R F D

(Results-Framework Document)

For

Department of Health and Family Welfare

(2013-14)

Section 1

DEPARTMENT'S VISION, MISSION, OBJECTIVES AND FUNCTIONS

Vision: Availability of quality healthcare on equitable, accessible and affordable basis across regions and communities with special focus on under-served population and marginalized groups.

Mission:

1. To establish comprehensive primary healthcare delivery system and well-functioning linkages with secondary and tertiary care health delivery system.
2. To improve maternal and child health outcomes.
3. To reduce the incidence of communicable diseases and putting in place a strategy to reduce the burden of non-communicable diseases.
4. To ensure a reduction in the growth rate of population with a view to achieve population stabilization.
5. To develop the training capacity for providing human resources for health (medical, paramedical and managerial) with adequate skill mix at all levels.
6. To regulate health service delivery and promote rational use of pharmaceuticals in the country.

Objectives:

1. Universal access to primary health care services for all sections of society with effective linkages to secondary and tertiary health care.
2. Improving Maternal and Child health.
3. Focusing on population stabilization in the country.
4. Developing human resources for health to achieve health goals.
5. Reducing overall disease burden of the society.
6. Strengthening Secondary and Tertiary health care.
7. Reducing burden of Leprosy with quality services and enhance Disability Prevention & Medical Rehabilitation(DPMR) services.

Functions:

1. Policy formulation on issues relating to health and family welfare sectors.
2. Management of hospitals and other health institutions under the control of Department of Health and Family Welfare.
3. Extending support to states for strengthening their health care and family welfare system.
4. Reducing the burden of Communicable and Non-Communicable diseases.
5. Focusing on development of human resources through appropriate medical and public health education.
6. Providing regulatory framework for matters in the Concurrent List of the Constitution viz. medical, nursing and paramedical education, pharmaceuticals, etc.
7. Formulation of guidelines on issues relating to implementation of Nation Leprosy Eradication Programme & strengthening supervision and Monitoring support to States/UTs

Section: 2

INTER SE PRIORITIES AMONG KEY OBJECTIVES, SUCCESS INDICATORS AND TARGETS

SECTION 2 - RESULTS FRAMEWORK DOCUMENT (RFD) 2013-14

Sl. No.	Objective	Weight	Action Points	Success Indicator				Excellent	Very Good	Good	Fair	Poor
				Success Indicator	Unit	Weight	w (%)					
1	2	3	4	5	6	7	8	9	10	11	12	13
1	**Universal access to primary health care services for all sections of society with effective linkages to secondary and tertiary health care**	32.0	Strengthening of Health Infrastructure	Operationalisation of 24X7 Facility at PHC level out of the total number of 24000 PHCs	%	4	12.50	35.0	34.5	34.0	33.5	33.0
				Operationalisation of CHCs into First Referral Units (FRU) out of the total number of 4000 CHCs	%	4	12.50	35.0	34.5	34.0	33.5	33.0
				Increase in the service delivery by MMU over baseline figure as on 31.03.2013	%	3	9.38	12	10	8	6	5
				Increase in the number of patient transported over the baseline figure for 2012-13.	%	4	12.50	12	10	8	6	5
				Establishment of Special New Born Care Units in District Hospitals	%	2	6.25	15	12	9	6	5
			Strengthening of Community Involvement	Utilization of funds by new Village Health, Sanitation & Nutrition Committees (VHSNC) released up to the end of previous financial year	%	2	6.25	55	50	45	40	35
			Augmentation of Availability of Human Resources in identified High Priority Districts	Deployment of new ANMs	Number	3	9.38	1300	1250	1000	900	800
				Deployment of new Doctors/Specialists	Number	3	9.38	300	250	200	175	150
				Deployment of new Staff Nurses	Number	3	9.38	600	500	450	400	375
			Capacity Building	ASHA Training (up to VI th & VIIth Module)	Number	4	12.50	100000	80000	60000	40000	20000

