EXECUTIVE SUMMARY OF Delhi State PIP (NRHM) 2011-12

Delhi is a unique state with a peculiarity of world class health care and an array of executive hospitals and medical personnel. But on the other hand a large chunk of the underprivileged population in Delhi is devoid of even basic health care because of large unserved and underserved areas because of inequitable distribution of health infrastructure and a continuous influx of migrant population Thus inspite of excellence in most of the areas, the health indicators of the state still fall short of the standards set by the government of India.

Thereby, Delhi Government is making two pronged efforts: (i) to expand the network of health delivery and (ii) to enforce structural reforms in the health delivery. Both these measures are intended to provide higher level of quality in medical services.

Health Concerns and Challenges:

1. A relatively low (70%) institutional deliveries as against the targets of 100% despite predominantly urban structures with multilateral health delivery mechanism's existence in the state.

2. High Infant Mortality (35; SRS 2009) per thousand of live births & low Immunization coverage's (71.5%;CES 2009) as reflected in recent national survey results.

3. Overcrowded tertiary level hospitals and primary and secondary level facilities needing improved management are the States challenges & priority attention areas.

4. Delhi has almost eighteen service providing agencies, main among them being the MCD & NDMC; effective Interagency convergence here remains a major challenge.

State launched its Mission in Oct 2006 with the Honorable CM heading it as the Chairperson.

Achievements for the period of NRHM

1. SPMU and DPMUS have been set up and functionalized. Decentralization and delegation of Powers to Districts. District Health plan are being prepared by the District Nodal Officers and Consolidated into the State Plan.
2. ASHA Scheme has been launched with almost 3000 ASHAs selected, trained and launched in the field for activity.
3. Almost all the unserved/underserved areas have been identified across the State. seed PUHCS have been proposed to be set up in these areas to provide comprehensive basic health services to 50,000 population and are subsequently to be upgraded into PUHCs. Of 61 such units almost 35 have already been put in place.
4. 36 Mother labs set by Directorate of health services have been provided with lab technicians to ensure availability of sophisticated investigations like LFT,KFT. Also about 60 basic labs in the MnCW centres under the administrative control of MCD have been strengthened in terms of manpower and equipments. Pathologist has been provided one for each district to supervise these activities.

5. Delhi specific standards for PUHCs have been finalized for strengthening of Primary Health Care Facilities .The process of upgradation of 214 PUHCs has already begun.
6. Strengthening of 23 maternity homes under the administrative control of MCD (identified for 24x7 delivery services) has been done in terms of manpower and equipments.
7. Rogi Kalyan Samitis have been setup in 24 hospitals.
8. Gaps in 14 hospitals have been identified for providing quality maternal health services and strengthened Also 11 hospitals have been strengthened to provide quality neonatal services.16 FRUs have been optimally functionalized.
9. IYCF centres and nutrition corners have been created in the hospitals in the state.
10. MAMTA Scheme for promotion of institutional deliveries has been launched with 27 nursing homes have already been identified and signed for providing services. Further participation of the other nursing homes is being encouraged.
11. HMIS: All the facilities have been provided with computer and internet facilities. Facility wise uploading of data is being done in almost 650 facilities.
12. GIS Mapping of health facilities and populations is being done.

State PIP:

The State PIP has been based on the requirements projected by the districts in their respective plans. The following thrust areas have been identified:

1. Coverage of Unserved/Underserved area across the state by Opening of new PUHCs and through Mobile Health Services.
2. Providing Link worker (ASHA) for better accessibility of health services by the needy population.
3. Special Initiatives for Vulnerable Population (homeless, destitute, senior citizen, women and children in need)-Janani Suraksha Yojana, Mobile Mental Health Units (MMHUs), Senior citizen friendly health services.
4. Strengthening Primary health facilities for Quality Health Services. Upgrading PUHCs as per standards set.
5. Strengthening of Maternity homes and secondary level hospitals to ensure quality maternal and newborn services. Ensuring effective Referral Linkages by setting up help desks in the higher institutions.
6. Strengthening of First Referral units.
7. Convergence with other line departments
8. Community Participation/accountability –RKS, HSC.
9. Newer Initiatives-MAMTA, Mobile Dental Health Vans.
10. Taking up Life style diseases (Diabetes, CVAD/Stroke/ Thalessemia /Osteoporosis) in a big way.

The contents of State PIP have been focused on the above identified issues.

1. Reorganization/up gradation of existing health services delivery systems (through Coordination amongst agencies).
2. Strengthening the existing facilities for effective service delivery.
3. Building linkages between Primary, Secondary & Tertiary health facilities.
4. Community Involvement in Planning, Implementing and monitoring their health care.

5. Capacity Building of service providers.
6. Increasing demand for services.
7. Effective Monitoring for quality assurance.

