCDC/ CTC ○ RBSK ○ Pediatric ward/ emergency		
• Discharged		
• Referral/ Medical transfer		
• LAMA		
• Died		
10. Home Based Newborn Care (HBNC)		
• Status of availability of HBNC kit with ASHAs		
• Newborns visited under HBNC		
• Status of availability of drug kit with ASHAs		
11. Number of Maternal Death Review conducted • Previous year • Current FY		
12. Number of Child Death Review conducted • Previous year • Current FY		
13. Number of blocks covered under Peer Education (PE) programme		
14. No. of villages covered under PE programme		
15. No. of PE selected		
16. No. of Adolescent Friendly Clinic (AFC) meetings held		

Indicator	Remarks/ Observation	
17. Weekly Iron Folic Acid Supplementation (WIFS) stockout		
18. No. of Mobile Medical Unit (MMU) (on the road) and micro-plan		
• No. of trips per MMU per month		
• No. of camps per MMU per month		
• No. of villages covered		
• Average number of OPD per MMU per month		
• Average no. of lab investigations per MMU per month		
• Avg. no. of X-ray investigations per MMU per month		
• Avg. no. of blood smears collected / Rapid Diagnostic Tests (RDT) done for Malaria, per MMU per month		
• Avg. no. of sputum collected for TB detection per MMU per month		
• Average Number of patients referred to higher facilities		
• Payment pending (if any) • If yes, since when and reasons thereof		
19. Vehicle for Referral Transport		
• No. of Basic Life Support (BLS) (on the road) and their distribution		
• No. of Advanced Life Support (ALS) (on the road) and their distribution		
	ALS	BLS
○ Operational agency (State/ NGO/ PPP)		
○ If the ambulances are GPS fitted and handled through centralized call centre		
○ Average number of calls received per day		
○ Average number of trips per ambulance per day		
○ Average km travelled per ambulance per day		
○ Key reasons for low utilization (if any)		
• No. of transport vehicle/102 vehicle (on the road)		
○ If the vehicles are GPS fitted and handled through centralized call centre		
○ Average number of trips per ambulance per day		
○ Average km travelled per ambulance per day		
○ Key reasons for low utilization (if any)		
20. Universal health screening		
• If conducted, what is the target population		

Indicator	Remarks/ Observation		
• Number of Community Based Assessment Checklist (CBAC) forms filled till date			
• No. of patients screened, diagnosed, and treated for: ○ Hypertension ○ Diabetes ○ Oral cancer ○ Breast Cancer ○ Cervical cancer			
21. If State notified a State Mental Health Authority			
22. If grievance redressal mechanism in place			
• Whether call center and toll-free number available			
• Percentage of complains resolved out of the total complains registered in current FY			
23. If Mera-aaspatal has been implemented			
24. Payment status:	No. of beneficiaries	Backlog	DBT status
• JSY beneficiaries			
• ASHA payment:			
○ A- Routine and recurring at increased rate of Rs. 2000 pm			
○ B- Incentive under NTEP			
○ C- Incentives under NLEP			
• Payment of ASHA facilitators as per revised norms (of a minimum of Rs. 300 per visit)			
• Patients incentive under NTEP programme			
• Provider's incentive under NTEP programme			
• FP compensation/ incentive			
25. Implementation of Integrated Disease Surveillance Programme (IDSP)			
• If Rapid Response Team constituted, what is the composition of the team • No. of outbreaks investigated in previous year and in current FY			
• How is IDSP data utilized			
• Proportion (% out of total) of Pvt health facilities reporting weekly data of IDSP			
26. Implementation of National Vector Borne Disease Control Programme (NVBDCP)			
• Micro plan and macro plan available at district level			
• Annual Blood Examination Rate			
• Reason for increase/ decrease (trend of last 3 years to be seen)			
• LLIN distribution status			
• IRS			

Indicator	Remarks/ Observation
• Anti-larval methods	
• Contingency plan for epidemic preparedness	
• Weekly epidemiological and entomological situations are monitored	
• No. of MDR rounds observed	
• No. of districts achieved elimination status for Lymphatic Filariasis i.e. mf rate <1%	
27. Implementation of National Tuberculosis Elimination Programme (NTEP)	
• Target TB notification achieved	
• Whether HIV Status of all TB patient is known	☐ Yes/ ☐No If No, no. of TB patients with known HIV status_____
• Eligible TB patients with UDST testing	
• Whether drugs for both drug sensitive and drug resistance TB available	
• Patients notification from public sector	No of patients notified: Treatment success rate: No. of MDR TB Patients: Treatment initiation among MDR TB patients:
• Patients notification from private sector	No of patients notified: Treatment success rate: No. of MDR TB Patients: Treatment initiation among MDR TB patients:
• Beneficiaries paid under NikshayPoshan Yojana	
• Active Case Finding conducted as per planned for the year	☐ Yes/ ☐No
28. Implementation of National Leprosy Eradication Programme (NLEP)	
• No. of new cases detected	
• No. of G2D cases	
• MDT available without interruption	
• Reconstructive surgery for G2D cases being conducted	
• MCR footwear and self-care kit available	
29. Number of treatment sites and Model Treatment Center (MTC) for viral hepatitis	
30. Percent of health workers immunized against Hep B	
31. Key activities performed in current FY as per ROP under National Fluorosis Control Programme	
32. Key activities performed in current FY as per ROP under National Iron Deficiency Disorders Control Programme	
33. Key activities performed in current FY as per ROP under National Tobacco Control Programme	

Indicator	Remarks/ Observation			
34. Number of ASHAs • Required as per population • Selected • No. of ASHAs covering more than 1500 (rural)/ 3000 (urban) population • No. of villages/ slum areas with no ASHA				
35. Status of social benefit scheme for ASHAs and ASHA Facilitators (if available) • No. of ASHAs enrolled for Pradhan Mantri Jeevan JyotiBima Yojana (PMJJBY) • No. of ASHA Facilitator enrolled for Pradhan Mantri Jeevan JyotiBima Yojana (PMJJBY) • No. of ASHAs enrolled for Pradhan Mantri Suraksha Bima Yojana (PMSBY) • No. of ASHA Facilitators enrolled for Pradhan Mantri Suraksha Bima Yojana (PMSBY) • No. of ASHAs enrolled for Pradhan MantriShram Yogi Maandhan Yojana (PMSYMY) • No. of ASHA Facilitators enrolled for Pradhan MantriShram Yogi Maandhan Yojana (PMSYMY) • Any other state specific scheme_____ _____				
36. Status of MahilaArogyaSamitis (MAS)- a. Formed b. Trained c. MAS account opened				
37. Status of Village Health Sanitation and Nutrition Committee (VHSNC) a. Formed b. Trained c. MAS account opened				
38. Number of facilities quality certified				
39. Status of Kayakalp and SwachhSwasthSarvatra (SSS)				
40. Activities performed by District Level Quality Assurance Committee (DQAC)				
41. Recruitment for any staff position/ cadre conducted at district level				
42. Details of recruitment	Previous year (2019-20)		Current FY (2020-21)	
	Regular cadre	NHM	Regular cadre	NHM
• Total no. of posts vacant at the beginning of FY				
• Among these, no. of posts filled by state				
• Among these, no. of posts filled at district level				

Indicator	Remarks/ Observation
43. If state has comprehensive (common for regular and contractual HR) Human Resource Information System (HRIS) in place	