SECTION 2 - RESULTS FRAMEWORK DOCUMENT (RFD) 2013-14

Sl. No.	Objective	Weight	Action Points	Success Indicator				Excellent	Very Good	Good	Fair	Poor
				Success Indicator	Unit	Weight	w (%)					
1	2	3	4	5	6	7	8	9	10	11	12	13
2	**Improving Maternal & Child Health**	8.0	Promote Institutional Deliveries	Institutional Deliveries as a percentage of total deliveries	%	3	37.50	85	82	80	78	75
			Promoting Safe deliveries	Reduction in unsafe deliveries in identified High Priority Districts	%	2	25.00	6	5	4	3	2
			Targeting Full Immunisation (Age group of 0-12 months)	Target Children immunised	%	3	37.50	87	85	83	81	79
3	**Focusing on population stabilization in the country**	8.0	Promoting Post Partum IUCD	Increase in IUCD insertions over previous financial year	%	2	25.00	15	10	8	7	6
			Registration of pregnancy in first trimester	Increase in the registration over the previous financial year	%	2	25.00	20	15	12	10	8
			Promoting interval Intra Uterine Device (IUD) Insertion	Increase in IUD Insertion over the previous financial year	%	2	25.00	15	10	8	7	6
			National Inspection & Monitoring Committee (PCPNDT Act) visits	Increase in number of visits	%	2	25.00	25	20	18	15	10
4	**Developing human resources for health to achieve health goals**	9.0	Strengthening & Up gradation of Govt. Medical Colleges	Completion of Up gradation of identified Medical Colleges	Number	5	55.56	24	20	15	13	10
			Setting up one National Institute of Para-medical Sciences(NIPS) and 8 Regional Institutes of Paramedical Sciences (RIPS)	Commencement of Work for NIPS	Date	1	11.11	5/3/2014	15/3/2014	20/3/2014	25/3/2014	31/3/2014
				Commencement of Work for RIPS	Number	1	11.11	6	5	3	2	1
			Establishment of Nursing Institutes at various levels	Commencement of teaching in ANM School	Number	1	11.11	27	25	20	15	3
				Release of funds for establishment GNM Schools	Number	1	11.11	28	25	20	15	10
5	**Reducing overall disease burden of the society**	18.0	Reduce incidence of Malaria cases	Annual Parasite Incidence (API)	per 1000 population	2.5	13.89	1.30	1.40	1.52	1.67	1.80
			Reduce incidence of Filariasis	Remaining Endemic Districts (64) achieving Micro Filaria rate of < 1 %	Number	2	11.11	50	45	40	35	30
			Reduce incidence of Kala-azar	BPHCs reporting less than 1 case of Kala-azar per 10000 population out of 275 remaining such BPHCs	Number	2	11.11	150	140	130	125	120

SECTION 2 - RESULTS FRAMEWORK DOCUMENT (RFD) 2013-14

Sl. No.	Objective	Weight	Action Points	Success Indicator				Excellent	Very Good	Good	Fair	Poor
				Success Indicator	Unit	Weight	w (%)					
1	2	3	4	5	6	7	8	9	10	11	12	13
			Reduce incidence of Leprosy	Annual prevalence rate of < 10 per Lakh population in High burden Districts (209)	Number	1	5.56	75	70	65	60	55
				Reconstructive Surgeries conducted	Number	0.5	2.78	3000	2700	2400	2100	1800
			Control of Tuberculosis	New Sputum Positive (NSP) Success rate	%	1	5.56	90	88	85	75	70
				Default rate amongst CAT-II patients	%	1	5.56	12.5	13	13.5	14	15
				MDR TB Cases notified put on treatment.	%	0.5	2.78	55	50	45	40	35
			Reduction in Prevalence of Blindness	Cataract Surgeries performed (in Lakhs)	Number	0.5	2.78	70	63	56	49	42
				Spectacles to school children screened with refractive error (in Lakhs)	Number	0.5	2.78	8	7.2	6.4	5.6	4.8
				Collection of donated eyes for corneal transplantation	Number	0.5	2.78	50000	45000	40000	35000	30000
			Strengthening facilities for diagnosis and treatment of cancer	Development of District Cancer Facilities	Number	0.5	2.78	75	70	65	60	50
				Strengthening of Tertiary Cancer Centres	Number	1	5.56	5	4	3	2	1