GOAL & KEY INDICATORS SET FOR THE STATE

OUTCOME INDICATOR	NFHS1	NFHS2	NFHS3	GOALS				Actions / Strategy Planned
				2007-08	2008-09	2009-10	2010-12	
IMR	65	47	40	30	25	20	<15	Improved SBA Increased Institutional Delivery & PNC, Implementation of IMNCI / IYCF Strengthening Immunization outreach sessions, Increased use of ORS in Diarrhea management PEM Reduction-ICDS capacity building & health coordination, Institutional strengthening for Slums / un-reached groups
Institutional Delivery	45.3	59.1	60.7	66.5	70.5	80	>90	PPP for BPL women delivery at NHs, JSY, BCC, Strengthened Referral System, Emergency transport, Capacity building of providers
TFR	3.02	2.40	2.13	2.12	2.11	2.1	2.1	Meeting Unmet needs, BCC, Institutional strengthening, Coordination, Training for skill improvement of providers
<5Child Stunted	39.7	36.8	35.4	33	30	25	<20	Strengthening ICDS delivery & capacity, coordinated care of Gr3/4 <5 children with health sector & ICDS Awareness on healthy weaning practices, IYCF
<Child Wasted	12.7	12.5	15.5	15	14	12	<10	Same as above. ASHA as health facilitator, IYCF

<5Child **Underweight**	40.9	34.7	33.1	30	25	22	<20	Same as above. ICDS & ASHA to coordinate with health sector& community
Initiated Breast feeding within first hour	6.3	23.8	19.3	25	30	35	>50	Health education for BCC, IMNCI / IYCF
EBF 6Months	NA	NA	34.5	40	45	50	>60	BCC, ASHA, Trainings, IMNCI
Vit A 12-35 months	NA	NA	17.1	25	50	65	>75	-same as above-
Healthy Weaning practices (6-9 months)	NA	NA	59.8	65	75	85	>90	-same as above-
ANC 3	72.2	68.9	74.4	78	82.5	85	>95	Institutional strengthening, Awareness, Skills trainings, ASHA, Accountability/Supervisory practices improved
IFA Consumption	NA	NA	38.3	45	50	65	>80	Same as above
Full Immunization	57.8	69.8	63.2	70	75	80	>90	Strengthening out- reach , Prioritizing the previously unreached, Capacity building & Effective Monitoring systems in place
Measles	69.6	77.5	78.2	80	85	90	>95	Same as above
Contracep-tive use	54.6	56.3	56.4	58.5	60	62	65	Improving male participation, Improving availability of NSV & Lap Sterilization at increased

								number of facilities with quality ingrained in them.
PNC with in 48 hr	NA	NA	50.4	53.3	57.2	60.0	65.0	ASHA, IMNCI, IPC of workers, Supervision & Improved Community awareness
2daughters considered by family as complete	43.8	52.9	70.7	72	72.8	73.5	>75	Effective regulation of PNDT Act, Large scale Awareness on Moral, Ethical, Demo-societal issues for providers & service seekers(community), Recognizing virtues of girl child & creating 'role models' amongst families
IUD insertion rate	7.8	6.2	5.0	6.0	8	10	>15	Facility strengthening, improved service delivery, BCC, Trainings
Unmet needs	15.5	13.4	8.0	7.5	<6	<5	<2	Same as above
Condom use preventive for HIV (Knowledge in Women)	NA	NA	77.0	80	85	90	100	BCC & strengthening, easy availability through Depot holders in community & at strategic habitations (high risk population)
Condom use as Preventive	NA	NA	92.4	95	96	97	100	Same as above

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

STRATEGIES & INTERVENTIONS PLANNED

1. Strengthening of State and District Programme Management Units: Strengthening of SPMU and DPMUs in terms of infrastructure and manpower. Most of the workforce has already been recruited and the remaining officials under SPMU/DPMU to be recruited soon. Also to ensure availability of rental space for DPMU. The constraint of rent identified in the last year has been taken care of by increasing the rent for hiring the space in the coming years' PIP.

DPMUs have been proposed for eight districts only. The DPMU for New Delhi district has not been proposed, since New Delhi consists of predominantly NDMC units and NDMC has refuted the support of NRHM for strengthening of service delivery from health institutions under NDMC. Since the mission director for the two districts is same, important activities for New Delhi district like HMIS,M&E,capacity building etc will be managed by DPMU, Central District.

2. Community Empowerment & Supportive facilitation

a) ASHA: There are vast pockets of urban slums having poor health indices. The linkage of the community with the healthcare delivery system is poor. ASHAs will provide this linkage and help to improve the health indices in these areas. In Delhi one ASHA is envisaged for 2000 population.

Under this scheme, 5450 ASHAs were to be selected and trained /diaries in two phases. About 3000 ASHAs have been trained, provided with drug kits launched in the field. The information generated from ASHA diary has been utilized for local area health planning. District level Mentor/Unit level mentor / support groups has been set up.

b) Rogi Kalyan Samitis (RKS): RKS is envisaged to achieve universalisation of health for all needy people and to make hospitals and dispensaries centers of excellence by ensuring optimum use of available resources and infrastructure. RKS in 24 hospitals have already been formed. District and State RKS Cells are being put in place.Setting up of RKS/Jan Swasthya Samitis (JSS) for 22 CHCs and 142 PUHCs are in process.

c) Health and Sanitation Committees: The guidelines have been finalized for the urban model and disseminated to the districts along with the funds and the Committees are being formed in six identified pilot areas. The districts having active and efficient NGOs have been advise to take help of the same in functionalizing these bodies. Almost 325 HSCs have been put in place. About 2800 more have been proposed.