Implementation of CPHC

Status as on: _____

Indicator	Planned	Completed
1. Number of individuals enumerated		
2. Number of CBAC forms filled		
3. Number of HWCs started NCD screening: a. SHC- HWC b. PHC- HWC c. UPHC – HWC		
4. Number of individuals screened for: f. Hypertension g. Diabetes h. Oral Cancer i. Breast Cancer j. Cervical Cancer		
5. Number of HWCs providing Teleconsultation services		
6. Number of HWCs organizing wellness activities		

Status of HRH

Status as on: _____

1. Staff details at public facility (Regular+ NHM+ other sources)	Sanctioned	In-place	Vacancy (%)
• ANM			
• MPW (Male)			
• Staff Nurse			
• Lab technician			
• Pharmacist (Allopathic)			
• MO (MBBS)			
• OBGY			
• Pediatrician			
• Anesthetist			
• Surgeon			
• Radiologists			
• Other Specialists			
• Dentists/ Dental Surgeon/ Dental MO			
• Dental technician			

• Dental Hygienist				
• Radiographer/ X-ray technician				
• CSSD Technician				
• OT technician				
• CHO/ MLHP				
• AYUSH MO				
• AYUSH Pharmacist				
2. Performance of EMOC/ LSAS trained doctors	Trained	Posted in FRU	Performing C-section	
• LSAS trained doctors				
• EmOC trained doctors				

State of Fund Utilization

FMR Wise (as per ROP budget heads, if available)

Status of Expenditure as on: _____ to _____

Indicator	Budget Released (in lakhs)	Budget utilized (in lakhs)	Reason for low utilization (if less than 60%)
19. FMR 1: Service Delivery: Facility Based			
20. FMR 2: Service Delivery: Community Based			
21. FMR 3: Community Intervention			
22. FMR 4: Untied grants			
23. FMR 5: Infrastructure			
24. FMR 6: Procurement			
25. FMR 7: Referral Transport			
26. FMR 8: Human Resource (Service Delivery)			
27. FMR 9: Training			
28. FMR 10: Review, Research and Surveillance			
29. FMR 11: IEC-BCC			
30. FMR 12: Printing			
31. FMR 13: Quality			
32. FMR 14: Drug Warehouse & Logistic			
33. FMR 15: PPP			
34. FMR 16: Programme Management			

• FMR 16.1: PM Activities Sub Annexure			
35. FMR 17: IT Initiatives for Service Delivery			
36. FMR 18: Innovations			

Programme Wise

Status of Expenditure as on: _____ to _____

Indicator	Budget Released (in lakhs)	Budget utilized (in lakhs)	Reason for low utilization (if less than 60%)
1. RCH and Health Systems Flexipool			
• Maternal Health			
• Child Health			
• RBSK			
• Family Planning			
• RKSK/ Adolescent health			
• PC-PNDT			
• Immunization			
• Untied Fund			
• Comprehensive Primary Healthcare (CPHC)			
• Blood Services and Disorders			
• Infrastructure			
• ASHAs			
• HR			
• Programme Management			
• MMU			
• Referral Transport			
• Procurement			
• Quality Assurance			
• PPP			
• NIDDCP			
2. NUHM			
3. Communicable Diseases Pool			
• Integrated Disease Surveillance Programme (IDSP)			
• National Vector Borne Disease Control Programme (NVBDCP)			
• National Leprosy Eradication Programme (NLEP)			

Indicator	Budget Released (in lakhs)	Budget utilized (in lakhs)	Reason for low utilization (if less than 60%)
• National TB Elimination Programme (NTEP)			
4. Non-Communicable Diseases Pool			
• National Program for Control of Blindness and Vision Impairment (NPCB+VI)			
• National Mental Health Program (NMHP)			
• National Programme for Health Care for the Elderly (NPHCE)			
• National Tobacco Control Programme (NTCP)			
• National Programme for Prevention and Control of Diabetes, Cardiovascular Disease and Stroke (NPCDCS)			
• National Dialysis Programme			
• National Program for Climate Change and Human Health (NPCCHH)			
• National Oral health programme (NOHP)			
• National Programme on palliative care (NPPC)			
• National Programme for Prevention and Control of Fluorosis (NPPCF)			
• National Rabies Control Programme (NRCP)			
• National Programme for Prevention and Control of Deafness (NPPCD)			
• National programme for Prevention and Management of Burn & Injuries			
• Programme for Prevention and Control of Leptospirosis (PPCL)			

Status of trainings

Status as on: _____

List of training (to be filled as per ROP approval)	Planned	Completed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

District Hospital (DH)/ Sub-District Hospital (SDH) Level Checklist

Service Delivery:

Name of facility visited	
Facility Type	☐ DH/ ☐ SDH
FRU	☐ Yes/ ☐No
Standalone/ Co-located	☐ Standalone/ ☐Co-located Co-located with (if applicable):
Accessible from nearest road head	☐ Yes/ ☐No
Date of Visit	
Next Referral Point	Facility: Distance:

Indicator	Remarks/ Observation
1. OPD Timing	
2. Condition of infrastructure/ building Please comment on the condition and tick the appropriate box	Comments:
	☐ 24*7 running water facility ☐ Facility is geriatric and disability friendly (ramps etc.) ☐ Clean functional toilets available (separate for Male and female) ☐ Drinking water facility available ☐ OPD waiting area has sufficient sitting arrangement ☐ ASHA rest room is available ☐Drug storeroom with rack is available Power backup: ☐ Complete Hospital/ ☐ Part of the hospital Last major renovation done in (Year): _____

<table>
<tr><th>Indicator</th><th>Remarks/ Observation</th></tr>
<tr><td>3. Number of functional in-patient beds</td><td>_____

No of ICU Beds available:</td></tr>
<tr><td>4. List of Services available</td><td></td></tr>
<tr><td>• Specialized services available in addition to General OPD, ANC, Delivery, PNC, Immunization, FP, Laboratory services</td><td>
<table>
<tr><th>Sl.</th><th>Service</th><th>Y/N</th></tr>
<tr><td>1</td><td>Medicine</td><td></td></tr>
<tr><td>2</td><td>O&G</td><td></td></tr>
<tr><td>3</td><td>Pediatric</td><td></td></tr>
<tr><td>4</td><td>General Surgery</td><td></td></tr>
<tr><td>5</td><td>Anesthesiology</td><td></td></tr>
<tr><td>6</td><td>Ophthalmology</td><td></td></tr>
<tr><td>7</td><td>Dental</td><td></td></tr>
<tr><td>8</td><td>Imaging Services (X – ray)</td><td></td></tr>
<tr><td>9</td><td>Imaging Services (USG)</td><td></td></tr>
<tr><td>10</td><td>District Early Intervention Centre (DEIC)</td><td></td></tr>
<tr><td>11</td><td>Nutritional Rehabilitation Centre (NRC)</td><td></td></tr>
<tr><td>12</td><td>SNCU/ Mother and Newborn Care Unit (MNCU)</td><td></td></tr>
<tr><td>13</td><td>Comprehensive Lactation Management Centre (CLMC) / Lactation Management Unit (LMU)</td><td></td></tr>
<tr><td>14</td><td>Neonatal Intensive Care Unit (NICU)</td><td></td></tr>
<tr><td>15</td><td>Pediatric Intensive Care Unit (PICU)</td><td></td></tr>
<tr><td>16</td><td>Labour Room Complex</td><td></td></tr>
<tr><td>17</td><td>ICU</td><td></td></tr>
<tr><td>18</td><td>Dialysis Unit</td><td></td></tr>
<tr><td>19</td><td>Emergency Care</td><td></td></tr>
<tr><td>20</td><td>Burn Unit</td><td></td></tr>
<tr><td>21</td><td>Teaching block (medical, nursing, paramedical)</td><td></td></tr>
<tr><td>22</td><td>Skill Lab</td><td></td></tr>
</table>
</td></tr>
<tr><td>5. Emergency</td><td>General emergency:
or
facilities available for:
1. Triage
2. Resuscitation
3. Stabilization</td></tr>
<tr><td>6. Tele-medicine/Consultation services available</td><td>☐ Yes/ ☐No