SECTION 2 - RESULTS FRAMEWORK DOCUMENT (RFD) 2013-14

Sl. No.	Objective	Weight	Action Points	Success Indicator				Excellent	Very Good	Good	Fair	Poor
				Success Indicator	Unit	Weight	w (%)					
1	2	3	4	5	6	7	8	9	10	11	12	13
			Establishment of Tobacco Testing laboratories	Operationalization of new Tobacco Testing labs for Nicotine and Tar	Number	0.5	2.78	6	4	3	2	1
			Ensure availability of minimum mental health care services	Starting of Academic Session in Centres of Excellence	Number	1	5.56	5	4	3	2	1
				Approval for starting up of PG courses in Mental Health Specialities	Number	0.5	2.78	25	20	15	10	5
			Opportunistic screening, diagnosis and management of Diabetes, Cardiovascular Diseases and Stroke	Set up NCD Clinics and Cardiac Care Units in District Hospitals	Number	0.5	2.78	80	70	60	50	40
				Screening of NCDs at District Hospital and below	Number	0.5	2.78	80	70	60	50	40
			Provide Health Care to the Elderly Population	Operationalization of Geriatric OPD and 10 beds ward at District Hospitals	Number	0.5	2.78	100	75	70	65	60
				Establishment of Regional Geriatric Centres	Number	0.5	2.78	5	4	3	2	1
				Establishment of National Institute of Aging at AIIMS, Delhi & MMC, Chennai	Number	0.5	2.78	2	1	1	1	0
6	**Strengthening Secondary and Tertiary health care**	10.0	Setting up of Institutions (6 No.)	Commencement of Nursing Teaching Academic Session in Medical Colleges	Number	4	40.0	5	4	3	2	1
				Completion of construction work in Hospitals	%	3	30.0	100	90	85	80	75
			Upgradation of Govt. Medical colleges (8 No.)	completion of construction work	Number	3	30.0	4	3	2	1	-

Mandatory Success Indicators RFD 2013-14

S. No.	Objective	Actions	Success Indicators	Unit	Weight	Target / Criteria value				
						Excellent	Very Good	Good	Fair	Poor
						100%	90%	80%	70%	60%
1	2	4	5	6	7	8	9	10	11	12
Mandatory Success Indicators										
1	**Efficient functioning of the RFD System**	Timely submission of draft RFD 2014-15 for Approval	On-time submission	Date	2	March 5, 2014	March 6, 2014	March 7, 2014	March 8, 2014	March 11, 2014
		Timely submission of results for 2012-13	On-time submission	Date	1	May 1, 2013	May 2, 2013	May 3, 2013	May 6, 2013	May 7, 2013
2	**Improving Internal Efficiency / responsiveness / service delivery of Ministry/ Department**	Update Departmental strategy to align with 12th Plan priorities	Timely updation of strategy	Date	2	September 10, 2013	September 17, 2013	September 24, 2013	October 1, 2013	October 8, 2013
		Independent Audit of implementation of Citizen's Charter (CCC)	% of implementation	%	2	100	95	90	85	80
		Independent Audit of implementation of public grievances redressal system	% of implementation	%	2	100	95	90	85	80
3	**Administrative Reforms**	Implement mitigating strategies for reducing potential risk of corruption	% of implementation	%	1	100	95	90	85	80
		Implement ISO 9001 as per the approved action plan	% of implementation	%	2	100	95	90	85	80
		Implement Innovation Action Plan (IAP)	% of agreed milestones achieved	%	2	100	95	90	85	80
		Identification of core and non-core activities of Ministry/Department as per 2nd ARC recommendations	Timely submission	%	1	October 1, 2013	October 15, 2013	October 30, 2013	November 10, 2013	November 20, 2013