3. Strengthening of Existing Infrastructure:

A)Primary Health Care Strengthening: This is to ensure uniformity and quality assurance in the primary healthcare tier. This would have following components:
a) Standards for a Primary Urban Health Centre (PUHC): A committee was set up to propose State specific modifications. The existing Indian Public Health Standards for PHCs have been revised / modified to become applicable to a PUHC. The standards have been finalized by the cabinet.

b) Facility survey of the Primary Health Care Units belonging to different agencies to help in identification of the existing better equipped facilities has been done. The identified units would be upgraded to the Standards laid. The performance will be monitored by Integrated District Health Society to assess if the objective of strengthening the unit has been achieved or not. This activity entails strengthening all the identified units in terms of infrastructure / manpower.

c) Up gradation of physical infrastructure as per standard norms.

d) The households of the attached population is being linked to the facility by family health cards. Formalization of linkages with Family Health Cards is synchronized with Upgradation.

Total Pr. Healthcare facilities selected for upgradation and strengthening are 215 which include Delhi Govt and MCD units. The centers selected for strengthening include:

1. Potential PUHCs (DG / MCD)
2. ASHA Units
3. Health Centers attached to Maternity Homes

ASHA units must have two MOs and a CDEO.
For centers attached to Maternity Homes already the Committee has given the norms. The gaps identified (mainly in terms of manpower) on facility survey have been filled for the selected units.

B) Strengthening of Lab Services: A major lacunae realized in the service delivery in the dispensaries under Delhi Government and M&CW centers / Maternity Homes under Municipal Corporation of Delhi (major primary health care providers) were deficient diagnostic services or non-availability of these at all.

Under the mission Mother Labs have been identified, each catering to a cluster of 5-6 Delhi Govt. Dispensaries for biochemical and hematological tests. Furthermore, 50 M&CW Centers under MCD are being provisioned with Basic Labs with facilities of few basic tests to begin with. The services provided by basic labs would include basic blood tests, routine microscopy and kit based tests.

C) Coverage of Unserved / Underserved Areas:

a) Setting up of Seed PUHCs: For Unserved / Underserved areas, seed PUHCs have been set up for around 50,000 population pockets to provide quality health care to these areas. Of 61 proposed, 35 have already been set up and the rest are in the process. The MOs and Pharmacists for few centers have been recruited.

b) PPP with APARNA: for South District

D) Maternity Home Strengthening: In order to increase the Institutional Delivery rate in Delhi, 23 maternity homes and the maternal wing of RFTC, Najafgarh have been strengthened in terms of manpower and equipments.

A Committee was set up to draft standards on the basis of available IPHS standards for CHCs and 30 to 50 bedded hospitals. Subsequently, a facility survey, 23 maternity homes have been selected for Upgradation. Manpower has been provided to functionalize these maternity homes for 24x7 delivery services.

E) **Strengthening of Secondary Care facilities:** Maternal wings of 14 Delhi Govt and MCD hospitals have been strengthened in terms of manpower, equipments and support has been provided for minor civil works. Also 11 Delhi Govt and MCD hospitals have been strengthened in terms of manpower, equipments and minor civil works for quality neonatal care services.

Referral linkages have been set up. Existence of multiple agencies delivering health at primary, secondary and tertiary level without any defined uniform system of population linkages and referral is another big challenge in Delhi faced by the health sector. This is further compounded by the paucity of functional secondary care units. Also help desks are being set up in 28 hospitals to honor the referrals. Each help desk is being provided with a CDEO, four social Mobilizers and a computer with internet facility to ensure round the clock services.

Family health Card and booklet: dedicated pages for each member in the family for necessary entries by health functionaries whenever health services are sought. With ASHA in position each 400 houses cluster will have an ID number and it will be easy to attatch these ASHA units. ASHA will play a crucial role in helping the families understand the importance of keeping & using the health book safely.

F) Innovations:

i) **MAMTA Scheme:** A PPP initiative involving private partners for ensuring quality antenatal care and institutional deliveries.

ii) **Augmentation of Mobile Health Services:** There is a definite gap for access of services for the homeless, people living in vulnerable areas, senior citizens, women and children in districts. In the current PIP, provision has been made for mobile medical units to provide services to the needy at the door step. MMUs are proposed to be accessible to telephone facilities and can be called for the identified category of vulnerable groups in case of emergency medical requirements.
Two mobile health units were proposed for community health services for mental health and have been functionalized. Two vans each were provisioned for IEC and Screening and also service delivery under Community Dental Services. The same will be functionalized soon.
Augmentation has been proposed with focus on vulnerable groups for service delivery at door step along with for disability prevention and promotion of health. One mobile unit each is being proposed for screening and referring cases under National Program for Prevention and Control of Deafness, National Programme for Control of Blindness and for Blood Donation Camps with Delhi State AIDS Control Society (DSACS).Also 8 MMUs are being proposed to help women and children in need, senior citizens and vulnerable living in slums and JJ Clusters. 8 mobile vans have been provided to the State by Ministry of Minority Affairs Support, for which the recurrent cost under NRHM has been sought.