If yes, average case per day_____</td></tr>
</table>

<table>
<tr><th>Indicator</th><th>Remarks/ Observation</th></tr>
<tr><td>7. Operation Theatre available</td><td>☐ Yes/ ☐No
If yes,
Single general OT:
Elective OT-Major (General):
Elective OT-Major (Ortho):
Obstetrics & Gynecology OT:
Ophthalmology/ENT OT:
Emergency OT:</td></tr>
<tr><td>8. Availability of functional Blood Bank</td><td>☐ Yes/ ☐No
If yes, number of units of blood currently available: _____
No. of blood transfusions done in last month: _____</td></tr>
<tr><td>9. Whether blood is issued free, or user-fee is being charged</td><td>☐Free for BPL
☐Free for elderly
☐Free for JSSK beneficiaries
☐Free for all</td></tr>
<tr><td>10. Biomedical waste management practices</td><td>1. Sharp pit
2. Deep Burial pit
3. Incinerator
4. Using Common Bio Medical Treatment plant
5.</td></tr>
<tr><td>11. Details of HR available in the facility (Sanctioned and In-place)</td><td>
<table>
<tr><th colspan="2">HR</th><th>San.</th><th>Reg.</th><th>Cont.</th></tr>
<tr><td colspan="2">MO (MBBS)</td><td></td><td></td><td></td></tr>
<tr><td rowspan="10">Specialists</td><td>Medicine</td><td></td><td></td><td></td></tr>
<tr><td>ObGy</td><td></td><td></td><td></td></tr>
<tr><td>Pediatrician</td><td></td><td></td><td></td></tr>
<tr><td>Anesthetist</td><td></td><td></td><td></td></tr>
<tr><td>Surgeon</td><td></td><td></td><td></td></tr>
<tr><td>Ophthalmologist</td><td></td><td></td><td></td></tr>
<tr><td>Orthopedic</td><td></td><td></td><td></td></tr>
<tr><td>Radiologist</td><td></td><td></td><td></td></tr>
<tr><td>Pathologist</td><td></td><td></td><td></td></tr>
<tr><td>Others</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Dentist</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Staff Nurses/ GNMs</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">LTs</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Pharmacist</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Dental Technician/ Hygienist</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Hospital/ Facility Manager</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">EmOC trained doctor</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">LSAS trained doctor</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Others</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>12. IT Services</td><td>• Desktop/ Laptop available: ☐Yes/ ☐No
• Internet connectivity: ☐Yes/ ☐No
Quality/strength of internet connection: _____</td></tr>
</table>

<table>
<tr><th>Indicator</th><th>Remarks/ Observation</th></tr>
<tr><td>13. Kayakalp</td><td>Initiated:
Facility score:
Award received:</td></tr>
<tr><td>14. NQAS</td><td>Assessment done: Internal/State
Facility score:
Certification Status:</td></tr>
<tr><td>15. LaQshya</td><td>Labour Room:
Operation Theatre:</td></tr>
<tr><td rowspan="2">16. Availability of list of essential medicines (EML)/ drugs (EDL)</td><td>☐Yes/ ☐No</td></tr>
<tr><td>If yes, total number of drugs in EDL_____

EDL displayed in OPD Area: ☐Yes/ ☐No

No. of drugs available on the day of visit (out of the EDL) _____</td></tr>
<tr><td>17. Implementation of DVDMS or similar supply chain management system</td><td>☐Yes/ ☐No

If other, which one_____</td></tr>
<tr><td>18. Shortage of 5 priority drugs from EDL in last 30 days, if any</td><td><table><tr><td>1</td><td></td></tr><tr><td>2</td><td></td></tr><tr><td>3</td><td></td></tr><tr><td>4</td><td></td></tr><tr><td>5</td><td></td></tr></table></td></tr>
<tr><td>19. Availability of Essential Consumables:</td><td>☐Sufficient Supply
☐Minimal Shortage
☐Acute shortage
List the consumables for with there was shortage
In last 6 months how many times there was shortage_____</td></tr>
<tr><td>20. Availability of essential diagnostics</td><td>☐In-house
☐Outsourced/ PPP
☐Both/ Mixed</td></tr>
<tr><td>• In-house tests
(For 2020-21)</td><td>Timing:
Total number of tests performed: _____
Details of tests performed:</td></tr>
<tr><td>• Outsourced/ PPP
(For 2020-21)</td><td>Timing:
Total number of tests performed: _____
Details of tests performed:</td></tr>
<tr><td>21. X-ray services is available</td><td>☐Yes/ ☐No
If Yes, type & nos. of functional X-ray machine is available in the hospital:</td></tr>
</table>

Indicator	Remarks/ Observation
	Is the X-ray machine AERB certified: ☐Yes/ ☐No
22. CT scan services available	☐Yes/ ☐No If yes: ☐In-house/ ☐PPP Out of Pocket expenditures associated with CT Scan services (if any, approx. amount per scan): _____
23. Whether diagnostic services (lab, X-ray, USG etc.) are free for all	☐Free for BPL ☐Free for elderly ☐Free for JSSK beneficiaries ☐Free for all
24. Availability of Testing kits/ Rapid Diagnostic Kits	☐Sufficient Supply ☐Minimal Shortage ☐Acute shortage
25. Implementation of PM-National Dialysis programme	☐Yes/ ☐No
	☐In-house ☐Outsourced/ PPP Total number of tests performed: _____
• Whether the services are free for all	☐Free for BPL ☐Free for elderly ☐Free for JSSK beneficiaries ☐Free for all
• Number of patients provided dialysis service (for 2020-21)	○ Previous year_____ ○ Current FY_____ **Calculate the approximate no. of patients provided dialysis per day*
26. If there is any shortage of major instruments/ equipment (List the Equipments)	
27. Average downtime of equipment. Details of equipment are nonfunctional for more than 7 days	
28. Availability of delivery services	☐Yes/ ☐No
• If the facility is designated as FRU, whether C-sections are performed	☐Yes/ ☐No Number of normal deliveries performed in last month: _____ No. of C-sections performed in last month: _____
• Comment on the condition of:	Labour room: OT:

Indicator	Remarks/ Observation
	Functional New-born care corner (functional radiant warmer with neo-natal ambu bag): ☐ Yes/ ☐ No
29. Status of JSY payments	Payment is up to date: ☐Yes/ ☐No Average delay: Payment done till: Reasons for delay:
30. Availability of JSSK entitlements	☐Yes/ ☐No If yes, whether all entitlements being provided ☐Free delivery services (Normal delivery/ C-section) ☐Free diet ☐Free drugs and consumables ☐Free diagnostics ☐Free blood services ☐Free referral transport (home to facility) ☐ Free referral transport (drop back from facility to home) ☐No user charges
31. PMSMA services provided on 9th of every month	☐Yes/ ☐No If yes, how are high risks identified on 9th? If No, reasons thereof:
32. Line listing of high-risk pregnancies	☐Yes/ ☐No
33. Practice related to Respectful Maternity Care	
34. Whether facility have registers for entering births and deaths	☐Yes/ ☐No
35. Number of Maternal Death reported in the facility	Previous year: Current year:
36. Number of Child Death reported in the facility	Previous year: Current year:
37. If Comprehensive Abortion Care (CAC) services available	☐Yes/ ☐No
38. Availability of vaccines and hub cutter	☐Yes/ ☐No Nurses/ ANM aware about open vial policy: ☐Yes/ ☐No