Section: 3

TREND VALUES OF SUCCESS INDICATORS

SECTION-3 TREND VALUE FOR SUCCESS INDICATORS RFD 2013-14

Sl. No.	Objective	Weight	Action Points	Success Indicators		Actual value	Anticipated value	Target value	Projected value	Projected value
				Success Indicator	Unit	2011-12	2012-13	2013-14	2014-15	2015-16
1	2		3	4	5	6	7	8	9	10
1	**Universal access to primary health care services for all sections of society with effective linkages to secondary and tertiary health care**	32.0	Strengthening of Health Infrastructure	Operationalisation of 24X7 Facility at PHC level out of the total number of 24000 PHCs	%	-	-	34.5	34.5	34.5
				Operationalisation of CHCs into First Referral Units (FRU) out of the total number of 4000 CHCs	%	-	-	34.5	34.5	34.5
				Increase in the service delivery by MMU over baseline figure as on 31.03.2013	%	-	-	10	10	10
				Increase in the number of patient transported over the baseline figure for 2012-13.	%	-	-	10	10	10
				Establishment of Special New Born Care Units in District Hospitals	%	-	-	12	12	12
			Strengthening of Community Involvement	Utilization of funds by new Village Health, Sanitation & Nutrition Committees (VHSNC) released up to the end of previous financial year	%	-	-	50	50	50
			Augmentation of Availability of Human Resources in identified High Priority Districts	Deployment of new ANMs	Number	7200	8000	1250	1250	1250
				Deployment of new Doctors/Specialists	Number	1000	1100	250	250	250
				Deployment of new Staff Nurses	Number	2500	3000	500	500	500
			Capacity Building	ASHA Training (up to VI th & VIIth Module)	Number	100000	130000	80000	80000	80000

Sl. No.	Objective	Weight	Action Points	Success Indicators		Actual value	Anticipated value	Target value	Projected value	Projected value
				Success Indicator	Unit	2011-12	2012-13	2013-14	2014-15	2015-16
1	2		3	4	5	6	7	8	9	10
2	**Improving Maternal & Child Health**	8.0	Promote Institutional Deliveries	Institutional Deliveries as a percentage of total deliveries	%	82	82	82	82	82
			Promoting Safe deliveries	Reduction in unsafe deliveries in identified High Priority Districts	%	-	-	5	5	5
			Targeting Full Immunisation (Age group of 0-12 months)	Target Children immunised	%	87	85	85	85	85
3	**Focusing on population stabilization in the country**	8.0	Promoting Post Partum IUCD	Increase in IUCD insertions over previous financial year	%	-	-	10	10	10
			Registration of pregnancy in first trimester	Increase in the registration over the previous financial year	%	-	-	15	15	15
			Promoting interval Intra Uterine Device (IUD) Insertion	Increase in IUD Insertion over the previous financial year	%	-	-	10	10	10
			National Inspection & Monitoring Committee (PCPNDT Act) visits	Increase in number of visits	%	-	-	20	20	20
4	**Developing human resources for health to achieve health goals**	9.0	Strengthening & Upgradation of Govt. Medical Colleges	Completion of Upgradation of identified Medical Colleges	Number	30	20	20	20	20
			Setting up one National Institute of Para-medical Sciences (NIPS) and 8 Regional Institutes of Paramedical Sciences (RIPS)	Commencement of Work for NIPS	Date	Dec., 31, 2011	Oct.31,2012	15/3/2014	Nil	Nil
				Commencement of Work for RIPS	Number	4	5	5	5	5
			Establishment of Nursing Institutes at various levels	Commencement of teaching in ANM School	Number	12	15	25	25	25
				Release of funds for establishment GNM Schools	Number	31	25	25	25	25
5	**Reducing overall disease burden of the society**	18.0	Reduce incidence of Malaria cases	Annual Parasite Incidence (API)	Per 1000 population	1.10	0.85	1.40	1.40	1.40
			Reduce incidence of Filariasis	Remaining Endemic Districts (64) achieving Micro Filarial rate of < 1 %	Number	-	-	45	45	45
			Reduce incidence of Kala-azar	BPHCs reporting less than 1 case of Kala-azar per 10000 population out of 275 remaining such BPHCs	Number	-	-	140	140	140