iii) Senior Citizen Friendly Health Services: The diseases like HT,Diabetes,CVD etc can be detected at early stage by screening of elderly people at Dispensary/ PUHC level and the complications can be averted. The interventions in the early stage modify the course of disease and prolong the life. The screening can be done of the elderly people coming to theses centers for problem or the elderly in the community can be motivated and mobilized for screening by ASHA workers. In view of above, a Senior Citizen Health Card is being developed. ASHA workers are being asked to identify, register Senior Citizens in their area. She will be motivating & mobilizing the senior citizens to the allotted nearby PUHC for screening. ASHA worker may be paid incentive for the same.

iv) Focus on Life Style Diseases: Govt. of NCT of Delhi has started a major focused programme for prevention of Diabetes with a view to decreasing the overall burden of Diabetes in Delhi. The State level programme for the prevention of Diabetes was started in June, 2010 with a launch of Diabetes – CARE (Campaign for Awareness, Risk Assessment & Education) and envisages several initiatives to be be implemented in a phased manner in the year 2011-12 and thereafter.

Three pronged strategy for diabetes awareness and care project

a. Creating awareness among the people of Delhi about the problem of Diabetes & its complications & prevention. These should include:
    i. People who are already diabetic
    ii. People who are at risk of diabetes
    iii. General public.

The awareness campaign would not be a stand alone campaign if it has to have its desired impact on reducing Diabetes burden. It should be combined with b & c.

b. Implement specific screening strategies in target groups
    i. Pregnant mothers
    ii. School Children
c. Other High risk Groups Strengthening of health care system for
    i. A early diagnosis of Diabetes
    ii. Prompt, early & effective treatment of newly diagnosed Diabetes cases, so that many complications of diabetes can be prevented / delayed.
    iii. Training of primary care physicians & paramedical staff by experts in diabetes care
    iv. Creation of a database of diabetes & its complications.
        Data management system that could constantly guide policy of diabetes by the state government is already being projected as an important & critical function of the Diabetes, Endocrine & Metabolic Care Center at GTB hospital which will serve as an
        apex referral center for Diabetes care for the government of Delhi.

v) **Quality Assurance in Hospitals:** Secondary and tertiary care hospitals are being upgraded as per the NABH standards.
vi).GIS Mapping

G) **Main Streaming of AYUSH:** 30 seed PUHCs have been proposed to be collocated with Allopathic dispensaries. Also capacity building of AYUSH doctors, pharmacist and class IV has been proposed.

H) Convergence

a) Proposed activities under DMHP:

1. Capacity Building
2. Preventive Under Swasth Yuva Pilot Project for school children
3. IEC

b) Convergence with Education: Strengthening the adolescent Health component of the school health-Role of Department of Health and Family Welfare in Social Welfare in YUVA. A doctor looks after five such clinics in school ie. will be available for fixed one day / week in the school. The room and support staff (cleaning) has been provided in the school. IEC material is being provided by the health department.
Initially it was taken up as a pilot project in two districts covering 200 schools in each (100 schools in each NW and South) .The project is being monitored with the help of predesigned formats / inspections / interviews with students and teachers / clinic records.

c) Intersectoral Convergence Dept of Social Welfare through ICDS: Strengthening of the existing anganwadis has been done by providing all anganwadis with weighing machines – adult and salter weighing machines. All Anganwaris have been provided of the display boards (3 x 2 by 3”) for all mother anganwadis.
2). Capacity building of 257 Master trainers (CDPOs and Supervisors) in nutritional monitoring / surveillance has been done.

3). Identification of Mother anganwadis. Conduct of health and nutrition days through the mother anganwadis.
4). Development and provision of management / follow-up cards for malnourished / anemic children.
5). Optimally functionalizing the ASHA – AWW –ANM –MO Team in picking out and providing targeted attention to all the identified malnourished and anemic children.
6). Formalizing necessary linkages for taking care of severe malnutrition.

I) Infrastructure Strengthening: State Health System Resource Centre (SHSRC) has been set. Strengthening of State district store has been done and district level stores are being set up.

J) Capacity Building/ Trainings: Training is the single most important input in any process to improve the quality of health services. Due emphasis has been given to the capacity building component in the District / State PIP. The achievement at the state and district level of 2009-10 is as follows:

1.) Recruitment of District Training Officers dedicated to looking after the trainings.
2.) Database of individuals to be trained in all categories from all agencies i.e. GNCTD, MCD, ICDS, NGOs
3.) Identifying and linking Training Venues / Facilities already present in the State / District. Also facilitating presence of one District Level furnished training venue equipped equipment / aids required for trainings and basic housekeeping staff.
4.) Building Database of and linkages with Resource persons/ Departments / Institutions which can help in imparting these trainings.

The activities planned under the current PIP are as follows:

State Level:
1. Training Activities under Maternal health, Child health, Adolescent health, disease control Programe.
2. Establishing fully equipped state level Conference & lecture hall / Library / E resource facility.
3. State officials will also be visiting to other well performing states for evidence based learning& sharing of experience for concurrent /future policy & programmatic course corrections as a part of Training/Capacity building efforts of the State.