Indicator	Remarks/ Observation		
39. Number of newborns immunized with birth dose at the facility in last 3 months			
40. Newborns breastfed within one hour of birth (observe if practiced and women are being counselled)			
41. Status of functionality of DEIC	☐Fully functional with all staff in place ☐Functional with few vacancies (approx. 20%-30%) ☐Functional with more than 50% vacancies ☐Not functional/ All posts vacant		
42. Number of sterilizations performed in last one month			
43. Availability of trained provider for IUCD/ PPIUCD	☐Yes/ ☐No		
44. Who counsels on FP services?			
45. Please comment on utilization of other FP services			
46. FPLMIS has been implemented	☐Yes/ ☐No		
47. Availability of functional Adolescent Friendly Health Clinic	☐Yes/ ☐No If yes, who provides counselling to adolescents: _____ Separate male and female counselors available: ☐Yes/ ☐No Total No of Adolescents counseled in last 6 months____		
48. Whether facility has fixed day NCD clinic	☐Yes/ ☐No If Yes, how many days in a week: _____ days		
49. Are service providers trained in cancer services?	☐Yes/ ☐No		
50. Number of individuals screened for the following in last 6 months:		Screened	Confirmed
	a. Hypertension		
	b. Diabetes		
	c. Oral Cancer		
	d. Breast Cancer		
	e. Cervical Cancer		
51. Whether reporting weekly data in P, S and L form under IDSP	☐Yes/ ☐No		
1. Status of TB elimination programme	Facility is designated as Designated Microscopy Centre (DMC): ☐Yes/ ☐No		
	If yes, percent of OPD whose samples were tested for TB (microscopy) in last 6 month (average) _____		
	If anti-TB drugs available at the facility: ☐Yes/ ☐No		

Indicator	Remarks/ Observation
	If yes, are there any patients currently taking anti-TB drugs from the facility: ☐Yes/ ☐No
	Availability of CBNAAT/ TruNat: ☐Yes/ ☐No Percent of patients tested through CBNAAT/TruNat for Drug resistance in the last 6 months _____
	Are all TB patients tested for HIV? ☐Yes/ ☐No Are all TB patients tested for Diabetes Mellitus: ☐Yes/ ☐No
	Percent of TB Patients for whom DBT installments have been initiated under NikshayPoshan Yojana in the last 6 months:
52. Maintenance of records on	• TB Treatment Card cases (both for drug sensitive and drug resistant cases): ☐Yes/ ☐No • TB Notification Registers: ☐Yes/ ☐No • Malaria cases: ☐Yes/ ☐No • Palliative cases: ☐Yes/ ☐No • Cases related to Dengue and Chikungunya: ☐Yes/ ☐No • Leprosy cases: ☐Yes/ ☐No
53. How much fund was received and utilized by the facility under NHM?	Fund Received last year: Fund utilized last year:
	Items/ Activities whose expenditure is met out of the RKS/ Untied Fund regularly:
	Reasons for underutilization of fund (if any)
54. Status of data entry in (match with physical records)	HMIS: ☐Updated/ ☐Not updated MCTS: ☐Updated/ ☐Not updated IHIP: ☐Updated/ ☐Not updated HWC Portal: ☐Updated/ ☐Not updated Nikshay Portal: ☐Updated/ ☐Not updated
55. Frequency of RKS meeting (check and obtain minutes of last meeting held)	
2. Availability of ambulance services in the area	☐Own ambulance available (Number)_____ ☐DH/ SDH has contracted out ambulance services (Number)_____ ☐Ambulances services with Centralized call centre ☐ Government ambulance services are not available
	Comment (if any):
• How many cases from CHC, PHC, SC, referred to in last month?	Number: CHC PHC

Indicator	Remarks/ Observation
	SC Types of cases referred in:
• How many cases were referred out last month?	Number: Types of cases referred out:
3. Key challenges in the facility and the root causes	
Challenge	Root causes
a)	
b)	
c)	
d)	
e)	

Ministry of Health & Family Welfare
Government of India

Community Health Centre (CHC)/ U-CHC Level Checklist

Service Delivery:

Name of facility visited	
Facility Type	☐ CHC/ ☐ U-CHC
FRU	☐ Yes/ ☐No
Standalone/ Co-located	☐ Standalone/ ☐Co-located Co-located with (if applicable):
Accessible from nearest road head	☐ Yes/ ☐No
Date of Visit	
Next Referral Point	Facility: Distance:
Indicator	Remarks/ Observation
4. OPD Timing	
5. Whether the facility is functioning in PPP mode	☐ Yes/ ☐No
	Comments:

<table>
<tr><td>6. Condition of infrastructure/ building

Please comment on the condition and tick the appropriate box</td><td>☐ 24*7 running water facility
☐ Facility is geriatric and disability friendly (ramps etc.)
☐ Clean functional toilets available (separate for Male and female)
☐ Drinking water facility available
☐ OPD waiting area has sufficient sitting arrangement
☐ ASHA rest room is available
☐Drug storeroom with rack is available

Power backup: ☐ Complete Hospital/ ☐ Part of the hospital</td></tr>
<tr><td>7. Number of functional in-patient beds</td><td></td></tr>
<tr><td>8. List of Services available</td><td></td></tr>
<tr><td>• Specialized services available in addition to General OPD, ANC, Delivery, PNC, Immunization, FP, Laboratory services</td><td>
<table>
<tr><th>Sl.</th><th>Service</th><th>Y/N</th></tr>
<tr><td>1</td><td>Medicine</td><td></td></tr>
<tr><td>2</td><td>O&G</td><td></td></tr>
<tr><td>3</td><td>Pediatric</td><td></td></tr>
<tr><td>4</td><td>General Surgery</td><td></td></tr>
<tr><td>5</td><td>Anesthesiology</td><td></td></tr>
<tr><td>6</td><td>Ophthalmology</td><td></td></tr>
<tr><td>7</td><td>Dental</td><td></td></tr>
<tr><td>8</td><td>Imaging Services (X – ray)</td><td></td></tr>
<tr><td>9</td><td>Imaging Services (USG)</td><td></td></tr>
<tr><td>10</td><td>Newborn Stabilization Unit</td><td></td></tr>
</table>
</td></tr>
<tr><td>• If any of the specialists are available 24*7</td><td>☐ Yes available
☐ Yes, available only on-call
☐ Not available</td></tr>
<tr><td>• Emergency</td><td>General emergency:
or
facilities available for:
1. Triage
2. Resuscitation
3. Stabilization</td></tr>
<tr><td>9. Tele-medicine/Consultation services available</td><td>☐ Yes/ ☐No

If yes, average case per day_____</td></tr>
<tr><td>10. Operation Theatre available</td><td>☐ Yes/ ☐No
If yes,
Major:</td></tr>
</table>