Sl. No.	Objective	Weight	Action Points	Success Indicators		Actual value	Anticipated value	Target value	Projected value	Projected value
				Success Indicator	Unit	2011-12	2012-13	2013-14	2014-15	2015-16
1	2		3	4	5	6	7	8	9	10
5	**Reducing overall disease burden of the society**		Reduce incidence of Leprosy	Annual prevalence rate of < 10 per Lakh population in High burden Districts (209)	Number	-	-	70	70	70
				Reconstructive Surgeries conducted	Number	2570	2548	2700	2700	2700
			Control of Tuberculosis	New Sputum Positive (NSP) Success rate	%	88.0	88.0	88.0	88.0	88.0
				Default rate amongst CAT-II patients	%	-	-	13	13	13
				MDR TB Cases notified put on treatment.	%	-	-	50.0	50.0	50.0
			Reduction in Prevalence of Blindness	Cataract Surgeries performed (in Lakhs)	Number	65	68	66	66	66
				Spectacles to school children screened with refractive error (in Lakhs)	Number	3	4	7.2	7.2	7.2
				Collection of donated eyes for corneal transplantation	Number	60000	60000	45000	45000	45000
			Strengthening facilities for diagnosis and treatment of cancer	Development of District Cancer Facilities	Number	70	75	70	70	70
				Strengthening of Tertiary Cancer Centres	Number	6	5	4	4	4
			Establishment of Tobacco Testing laboratories	Operationalization of new Tobacco Testing labs for Nicotine and Tar	Number	4	6	4	4	4

Sl. No.	Objective	Weight	Action Points	Success Indicators		Actual value	Anticipated value	Target value	Projected value	Projected value
				Success Indicator	Unit	2011-12	2012-13	2013-14	2014-15	2015-16
1	2		3	4	5	6	7	8	9	10
5	**Reducing overall disease burden of the society**		Ensure availability of minimum mental health care services	Starting of Academic Session in Centres of Excellence	Number	1	1	4	4	4
				Approval for starting up of PG courses in Mental Health Specialities	Number	-	-	20	20	20
			Opportunistic screening, diagnosis and management of Diabetes, Cardiovascular Diseases and Stroke	Set up NCD Clinics and Cardiac Care Units in District Hospitals	Number	70	80	70	70	70
				Screening of NCDs at District Hospital and below	Number	70	80	70	70	70
			Provide Health Care to the Elderly Population	Operationalization of Geriatric OPD and 10 beds ward at District Hospitals	Number	70	80	75	75	75
				Establishment of Regional Geriatric Centres	Number	8	4	4	4	4
				Establishment of National Institute of Aging at AIIMS, Delhi & MMC, Chennai	Number	-	-	1	1	1
6	**Strengthening Seconday and Tertiary health care**	10.0	Setting up of Institutions (6 No.)	Commencement of Nursing Teaching Academic Session in Medical Colleges	Number	-	-	4	4	4
				Completion of construction work in Hospitals	%	-	-	90	90	90
			Upgradation of Govt. Medical colleges (8 No.)	completion of construction work	Number	-	-	3	3	3

Section: 4

DESCRIPTION AND DEFINITION OF SUCCESS INDICATORS AND PROPOSED MEASUREMENT METHODLOGY

1. PRIMARY HEALTH CENTRES (PHCS)

PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/Basic Minimum Services (BMS) Programme. As per minimum requirement a PHC is to be manned by a Medical Officer supported by 14 paramedical and other staff. There were 23,887 PHCs functioning in the country as on March 2011.