District Level:
Training Activities have been planned

K. Behavior Change Communication: There has to be **a paradigm shift** from the conventional IEC Planning wherein a myriad of messages is prepared and distributed for dissemination in various forms with no post activity evaluation to the disease / issue specific, behavior change sought in the target group with a mandatory post activity evaluation. Specific Behaviour Change Strategies chosen for the year:
1. To save the girl child
2. BCC for ASHA/MAMTA have been built within the scheme
3. Monitoring and Evaluation

L. <u>Monitoring and Evaluation/ HMIS:</u> Under the Mission it is envisaged to simplify and streamline collection, transmission, collation and compilation of data coming from the field. This collected data has to be interpretation friendly and it has to be examined and evaluated by the empowered officials to institute online rectification.

Computerization of the potential PUHCs, ASHA Units and Maternity homes and provision of CDEO has been done. Facility wise uploading of data has been commenced from almost 650 facilities. All these units have been strengthened in terms of CDEOs, computers and internet facility. The focus of current PIP is:

1. Building capacity for complete quality facility wise data capture.
2. Strengthening of District MIS cell.
3. Coordination with MCD MIS cell for on line transmission of data in new format to the district MIS cell
4. Full fledged MIS expert available in 9 districts
5. The ANM registers need to be designed by the experts to ensure capturing of accurate and complete data
6. Training to reporting / recording personnel on HMIS format and on line data capture
7. Proper supervision and guidance for improvement in quality of data collection and compilation
8. Ensure better co-ordination and support with regard to M&E at senior level administration / officers in all districts and agencies
9. For ensuring timely submission of correct and complete reports, responsibility / accountability should be fixed to M.O.I. /C of a particular unit
10. Training is mandatory for strengthening and streamlines the reporting system.

<u>Monitoring and Evaluation:</u> Mission provides an excellent opportunity to put sound, workable monitoring and evaluation mechanisms in place by revitalizing the existing mechanisms and introducing new ones wherever required

1. Primary ongoing evaluation by the Supervisors and immediate In charges using field visits and inspections.

The monitoring of all the activities under the programme would be done at three levels.

1. **<u>Community Monitoring:</u>** The mechanism for monitoring at community level would be through the ASHA and Rogi Kalyan Samitis (RKS).

   Provision will be made to display Citizen’s Charter in the premises of all the PUHCs. A detailed copy of Citizen’s Charter would also be made available with the RKS to ensure optimum quality in service delivery.

2. **<u>Internal Monitoring:</u>** The MO in-charge of a health facility would be responsible for regular monitoring of the routine activities in the centre. This report would be forwarded to the district HQ (Addl. CDMO) on monthly basis and then the action / feedback will be generated at the district level.

3. **<u>External Monitoring:</u>** The external Monitoring would be done at the district level on monthly basis.

<u>At district Level:</u> Addl. CDMO will be the nodal officer in charge responsible for all the Monitoring and Evaluation activities in the districts. The DPMU staff / Officers from the districts are involved in monitoring activities. The monitoring will be done on all the aspects of NRHM Additionalities and other programmes on pre-designed formats.

The State monitoring and evaluation cell is responsible for preparing the monitoring formats for all the units. For programmes other than NRHM Additionalities, the programme specific monitoring formats and evaluation indicators would be developed circulated by respective SPOs to the districts.

Monitoring and Evaluation Review Committee: comprising of Mission Director, DHS, DFW and SPOs (NRHM) will hold a quarterly meeting to review the monitoring activities across the state and districts.

Evaluation as a crosscutting issue will continue to use mainly process indicators and output indicators wherever applicable that will be designed to be comparable across the districts.

OTHER HEALTH PROGRAMMES

1. <u>Reproductive and Child Health (RCH-II):</u> RCH programme was started by Govt. of India in 1997. RCH I continued from 1997 to March, 2005. From April, 2005 RCH – II was launched and presently programme is till March, 2012.

RCH PIP for year 2011-12 has been prepared after incorporating District Health Action Plans of 9 district and state input.

A state level team of various programme officers in DFW was constituted and input from various stake holders like MCD, NDMC, Delhi Cantt., GIA NGOs, SPO Delhi State Health Mission, Principal Training Centre, CMO Policy & account functionaries were taken and after lot of discussions and deliberations it was worked out and discussed in State Health Society Meeting and got necessary approval from State Health Society Delhi.

Whole PIP has been divided into various parts like MH, CH, FP, ARSH, Urban RCH, Vulnerable Group, PPP / NGO/ Innovations, Institutional Strengthening, Infrastructure & HR, Training, IEC/BCC, Procurement & Programme Management. Funds of MH **Rs. 287.3675 lacs**, CH **Rs 113.5352 lacs** FP **Rs 368.59 lacs** ARSH **Rs 29.093 lacs**, Urban RCH **Rs 56.0 lacs**, Vulnerable Group **Rs 22.60 lacs**, PPP / NGO/ Innovations **Rs 13.5 lacs** Institutional Strengthening **Rs 56.5392 lacs**, Infrastructure & HR **Rs. 2921.4222 lacs**, Training **Rs 84.99 lacs**, IEC/BCC **Rs 180.334 lacs**, Procurement **Rs 283.15 lacs** & Programme Management **Rs. 106.0872 lacs** has been kept under the PIP. Total Fund Rs. **4514.2083 Lacs**

Newer initiatives for 2011-12 are :

Transportation money to ANM for coming back from institutional delivery in JSY cases from hospitals to her residence, Maternal Death Audit, Infant Death Audit, Provision of RTI / STI syndromic management services in dispensaries & hospitals, tracking of severely anemic pregnant woman by ANM / ASHA & name based tracking of pregnant woman for complete ANC and under 5 children for complete immunization.