<table>
<tr><td></td><td>Minor:</td></tr>
<tr><td>11. Availability of functional Blood Storage Unit</td><td>☐ Yes/ ☐No
If yes, number of units of blood currently available: _____
No. of blood transfusions done in last month: _____</td></tr>
<tr><td>12. Whether blood is issued free, or user-fee is being charged</td><td>☐Free for BPL
☐Free for elderly
☐Free for JSSK beneficiaries
☐Free for all</td></tr>
<tr><td>13. Biomedical waste management practices</td><td>Sharp pit:
Deep Burial pit:
Other System, if any:</td></tr>
<tr><td>14. Details of HR available in the facility (Sanctioned and In-place)</td><td>
<table>
<tr><th colspan="2">HR</th><th>San.</th><th>Reg.</th><th>Cont.</th></tr>
<tr><td colspan="2">MO (MBBS)</td><td></td><td></td><td></td></tr>
<tr><td rowspan="4">Specialists</td><td>Medicine</td><td></td><td></td><td></td></tr>
<tr><td>ObGy</td><td></td><td></td><td></td></tr>
<tr><td>Pediatrician</td><td></td><td></td><td></td></tr>
<tr><td>Anesthetist</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Dentist</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">SNs/ GNMs</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">LTs</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Pharmacist</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Dental Assistant/ Hygienist</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Hospital/ Facility Manager</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">EmOC trained doctor</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">LSAS trained doctor</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Others</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>15. IT Services</td><td>• Desktop/ Laptop available: ☐Yes/ ☐No
• Internet connectivity: ☐Yes/ ☐No
Quality/strength of internet connection: _____</td></tr>
<tr><td>16. Kayakalp</td><td>Initiated:
Facility score:
Award received:</td></tr>
<tr><td>17. NQAS</td><td>Assessment done: Internal/State
Facility score:
Certification Status:</td></tr>
<tr><td>18. LaQshya</td><td>Labour Room:
Operation Theatre:</td></tr>
<tr><td rowspan="2">19. Availability of list of essential medicines (EML)/ drugs (EDL)</td><td>☐Yes/ ☐No</td></tr>
<tr><td>If yes, total number of drugs in EDL_____

EDL displayed in OPD Area: ☐Yes/ ☐No

No. of drugs available on the day of visit (out of the EDL) _____</td></tr>
<tr><td>20. Implementation of DVDMS or similar supply chain management system</td><td>☐Yes/ ☐No

If other, which one_____</td></tr>
</table>

21. Shortage of 5 priority drugs from EDL in last 30 days, if any	1 2 3 4 5
22. Availability of Essential Consumables:	☐Sufficient Supply ☐Minimal Shortage ☐Acute shortage In last 6 months how many times there was shortage_____ List the consumables for which there has been shortage_____
23. Availability of essential diagnostics	☐In-house ☐Outsourced/ PPP ☐Both/ Mixed
• In-house tests (for 2020-21)	Timing: Total number of tests performed: _____ Details of tests performed:
• Outsourced/ PPP (for 2020-21)	Timing: Total number of tests performed: _____ Details of tests performed:
24. X-ray services is available	☐Yes/ ☐No If Yes, type & nos. of functional X-ray machine is available in the hospital: Is the X-ray machine AERB certified: ☐Yes/ ☐No
25. Whether diagnostic services (lab, X-ray, USG etc.) are free for all	☐Free for BPL ☐Free for elderly ☐Free for JSSK beneficiaries ☐Free for all
26. Availability of Testing kits/ Rapid Diagnostic Kits	☐Sufficient Supply ☐Minimal Shortage ☐Acute shortage (List the name of kits for which there is shortage)
27. If there is any shortage of major instruments/ equipment (List the Name of Equipment)	
28. Average downtime of equipment. Details of	

equipment are nonfunctional for more than 7 days	
29. Availability of delivery services	☐Yes/ ☐No
• If the facility is designated as FRU, whether C-sections are performed	☐Yes/ ☐No Number of normal deliveries performed in last month: _____ No. of C-sections performed in last month: _____
• Comment on condition of:	Labour room: OT: Functional New-born care corner (functional radiant warmer with neo-natal ambu bag): ☐ Yes/ ☐ No
30. Status of JSY payments	Payment is up to date: ☐Yes/ ☐No Average delay: Payment done till: Reasons for delay:
31. Availability of JSSK entitlements	☐Yes/ ☐No If yes, whether all entitlements being provided ☐Free delivery services (Normal delivery/ C-section) ☐Free diet ☐Free drugs and consumables ☐Free diagnostics ☐Free blood services ☐Free referral transport (home to facility) ☐ Free referral transport (drop back from facility to home) ☐No user charges
32. PMSMA services provided on 9th of every month	☐Yes/ ☐No If yes, how are high risks identified on 9th? If No, reasons thereof:
33. Line listing of high-risk pregnancies	☐Yes/ ☐No
34. Practice related to Respectful Maternity Care	
35. Whether facility have registers for entering births and deaths	☐Yes/ ☐No

36. Number of Maternal Death reported in the facility	Previous year: 2019-20____ Current year:2020-21__		
37. Number of Child Death reported in the facility	Previous year: Current year:		
38. If Comprehensive Abortion Care (CAC) services available	☐Yes/ ☐No		
39. Availability of vaccines and hub cutter	☐Yes/ ☐No Nurses/ ANM aware about open vial policy: ☐Yes/ ☐No		
40. Number of newborns immunized with birth dose at the facility in last 3 months			
41. Newborns breastfed within one hour of birth (observe if practiced and women are being counselled)			
42. Number of sterilizations performed in last one month	Male__ Female____		
43. Availability of trained provider for IUCD/ PPIUCD	☐Yes/ ☐No		
44. Who counsels on FP services?			
45. Please comment on utilization of other FP services			
46. FPLMIS has been implemented	☐Yes/ ☐No		
47. Availability of functional Adolescent Friendly Health Clinic	☐Yes/ ☐No If yes, who provides counselling to adolescents: _____ Separate male and female counselors available: ☐Yes/ ☐No Number of Adolescents counseledin last 6 months_____		
48. Whether facility has fixed day NCD clinic	☐Yes/ ☐No If Yes, how many days in a week: _____ days		
49. Are service providers trained in cancer services?	☐Yes/ ☐No		
50. Number of individuals screened for the following in last 6 months:		Screened	Confirmed
	a. Hypertension		
	b. Diabetes		
	c. Oral Cancer		
	d. Breast Cancer		
	e. Cervical Cancer		
51. Are service providers trained in cancer services?	☐Yes/ ☐No		
52. Whether reporting weekly data in P, S and L form under IDSP	☐Yes/ ☐No		