STAFF FOR NEW PRIMARY HEALTH CENTRE

1. Medical Officer 1
2. Pharmacist 1
3. Nurse Mid-wife (Staff Nurse).....1 + 2 additional Staff Nurses on contract
4. Health Worker (Female)/ANM.....1
5. Health Educator 1
6. Health Assistant (Male).....1
7. Health Assistant (Female)/LHV.....1
8. Upper Division Clerk 1
9. Lower Division Clerk 1
10. Laboratory Technician.....1
11. Driver (Subject to availability of Vehicle).....1
12. Class IV.....4

Total (excluding contractual staff):.....15

2. OPERATIONALISATION OF 24 X 7 FACILITY AT PHC LEVEL

To ensure round the clock access to public health facilities, Primary Health Centres are expected to provide 24-hour service in basic Obstetric and Nursing facilities. Under NRHM, PHCs are being operationalized for providing 24X7 services in a phased manner by placing at least 1-2 Medical Officers and more than 3 Staff Nurses in these facilities. All 24x7 PHCs, providing delivery services, would also have new-born care corners and provide basic new born care services including resuscitation, prevention of infections, provision of warmth and early and exclusively breast feeding.

3. COMMUNITY HEALTH CENTRES (CHCS)

CHCs are being established and maintained by the State Government under MNP/BMS programme. As per minimum norms a CHC is required to be manned by four Medical Specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff (See Annexure-D for IPHS norms). It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations. As on March, 2011, there are 4,809 CHCs functioning in the country.

STAFF FOR COMMUNITY HEALTH CENTRE:

1. Medical Officer (One trained in Public Health & remaining 3 should be qualified Surgeon, Obstetrician, Physician, Pediatrician).....4
2. Nurse Mid– Wife(staff Nurse).....7
3. Dresser.....1
4. Pharmacist/Compounder 1
5. Laboratory Technician.....1
6. Radiographer 1
7. Ward Boys.....2
8. Dhobi.....1
9. Sweepers 3
10. Mali.....1
11. Chowkidar 1
12. Aya.....1
13. Peon.....1

Total: 25

4. FIRST REFERRAL UNITS (FRUS)

Upgradation of District Hospitals, Sub District Hospitals and Community Health Centres as First referral Units is being attempted to provide for Comprehensive Obstetric Care for Women and Acute Respiratory Infection (ARI) treatment for children. It requires holistic planning by linking Human Resources, Blood Storage Centers (BSCs) and other logistics. The definition of FRU includes the following three components.

a. Essential Obstetric Care
b. Provision of Blood Storage Unit
c. New Born Care Services

FRU Guidelines could be refer to, if necessary.

5. MOBILE MEDICAL UNITS (MMU)

The main objective is to provide basic healthcare facilities in remote, far-flung hilly and tribal areas through the use of Mobile Medical Units. As a first step, it is envisaged to have one MMU in all the districts in the country.

6. PATIENT TRANSPORT SYSTEM

Transportation from the site of accident or home or any other place to nearest appropriate First Referral Unit hospital in case of medical need, and transportation from a Medical Facility to a higher medical facility.

7. SPECIAL NEW BORN CHILD CARE UNITS (SNCU)

These are specialised new born and sick child care units at district hospitals with specialised equipment, which include phototherapy unit, oxygen hoods, infusion pumps, radiant warmer, Laryngoscope and ET tubes, nasal cannulas Bag and mask, and weighing scale.

These units have a minimum of 12 to 16 beds with a staff of 3 physicians, 10 nurses, and 4 support staff to provide round the clock services for a new born or child requiring special care such as managing new-born with neonatal sepsis and child with pneumonia, dehydration, etc., prevention of hypothermia, prevention of infection, early initiation and exclusive breast feeding, post-natal care, immunisation and referral services.

8. VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE (VHSNC)

VHSNC is expected to prepare village level health action plan. It comprises Panchayat president / member, representative from civil society, Anganwadi Worker (AWW) and Auxiliary Nurse Midwife (ANM). To encourage Panchayats to constitute VHSNCs, untied grants are given through NRHM. These grants are used to meet local health needs of the villages, including maintenance needs of the Sub-centres.