Other newer initiatives are : Transportation money to health worker to take cases of family planning operation from dispensaries to the hospital & coming back. Provision of sanitary napkins to adolescent girls in rural area has been reflected.

Training on RTI / STI for Medical Officers, ANM has been included for the first time.

Training of the dispensary staff on counseling skill in RTI / STI and HIV / AIDS is also part of the PIP.

Services of IPP VIII MCD Training Centre will be taken for training on ARSH and RTI / STI issues.

PPIUD Insertion Training of the M.O. has already started and will continue in 2011-12 also in all the 9 districts.

Organization of the Tubectomy Camps and IUD Insertion Camps has also been kept for the first time in the PIP.

State will continue support to 5 medical colleges for pre-services IMNCI training to medical officers / medical students.

5 new hospitals has been recognized and will be strengthened regarding out born nursery strengthening.

More IYCF centres will be set up in 100 bedded hospitals (FRU) to promote exclusive breast feeding. Four more FRUs will be made functional in 24 x 7 (Moti Nagar, Patel Nagar, Dada Dev & Malviya Nagar)

MCH I, II, III Level centre will be made operational as per GoI guidelines for sick & malnourished new born.

Tracking of under 5 children discharged from hospital will be carried out by ASHA and she will be given incentive.

Thematic workshop / events will be organized like Hepatitis B Day, World Population Week, Workshop with DLSA on girl Child.

Participation in IITF and setting up of NSV camp there will continue.

Implementation of SABLA and IGMSY schemes of WCD Ministry will be carried out by the RCH Programme as part of convergence.

Empanelment of doctors for lap sterilization and NSV will continue.

Setting up of ARSH Clinics in Delhi University & six remaining Districts of Delhi is part of the plan.

Appointment of Youth Consultant at Adolescent Friendly Health Clinic at Jamia Milia Islamia University has been projected.

Sting Operation on PNDT issues to correct the adverse sex ratio in Delhi has found a place in the PIP.

Syndromic management of RTI / STI and funds for procurement of drug kits for RTI / STI has been projected from NRHM funds.

Continuation of the remaining activities as carried out in 2010-11 will continue and will help in achieving the goal of MMR <100/lac live birth, IMR <30/1000 live births. Delhi has already achieved the TFR of 2.0

2. National Leprosy Eradication Programme (NLEP):

NCT of Delhi is still recognized as a problem state, because of its urbanization and a large chunk of migratory population. With an overall objective of reduction of leprosy burden in line with National scenario through sustainable and quality leprosy services, the following strategies have been planned:

1. Increase early self reporting through intensive IEC and Trainings to the service providers
2. Improvement in quality of Case management
3. Improved DPMR rate and referral system
4. Improved progamme management and Supervision at all levels
5. **Urban Leprosy Control** through 9 identified urban areas located in Delhi

The dermatologists / private practitioners will be involved for NLEP activities
6. NGO Services
7. Monitoring and Evaluation:
For these urban areas for continuation of the activities fund is proposed under –
   - Supportive Medicine: In addition to the district procurement plan
   - Honorarium to part time dressers
   - Leprosy assistants in major hospitals
   - MDT delivery services: Includes case follow up for treatment completion
   - Monitoring & Supervision: Includes periodic meetings & mobility
   - In addition, Training and IEC are also included in the respective heads for the district. While preparing Action plan, the marginalized urban poor groups and also those who are not living in the slums and colonies are given priority

3. National Programme for Control of Blindness:

The prevalence as on date is 1.0% and goal set for the terminal year of 11th plan is to reduce the prevalence of blindness to 0.8% by 2012

The main objectives of the Programme are:

1. To provide high quality of eye care to the affected population;
2. To expand coverage of eye care services to the underserved areas;
3. To reduce the backlog of blindness by identifying and providing services to the affected population; and
4. To develop institutional capacity of eye care services by providing support for equipment and material and training personnel

Activities Planned:
1. Strengthening of Vision Centers at PHCs/in voluntary Sector along with the district hospitals
2. Financial Support to Eye banks in Govt. and Voluntary sectors
3. Grant in aid to District Blindness Control Societies / Distt. Units under the Integrated Distt. Health Societies
4. Grant-in-aid for free Cataract Operations by voluntary organizations in fixed facilities
5. Non-recurring GIA for strengthening/expansion of Eye Care Units in Rural/underserved areas
6. Training of Ophthalmic and Support Manpower
7. IEC and also Developing an effective management information system, monitoring & evaluation system