53. Status of TB elimination programme	Facility is designated as Designated Microscopy Centre (DMC): ☐Yes/ ☐No
	If yes, percent of OPD whose samples were tested for TB (microscopy) in last 6 month (average) _____
	If anti-TB drugs available at the facility: ☐Yes/ ☐No If yes, are there any patients currently taking anti-TB drugs from the facility: ☐Yes/ ☐No
	Percent of patients tested through CBNAAT/TruNat for Drug resistance in the last 6 months _____
	Is there a sample transport mechanism in place for: • investigations within public sector for TB testing? ☐Yes/ ☐No • investigations within public sector for other tests?☐Yes/ ☐No • outsourced testing? ☐Yes/ ☐No
	Are all TB patients tested for HIV? ☐Yes/ ☐No Are all TB patients tested for Diabetes Mellitus: ☐Yes/ ☐No
	Percent of TB Patients for whom DBT installments have been initiated under NikshayPoshan Yojana in the last 6 months:
54. Status on Leprosy eradication programme	Nos. of new case detected by Field Worker in last 12 months: Out of those, how many are having Gr. II deformity: Frequency of Community Surveillance:
55. Maintenance of records on	• TB Treatment Card cases (both for drug sensitive and drug resistant cases): ☐Yes/ ☐No • TB Notification Registers: ☐Yes/ ☐No • Malaria cases: ☐Yes/ ☐No • Palliative cases: ☐Yes/ ☐No • Cases related to Dengue and Chikungunya: ☐Yes/ ☐No • Leprosy cases: ☐Yes/ ☐No
56. How much fund was received and utilized by the facility under NHM?	Fund Received last year: Fund utilized last year:
	Items/ Activities whose expenditure is met out of the RKS/ Untied Fund regularly:
	Reasons for underutilization of fund (if any)
57. Status of data entry in (match with physical records)	HMIS: ☐Updated/ ☐Not updated MCTS: ☐Updated/ ☐Not updated IHIP: ☐Updated/ ☐Not updated HWC Portal: ☐Updated/ ☐Not updated Nikshay Portal: ☐Updated/ ☐Not updated
58. Frequency of RKS meeting (check and obtain minutes of last meeting held)	

59. Availability of ambulance services in the area	☐CHC own ambulance available Number____ ☐CHC has contracted out ambulance services Number_____ ☐Ambulances services with Centralized call centre ☐Government ambulance services are not available
	Comment (if any):
• How many cases from sub centre/ PHC were referred to this CHC last month?	Number: Sub centre PHC Types of cases referred in:
• How many cases from the CHC were referred to the DH last month?	Number: Types of cases referred out:

60. Key challenges in the facility and the root causes

Challenge	Root causes
a)	
b)	
c)	
d)	
e)	

Primary Health Centre (PHC/U-PHC) Level Checklist

Service Delivery:

Name of facility visited	
Facility Type	☐ PHC/ ☐ U-PHC
Whether the facility has been converted to HWC	☐ Yes/ ☐No
Standalone/ Co-located	☐ Standalone/ ☐Co-located Co-located with (if applicable):
Accessible from nearest road head	☐ Yes/ ☐No
Date of Visit	
Next Referral Point	Facility: Distance:

<table>
<tr><th>Indicator</th><th>Remarks/ Observation</th></tr>
<tr><td>1. OPD Timing

• For U-PHC, check if evening/morning OPD/Clinics being conducted</td><td>☐ Yes/ ☐No</td></tr>
<tr><td>2. Whether the facility is functioning in PPP mode</td><td>☐ Yes/ ☐No</td></tr>
<tr><td>3. Condition of infrastructure/ building

Please comment on the condition and tick the appropriate box</td><td>Comments:

☐ 24*7 running water facility
☐ Facility is geriatric and disability friendly (Ramps etc.)
☐ Clean functional toilets available (separate for Male and female)
☐ Drinking water facility available
☐ OPD waiting area has sufficient sitting arrangement
☐ ASHA rest room is available
☐Drug storeroom with rack is available
☐ Power backup
☐ Branding</td></tr>
<tr><td>4. Number of functional in-patient beds</td><td></td></tr>
<tr><td>5. List of Services available</td><td></td></tr>
<tr><td>6. If 24*7 delivery services available</td><td>☐ Yes/ ☐No</td></tr>
<tr><td>7. Tele-medicine/Consultation services available</td><td>☐ Yes/ ☐No

If yes, average case per day_____</td></tr>
<tr><td>8. Biomedical waste management practices</td><td>Sharp pit:
Deep Burial pit:
Other System, if any:</td></tr>
<tr><td>9. Details of HR available in the facility (Sanctioned and In-place)</td><td>
<table>
<tr><th>HR</th><th>San.</th><th>Reg.</th><th>Cont.</th></tr>
<tr><td>MO (MBBS)</td><td></td><td></td><td></td></tr>
<tr><td>MO (AYUSH)</td><td></td><td></td><td></td></tr>
<tr><td>SNs/ GNMs</td><td></td><td></td><td></td></tr>
<tr><td>ANM</td><td></td><td></td><td></td></tr>
<tr><td>LTs</td><td></td><td></td><td></td></tr>
<tr><td>Pharmacist</td><td></td><td></td><td></td></tr>
<tr><td>Public Health Manager (NUHM)</td><td></td><td></td><td></td></tr>
<tr><td>LHV/PHN</td><td></td><td></td><td></td></tr>
<tr><td>Others</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>10. IT Services</td><td>• Desktop/ Laptop available: ☐Yes/ ☐No</td></tr>
</table>

<table>
<tr><td></td><td>• All ANMs have functional Tablets: ☐Yes/ ☐No
• Smart phones given to all ASHAs: ☐Yes/ ☐No
• Internet connectivity: ☐Yes/ ☐No
Quality/strength of internet connection: _____</td></tr>
<tr><td>11. Kayakalp</td><td>Initiated:
Facility score:
Award received:</td></tr>
<tr><td>12. NQAS</td><td>Assessment done: Internal/State
Facility score:
Certification Status:</td></tr>
<tr><td rowspan="2">13. Availability of list of essential medicines (EML)/ drugs (EDL)</td><td>☐Yes/ ☐No</td></tr>
<tr><td>If yes, total number of drugs in EDL_____

EDL displayed in OPD Area: ☐Yes/ ☐No

No. of drugs available on the day of visit (out of the EDL) _____</td></tr>
<tr><td>14. Implementation of DVDMS or similar supply chain management system</td><td>☐Yes/ ☐No

If other, which one_____</td></tr>
<tr><td>15. Shortage of 5 priority drugs from EDL in last 30 days, if any</td><td><table><tr><td>1</td><td></td></tr><tr><td>2</td><td></td></tr><tr><td>3</td><td></td></tr><tr><td>4</td><td></td></tr><tr><td>5</td><td></td></tr></table></td></tr>
<tr><td>16. Drugs Available for Hypertension & Diabetic patients:</td><td><table><tr><td>1</td><td></td></tr><tr><td>2</td><td></td></tr><tr><td>3</td><td></td></tr></table></td></tr>
<tr><td>17. Shortage of sufficient number of Hypertension & Diabetic in last 7 days</td><td><table><tr><td>1</td><td></td></tr><tr><td>2</td><td></td></tr><tr><td>3</td><td></td></tr></table></td></tr>
<tr><td>18. Availability of Essential Consumables:</td><td>☐Sufficient Supply
☐Minimal Shortage
☐Acute shortage

In last 6 months how many times there was shortage_____
(Also list the consumables for which there was shortage)</td></tr>
<tr><td>19. Availability of essential diagnostics</td><td>☐In-house
☐Outsourced/ PPP
☐Both/ Mixed</td></tr>
<tr><td>• In-house tests
For 2020-21</td><td>Timing:
Total number of tests performed: _____
Details of tests performed:</td></tr>
<tr><td>• Outsourced/ PPP
For 2020-21</td><td>Timing:
Total number of tests performed: _____
Details of tests performed:</td></tr>
</table>