9. HIGH PRIORITY/FOCUSSED STATES/DISTRICTS

The mission cover the entire country. The 18 high focus state are Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, Himachal Pradesh, Jammu and Kashmir, Assam, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Mizoram, Sikkim and Tripura. The rest of the states have to follow the pattern of high focus states for programme management units and up-gradation of SC, PHC and CHC through integrated financial envelope.

The State Health Mission shall prepare the roadmap for architectural correction of the Health System, including merger/integration of vertical structures; delegation and de-centralisation of administrative and financial powers; empowering the PRIs; preparation of Operational Guidelines for the implementation of the Mission; logistics arrangements; disease surveillance; IEC; and MIS, whereas, the District Health Mission shall control, guide and manage all public health institutions in the district and at sub-district levels. It will be responsible for preparation and implementation of an integrated District Action Plan in respect of funds received from all funding agencies into the District Health Fund.

10. Auxiliary Nurse Midwives

The Auxiliary Nurse Midwives is one of the main agents for increasing the utilization of health & Family Welfare Services in India. An ANM is expected to participate in Maternal Health, Child Health and Family Planning Services; Nutrition Education; Health Education; Collaborative Service for Improvement of Environmental Sanitation; Immunisation for Control of Communicable Diseases; Treatment of Minor Ailments and First Aid in Emergencies and Disasters.

In addition to these duties, the ANM would perform the following functions in guiding and training the female Accredited Social Health Activist (ASHA), as envisaged in the Guidelines on ASHA, under NRHM:

- Holding weekly / fortnightly meeting with ASHA to discuss the activities undertaken during the week/fortnight.
- Acting as a resource person, along with Anganwadi Worker (AWW), for the training of ASHA.
- Informing ASHA about date and time of the outreach session and also guiding her to bring the prospective beneficiaries to the outreach session.
- Participating and guiding in organising Health Days at Anganwadi Centre.
- Taking help of ASHA in updating eligible couples register of the village concerned.
- Utilising ASHA in motivating the pregnant women for coming to Sub-Centre for initial check-ups.

- ASHA helps ANMs in bringing married couples to Sub-Centres for adopting family planning.
- Guiding ASHA in motivating pregnant women for taking full course of iron folic acid (IFA) tablets and TT injections, etc.
- Orienting ASHA on the dose schedule and side affects of oral pills.
- Educating ASHA on danger signs of pregnancy and labour so that she can timely identify and help beneficiary in getting further treatment.
- Informing ASHA about date, time and place for initial and periodic training schedule. ANM would also ensure that during the training ASHA gets the compensation for performance and also TA/DA for attending the training.

ANM is expected to get information from ASHAs regarding the progress made and consolidate the report at PHC level. ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.

11. ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)

The Accredited Social Health Activist (ASHA) is the essential link between the community and the health facility. A trained female community health worker – ASHA – is being provided in each village in the ratio of one per 1000 population. For tribal, hilly, desert areas, the norms are relaxed for one ASHA per habitation depending on the workload

12. INSTITUTIONAL DELIVERIES

Institutional Deliveries include the deliveries in the following categories of health facilities:

- Hospitals
- Dispensaries / Clinics
- UHC/UHP/UFWC
- CHC/ Rural Hospital
- PHC

- Sub Centre
- AYUSH Hospital/ Clinic

13. UN-SAFE DELIVERY

Un-safe delivery is defined as deliveries conducted at home or institute not attended by skilled staff and/or trained birth attendant (dais).

14. IMMUNISATION PROGRAMME

Immunisation programme is one of the essential interventions for protection of children from life threatening diseases, which are avertable.

15. INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)

An Intrauterine Contraceptive Device (IUCD) is a small device made of plastic or copper that is placed into the uterus as an effective method of contraception. Insertion should only be undertaken by a trained family planning professional.

16. POSTPARTUM INSERTION OF COPPER-BEARING INTRAUTERINE DEVICES (IUDS)

Immediate postpartum insertion (within 10 minutes of delivery of the placenta) of copper-bearing intrauterine devices (IUDs) is generally safe and effective, although compared with interval insertion it carries a higher risk of expulsion. Immediate postpartum IUD insertions can be implemented in most developing-country settings and any available copper-bearing IUD can be used for this purpose.