4. National Programme for Prevention and Control of Deafness (NPPCD):

PROGRESS so far :
1. **Manpower recruitment:** Two Au`iological assistants and two Instructors for Young Hearing Impaired have been recruited
2. **Fund release:** Fund amount of Rs. 9.5 lacs each have been released to the Integrated District Health Societies of West and North-West districts for purchase of ENT equipments and provision of sound proof room in Deen Dayal Upadhyay Hospital, Harinagar (West district) and Dr. Baba Saheb

Ambedkar Hospital, Rohini (North-West District). Similarly, fund amount of Rs. 10,000/- and Rs. 20,000 have been released to West and North-West districts for purchase of ENT kits in one and two dispensaries of the respective districts

3. **Sensitization of 40 school health medical officers** have been done
4. **NGO identification** for screening camp organization
5. **Provision of hearing aids:** Process of identification of children coming from families having monthly income of Rs. 6500/- is underway both from the communities and ENT OPD of Deen Dayal Upadhayay hospital and Dr. Baba Sahib Ambedkar Hospital, Rohini
6. **Trainings:** Process for organizing training programme for 1000 school teachers in West district and 39 obstetricians and 37 pediatricians in both districts are in process
7. **IEC:** The IEC materials have been developed.

STRATEGIES:

1. To strengthen the service delivery including rehabilitation
2. To develop human resource for ear care
3. To promote outreach activities and public awareness through appropriate and effective IEC strategies with special emphasis on prevention of deafness
4. To develop institutional capacity of the district hospitals, community health centers and primary health centers, selected under the project.

5. National Iodine Disease Control Programme (NIDDCP):

Details of the activities that have been carried out during 2010-11 are as follows:-

a) Goiter detection activities :-

These were carried out among patients & attendants who presented to Delhi Govt Dispensaries & children of age group 6-12 years & pregnant women.

b) IEC activities :-

These have been carried out through lectures, group discussions, distribution of pamphlets, etc as well as one to one interaction with the patients regarding proper use and benefits of iodized salt and the harmful effects of iodine deficiency in various districts all round the year in addition to special campaigns during IDD week.

c) Iodine estimation in salt samples :-

Collection of salt samples from the patients/ attendants/ school children/households/retailers for salt was done in various districts & Iodine estimations done by :-

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

d) Iodine Estimation In Urine Samples :-

Urine samples have been collected from the patients/ attendants for urine iodine estimation from various districts. These have been analyzed later in the IDD monitoring lab at GTB hospital.

e) Resurveys of IDD prevalence and impact of salt iodization has been carried out in two districts in school children aged 6-12 years as per standard techniques and guidelines prescribed for surveys under NIDDCP guidelines .

6. Revised National Tuberculosis Control Programme (RNTCP):

The priority areas that have been identified under RNTCP for the current year are:

1. Enhanced coverage in slums
2. Enhanced participation of private, NGOs and voluntary sectors
3. Increased case detection rate
4. Increased sputum conversion & cure rate
5. Increased HIV-TB collaboration
6. Introduction to DOTS plus

7. National Vector Borne Disease Control Programme (NVBDCP):

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

8. Integrated Disease Surveillance Project (IDSP): The projects aim to:

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

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

The activities under the programme have been planned to be implemented in the horizontal mode under NRHM and the programme implementation plan has been structured accordingly.

9. National Polio Surveillance Project:

Pulse Polio Programme is implemented on recommendation and as per the guideliens of Govt. of India. It is a centrally sponsored scheme and funds are received from GOI phase wise. Funds are also provided by Delhi Govt. for certain activities like IEC, Social mobilization, cold chain maintenance

etc. Each round of Pulse Polio has one day NID / SNID activity followed by 5 days of H-T-H activity. Till date there are no confirmed polio cases in the State.

10. **Tobacco Control Programme (Smoke Free Delhi):** The purpose of the proposal is to ensure smoke free environments in all public and work places in Delhi- 'MODEL SMOKE FREE DELHI CITY'. This is being achieved by stringent enforcement of the Delhi and the Central Tobacco Control Acts and their amendments. The enforcement mechanisms have been delegated to the state authorities.

	Main Heads	Components	Budget Amount (Rs in Lakh)
		Contractual Remuneration for ANMs(906), Nurses(411)	**2494.03**
1	**Human Resources**	Contractual Remuneration for LTs(288),LA(26)	**522.77**
		Contractual Remuneration of Specialists (Anesthetists, Pediatricians, Ob/Gyn, Surgeons, Physicians, Dental Surgeons, Radiologist, Sonologist, Pathologist, Specialist for CHCs.)(83+74)	**893.20**
		Medical Officers at CHCs / PHCs(544+62)	**3017.15**
		Contractual Remuneration of PHNs at CHC, PHC level(131+12)	**406.86**
		Additional Allowances/ Incentives to M.O.s of PHCs and CHCs(544)	**2.0**
		Payment to Others - Computer Assistants(324) / 9 BCC Co-coordinator,2 BCC consultants etc	**536.18**
		Incentive/ Awards etc. to SN, ANMs etc.	0
		Human Resources Development (MSW(2),Technician(3ECG,4 X ray,1ICU,11OT),1 BMEngineer,2 BM Asst	**27.74**
		Other Incentives Schemes (Please Specify)	0
		Strengthening of SHS /SPMU/DFW (Including HR, Management Cost, Mobility Support, Field Visits)	**211.21**
		Strengthening of DHS/DPMU (Including HR, Management Cost,)	**471.19**
		Strengthening of Block PMU (Including HR, Management Cost, Mobility Support, Field Visits)	**130.86**
		Strengthening (Others) SHSRC, warehouse, district stores	**288.1**
		Other Programme Management Costs (Audit Fees, Concurrent Audit	**5**
		Mobility Support, Field Visits to BMO/MO/Others	**2**