20. X-ray services is available	☐Yes/ ☐No If Yes, type & nos. of functional X-ray machine is available in the hospital: Is the X-ray machine AERB certified: ☐Yes/ ☐No
21. Whether diagnostic services (lab, X-ray etc.) are free for all	☐Free for BPL ☐Free for elderly ☐Free for JSSK beneficiaries ☐Free for all
22. Availability of Testing kits/ Rapid Diagnostic Kits	☐Sufficient Supply ☐Minimal Shortage ☐Acute shortage
23. If there is any shortage of major instruments/ equipment	List of Equipment
24. Average downtime of equipment. Details of equipment are nonfunctional for more than 7 days	
25. Availability of delivery services	☐Yes/ ☐No
• If yes, details	Comment on condition of labour room: Functional New-born care corner (functional radiant warmer with neo-natal ambu bag): ☐ Yes/ ☐ No
26. Status of JSY payments	Payment is up to date: ☐Yes/ ☐No Average delay: Payment done till: Reasons for delay:
27. Availability of JSSK entitlements	☐Yes/ ☐No If yes, whether all entitlements being provided ☐Free delivery services (Normal delivery/ C-section) ☐Free diet ☐Free drugs and consumables ☐Free diagnostics ☐Free blood services ☐Free referral transport (home to facility) ☐ Free referral transport (drop back from facility to home) ☐No user charges
28. Line listing of high-risk pregnancies	☐Yes/ ☐No
29. Number of normal deliveries in last three month	

30. Availability of Daksh/ Dakshta trained/SBA trained MO/SN/ANM in Labour Room	☐Yes ☐No		
31. Practice related to Respectful Maternity Care			
32. Number of Maternal Death reported in the facility	Previous year:2019-2020 Current FY:2020-2021		
33. Number of Child Death reported in the facility	Previous year: Current year:		
34. Availability of vaccines and hub cutter	☐Yes/ ☐No Nurses/ ANM aware about open vial policy: ☐Yes/ ☐No		
35. Number of newborns immunized with birth dose at the facility in last 3 months			
36. Newborns breastfed within one hour of birth (observe if practiced and women are being counselled)			
37. Number of sterilizations performed in last one month	Male Female		
38. Availability of trained provider for IUCD/ PPIUCD	☐Yes/ ☐No		
39. Who counsels on FP services?			
40. Please comment on utilization of other FP services			
41. FPLMIS has been implemented	☐Yes/ ☐No		
42. Availability of functional Adolescent Friendly Health Clinic	☐Yes/ ☐No If yes, who provides counselling to adolescents: _____ Separate male and female counselors available: ☐Yes/ ☐No		
43. Whether facility has fixed day NCD clinic	☐Yes/ ☐No If Yes, how many days in a week: _____ days		
44. Are service providers trained in cancer services?	☐Yes/ ☐No		
45. Number of individuals screened for the following in last 6 months:		Screened	Confirmed
	a. Hypertension		
	b. Diabetes		
	c. Oral Cancer		
	d. Breast Cancer		
	e. Cervical Cancer		
46. Whether wellness activities are performed	☐Yes/ ☐No Frequency:		

47. Whether reporting weekly data in P and L form under IDSP	☐Yes/ ☐No
48. Distribution of Long lasting Insecticidal nets (LLIN) in high-risk areas	No. of LLIN distributed per household: ☐1 per family/ ☐Others (Specify): _____
49. Status of TB elimination programme	Facility is designated as Designated Microscopy Centre (DMC): ☐Yes/ ☐No
	If yes, percent of OPD whose samples were tested for TB (microscopy) in last 6 month (average) _____
	If anti-TB drugs available at the facility: ☐Yes/ ☐No If yes, are there any patients currently taking anti-TB drugs from the facility: ☐Yes/ ☐No
	Percent of patients tested through CBNAAT/TruNat for Drug resistance in the last 6 months _____
	Is there a sample transport mechanism in place for: • investigations within public sector for TB testing? ☐Yes/ ☐No • investigations within public sector for other tests?☐Yes/ ☐No • outsourced testing? ☐Yes/ ☐No
	Are all TB patients tested for HIV? ☐Yes/ ☐No Are all TB patients tested for Diabetes Mellitus: ☐Yes/ ☐No
	Percent of TB Patients for whom DBT installments have been initiated under NikshayPoshan Yojana in the last 6 months:
50. Status on Leprosy eradication programme	Nos. of new case detected by Field Worker in last 12 months: Out of those, how many are having Gr. II deformity: Frequency of Community Surveillance:
51. Maintenance of records on	• TB Treatment Card cases (both for drug sensitive and drug resistant cases): ☐Yes/ ☐No • TB Notification Registers: ☐Yes/ ☐No • Malaria cases: ☐Yes/ ☐No • Palliative cases: ☐Yes/ ☐No • Cases related to Dengue and Chikungunya: ☐Yes/ ☐No • Leprosy cases: ☐Yes/ ☐No
52. How much fund was received and utilized by the facility under NHM?	Fund Received last year: Fund utilized last year:
	Items/ Activities whose expenditure is met out of the RKS/ Untied Fund regularly:
	Reasons for underutilization of fund (if any)
53. Status of data entry in (match with physical records)	HMIS: ☐Updated/ ☐Not updated MCTS: ☐Updated/ ☐Not updated IHIP: ☐Updated/ ☐Not updated HWC Portal: ☐Updated/ ☐Not updated Nikshay Portal: ☐Updated/ ☐Not updated
54. Frequency of RKS meeting (check and obtain minutes of last meeting held)	

55. Availability of ambulance services in the area	☐PHC own ambulance available Number_____ ☐PHC has contracted out ambulance services Number_____ ☐Ambulances services with Centralized call centre ☐Government ambulance services are not available
	Comment (if any):
• How many cases from sub centre were referred to this PHC last month?	Number: Types of cases referred in:
• How many cases from the PHC were referred to the CHC last month?	Number: Types of cases referred out:
56. Key challenges in the facility and the root causes	
Challenge	Root causes
a)	
b)	
c)	
d)	
e)	
Only for U-PHC	
57. Population enumeration initiated for slum population	☐Not yet initiated ☐Initiated ☐Completed
58. Number of CBAC forms filled (NUHM)	
59. Is Specialist services provided at U-PHC?	☐Yes/ ☐No
	If yes, specialist services are provided through: ☐Teleconsultation/ ☐Clinic Schedule: ☐Fixed/ ☐Rotational Type of specialist services available: ☐OBGY, ☐Pediatrics, ☐Medicine, ☐Dermatology, ☐Ophthalmology, Others_____
60. UHNDs Conducted:	☐Yes/ ☐No If yes, no. of UHND conducted per month_____
61. Special Outreach camps conducted:	☐Yes/ ☐No If yes, no. of UHND conducted during last quarter_____ Type of specialties provided during special outreach camps: _____

सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

Sub-Centre (SC) Level Checklist

Service Delivery: Sub Centre

Name of facility visited	
Whether the facility has been converted to HWC	☐ Yes/ ☐No
Standalone/ Co-located	☐ Standalone/ ☐Co-located Co-located with (if applicable):
Accessible from nearest road head	☐ Yes/ ☐No
Date of Visit	
Next Referral Point	Facility:

	Distance:

Indicator	Remarks/ Observation
1. List of Services available	
2. Condition of infrastructure/ building Please comment on the condition and tick the appropriate box	Comments: ☐ 24*7 running water facility ☐ Facility is geriatric and disability friendly ☐ Clean functional toilets available (separate for Male and female) ☐ Drinking water facility available ☐ OPD waiting area has sufficient sitting arrangement ☐ ASHA rest room is available ☐Drug storeroom with rack is available ☐ Branding ☐ Specified area for Yoga / welfare activities ☐ Power backup
3. Biomedical waste management practices	
4. Details of HR available in the facility (Sanctioned and In-place)	HR / San. / Reg. / Cont. ANM/ MPW Female MPW Male MLHP/ CHO ASHA Others
5. IT Services	• Functional Tablet/ laptop with CHO: ☐Yes/ ☐No • Electronic Tablets with MPWs (ANM): ☐Yes/ ☐No • Smart phones given to all ASHAs: ☐Yes/ ☐No • Internet connectivity: ☐Yes/ ☐No Quality/strength of internet connection: _____
6. Availability of list of essential medicines (EML)/ drugs (EDL)	☐Yes/ ☐No If yes, total number of drugs in EDL_____ EDL displayed in OPD Area: ☐Yes/ ☐No No. of drugs available on the day of visit (out of the EDL) _____
7. Are anti-TB drugs available at the SHC?	☐Yes/ ☐No If yes, are there any patients currently taking anti-TB drugs from the SHC? ☐Yes/ ☐No
8. Shortage of 5 priority drugs from EDL in last 30 days, if any	1 2

Indicator	Remarks/ Observation
	3 4 5
9. Drugs Available for Hypertension & Diabetic patients:	1 2 3
10. Shortage of sufficient number of Hypertension & Diabetic in last 7 days	1 2 3
11. Are CHOs dispensing medicines for hypertension and diabetes at SHC-HWC	☐Yes/ ☐No
12. Availability of Testing kits/ Rapid Diagnostic Kits	☐Sufficient Supply ☐Minimal Shortage ☐Acute shortage List of Kits (Shortage)_____
13. Availability of:	• BP instrument: ☐Yes/ ☐No. If yes, Type: _____ • Thermometer: ☐Yes/ ☐No • Contraceptives: ☐Yes/ ☐No. If yes, Type: _____ • Glucometer: ☐Yes/ ☐No
14. Line listing of all Pregnant women in the area	☐Yes/ ☐No • High risk women identified: ☐Yes/ ☐No • MCP cards duly filled: ☐Yes/ ☐No
15. Number of Maternal Death Review conducted	Previous year:2019-20 Current year:2020-21
16. Number of Child Death Review conducted	Previous year: Current year:
17. Availability of vaccines and hub cutter	☐Yes/ ☐No • Awareness of ANM on vaccine schedule: ☐Yes/ ☐No • Awareness about open vial policy: ☐Yes/ ☐No
18. Availability of micro-plan for immunization	☐Yes/ ☐No
19. Follow up of:	SNCU discharge babies: ☐Yes/ ☐No LBW babies: ☐Yes/ ☐No
20. Line listing of all eligible couple in the area	☐Yes/ ☐No
21. Availability of trained provider for IUCD/ PPIUCD	☐Yes/ ☐No
22. Please comment on utilization of other FP services	

<table>
<tr><th>Indicator</th><th colspan="4">Remarks/ Observation</th></tr>
<tr><td>23. Number of individuals above 30 years of age in the HWC population</td><td colspan="4"></td></tr>
<tr><td>24. Number of CBAC forms filled in last 6 months</td><td colspan="4"></td></tr>
<tr><td>25. Report for number of individuals for whom CBAC form has been filled in last six months.</td><td colspan="4">Score with below 4:
4 and above score:</td></tr>
<tr><td>26. Whether universal screening of NCD has started</td><td colspan="4">☐Yes/ ☐No</td></tr>
<tr><td rowspan="6">27. Number of individuals screened for the following in last 6 months:</td><td></td><td>Screened</td><td>Confirmed</td><td></td></tr>
<tr><td>a. Hypertension</td><td></td><td></td><td></td></tr>
<tr><td>b. Diabetes</td><td></td><td></td><td></td></tr>
<tr><td>c. Oral Cancer</td><td></td><td></td><td></td></tr>
<tr><td>d. Breast Cancer</td><td></td><td></td><td></td></tr>
<tr><td>e. Cervical Cancer</td><td></td><td></td><td></td></tr>
<tr><td>28. Number of individuals who had initiated treatment for HTN, DM and others during last six months</td><td colspan="4">Advised for Lifestyle management:
Medicines for Hypertension:
Medicines for Diabetes:
Medicines for Others:</td></tr>
<tr><td>29. Source of getting drugs/ medications for individual.

Number of individuals taking medication for HTN and DM during last six months from which source

Taking medication for HTN/DM</td><td colspan="4">From SC-HWC:
From Linked PHC:
From other govt. facilities: (Specify)
From pvt. Chemist shop:

(Average OOP/month)</td></tr>
<tr><td>30. Status of use of:</td><td colspan="4">• Tele-consultation services
• HWC App
Details:</td></tr>
<tr><td>31. Whether wellness activities are performed</td><td colspan="4">☐Yes/ ☐No
Frequency:</td></tr>
<tr><td>32. Whether reporting weekly data in S form under IDSP</td><td colspan="4">☐Yes/ ☐No</td></tr>
<tr><td rowspan="5">33. Status of Tuberculosis in the area:</td><td colspan="2">Indicators</td><td>2019-20</td><td>2020-21</td></tr>
<tr><td colspan="2">Number of presumptive TB patients identified:</td><td></td><td></td></tr>
<tr><td colspan="2">Number of presumptive TB patients referred for testing</td><td></td><td></td></tr>
<tr><td colspan="2">Number of TB patients diagnosed out of the presumptive patients referred</td><td></td><td></td></tr>
<tr><td colspan="2">Number of TB patients taking treatment under the Sub centre area</td><td></td><td></td></tr>
<tr><td>34. ASHA Interaction</td><td colspan="4"></td></tr>
</table>

Indicator	Remarks/ Observation
• Status of availability of Functional HBNC Kits (weighing scale/ digital thermometer/ blanket or warm bag)	
• Status of availability of Drug Kits (Check for PCM/ Amoxicillin/ IFA/ ORS/ Zinc/ IFA Syrup/ Cotrimoxazole)	
• ASHA Incentives: Any Time lag /Delay in Payment after submission of voucher. o Average delay	
• ASHA is aware about provision of incentives under NTEP (Informant Incentives, Treatment Supporter Incentives) and NikshayPoshan Yojana (₹500 per month incentive to the TB patient for the duration of treatment)	
35. Number of Village Health & Sanitation days conducted in last 6 months	
36. Incentives:	• Performance Incentives is disbursed to CHOs on monthly basis: ☐Yes/ ☐No • Team-based incentive being disbursed for all HWC staffs: ☐Yes/ ☐No
37. Frequency of VHSNC/ MAS meeting (check and obtain minutes of last meeting held)	
38. Whether CHOs and HWC staffs are involved in VHSNC/ MAS meeting	☐Yes/ ☐No
39. Maintenance of records on	• TB cases: ☐drug sensitive/ ☐drug resistant cases/ ☐both • Malaria cases: ☐Yes/ ☐No • Palliative cases: ☐Yes/ ☐No • Cases related to Dengue and Chikungunya: ☐Yes/ ☐No • Leprosy cases: ☐Yes/ ☐No
40. How much fund was received and utilized by the facility under NHM?	Fund Received last year: Fund utilized last year:
	Items/ Activities whose expenditure is met out of the RKS/ Untied Fund regularly:
	Reasons for underutilization of fund (if any)
41. Availability of ambulance services in the area	
• How many cases from the Sub Centre were referred to PHC in last month?	Number: Types of cases referred out:

Indicator	Remarks/ Observation
42. Key challenges in the facility and the root causes	
Challenge	Root causes
a)	
b)	
c)	
d)	
e)	