		Payment to AYUSH M.O.s	0
		Payment to AYUSH Other Staffs	0
2	**Training**	Training under Maternal Health	**13.2**
		Training under Child Health	**30.65**
		Training under Family Planning Services	**8.98**
		Strengthening Training Institutions	**151.83**
		Development of training packages	**7.00**
		IMEP Trainings	**0**
		ARSH Training	**9.77**
		Programme Management Training	**163.93**
		Training (Nursing)	
		Training (Other Health Personnel)	**2.68**
		Training for Cold Chain Handlers/refrigerator mechanics	**0.45**
		Training of M.O.s /Other Staffs on R.I.	**7.26**
3	**Infrastructure**	Upgradation of CHCs, PHCs, Dist. Hospitals to IPHS)	**1593.39**
		Strengthening of District, Sub-divisional Hospitals, CHCs, PHCs	**2838.08**
		New Constructions/ Renovation and Setting up CHCs, PHCs, HSCs,(SCNU)	**175.5**
		Construction (Others)	**0**
		Minor civil works for operationalisation of FRUs	**3**
		Minor civil works for operationalisation of 24 hour services at PHCs	**0**
		Civil Work under RNTCP	**56.53**
		Other Civil Works	**0**
4	**Procurement**	Procurement of Drugs & Supplies	**63.19**
		Procurement of Equipment	**650.55**
		Procurement of Others	**0**
5	**IEC/BCC**	Development of State BCC/IEC strategy	**0**
		Implementation of BCC/IEC strategy	**239.52**
		Health Mela	**0.5**
		Creating awareness on declining sex ratio issue	**29.1**
		Other activities	0
6	**Untied funds**	Untied funds for,VHSC, SC CHC,PHC	**361.6**
		Annual Maintenance Grants for CHCs, PHCs	**93**

		Panchayati Raj Initiatives	0
7	**ASHA**		
		Selection & Training of ASHA	**405.92**
		Procurement of ASHA Drug Kit	**33.06**
		Incentive to ASHAs under JSY	**20.0**
		Incentive under Family Planning Services	0
		Incentive under Child Health	0
		Incentive to ASHA's for motivating families for Sanitary Toilets/Other	0
		Awards to ASHA's/Link workers	0
		ASHA Incentive under **Immunisation**	5
		ASHA Incentive under **NLEP**	**20**

		ASHA Incentive under **NVBDCP**	0
		ASHA Incentive under **NBCP**	**11.9**
		ASHA Incentive under **RNTCP**	
8	**RKS**	Corpus grants to RKS	**992**
9	**JSY**	Home Deliveries	**12.35**
		Institutional Deliveries	**206.04**
10	**Sterlisation**	Compensation for Male sterlisation	**97.5**
		Compensation for Female sterlisation	**230.0**
		NSV Camps	**9.15**
		Female Sterlisation Camps	**1.2**
		IUD Camps	**0.2**
		Social Marketing of contraceptives	0
		POL for Family Planning	**4.1**
		Repairs of Laparo scopes	**15**
		Other Expenses(contraceptive updates,IUD)	**11.4**
11	**Referral Transport**	Referral Transport including back transport of ANM/health worker	**174**
12	**Other RCH Activities**	ARSH	**29.1**
		Urban RCH	**56**
13	**Vulnerable Group**	Tribal RCH	0
		Vulnerable Groups	**22.6**
14	**Other Mission Activities**	Research Studies,	**5**
		New Initiatives	**194.08**

		Support to other programmes	0
		District Health Action Plan	**56.5**
		Mainstreaming of AYUSH	**98.65**
		MMU	**0**
		SHSRC	**46**
		School Health Programme	**0**
		Health Insurance	**0**
		Planning , Implementation, Monitoring	**853.21**
15	**PPP/NGO**	NGO activities, PPP under NRHM Additionalities	**39.06**
		Other NDCPs (RNTCP, NPCB etc)	**94.62**
16	**Operational Cost (NDCPs)**	Mobility, Review Meeting ,field visits, formats & reports, Communication etc for NDCPs(NLEP,RNTCP,)	**81.05**
		Lab consumables, AMC etc for NDCPs(RNTCP)	**97.9**
17	**Financial aid/grant to Institutions (NDCPs)**	Financial Support to Medical colleges(RNTCP,RCH)	**52.64**
		Financial Support to Referral Institutes	
		Financial Support to Sentinel sites	
	Grand Total		**19483.23**