17. PREGNANCY REGISTRATION SYSTEMS

System aim to strengthen frontline health workers and the health systems within which they work, by enabling the registration of pregnancies, births and outcomes to achieve targets of reduced maternal, neonatal and infant mortality. Accurate, population-based numerators and denominators can help to improve accountability of the health system to provide expected routine antenatal and post-natal care, as well as emergency support and referral, as needed. Thus pregnancy registration systems can enhance health systems, increase accountability and reduce mortality.

18. NATIONAL INSPECTION & MONITORING COMMITTEE (NIMC) UNDER PCPNDT ACT

GOI has constituted NIMC with following terms & conditions:-:

• Undertake field visits to States/UTs in connection with effective Implementation of the PC & PNDT Act, 1994.

• Convene Meetings with members of the State Appropriate Authority, State Advisory Committee constituted to monitor the implementation of the PC & PNDT Act, 1994.

• Evaluation of records maintained by the District Appropriate Authority, including examination of the consolidated reports of Form-F submitted by all registered USG clinics by the 5th of every month.

• Convene meetings with the District/Sub-district Advisory Committees and sensitize members of their roles and responsibilities for implementation of the law.

• Random inspection of records maintained by the facility including Registration (Form-A), renewal, Form-F etc. as per the provisions of the PC & PNDT Act, 1994.

• Facilities the search/Seizure of records/instruments of facilities by District Appropriate Authority, including building up a strong case for conviction of offenders with regard to non-registration of facilities / no maintenance of records, carrying out sex determination services/advertisement of sex determination/violations under the PC & PNDT Act.

• Follow-up with States/UTs with regard to action taken report and court cases, against violations under the Act.

19. UPGRADATION OF IDENTIFIED MEDICAL COLLEGES

Identified Govt. Medical Colleges are upgraded by way of one time grant under central funding for starting PG courses/increasing seats in PG courses.

20. NATIONAL INSTITUTE OF PARAMEDICAL SCIENCES (NIPS) IN DELHI AND EIGHT REGIONAL INSTITUTES OF PARAMEDICAL SCIENCES (RIPS)

Under the centrally sponsored scheme namely "Establishment of NIPS, RIPS and supporting the state governments medical college for conducting paramedical courses through one time grant," the health ministry will establish one NIPS at Najafgarh in Delhi and eight RIPS at Nagpur, Bhopal, Bhubaneswar, Chandigarh, Coimbatore, Hyderabad, Lucknow and Bihar.

21. ANM (AUXILIARY NURSING AND MIDWIFERY) AND GNM (GENERAL NURSING AND MIDWIFERY) SCHOOLS

In order to meet the shortage of nurses and bring the availability of nursing personnel at par with the developed countries new schemes being envisaged for promoting nursing in the country. GOI policy is to open ANM (Auxiliary Nursing and Midwifery) schools and GNM (General Nursing and Midwifery) Schools in those districts, where there are no such schools at present, thereby ensuring that all the districts of the country will have at least one Nursing School.

22. ANNUAL PARASITE INCIDENCE (API)

It is an index to highlight incidence of parasite which can be worked out through following formula:

API = (confirmed cases during 1 year/population under surveillance) x 1000.

23. ENDEMIC DISTRICTS

Asymptomatic carriage of malaria/Filariasis parasites occurs frequently in endemic areas and the detection of parasites in a blood film from a febrile. In areas of very high transmission such estimates of the attributable fraction may be imprecise because very few individuals are without parasites. Furthermore, non-malarial fevers appear to suppress low levels of parasitaemia resulting in biased estimates of the attributable fraction.

24. MALARIA:

The following indicators are used for assessment of Malaria:

a. Surveillance – Annual Blood Examination Rate (ABER): Percentage of total no of slides examined annually out of total population under surveillance. This is calculated as:

$$\frac{\text{Number of Slide Examined in the Year}}{\text{Population under surveillance}} \times 100$$

b. Incidence of Malaria – Annual Parasite Incidence (API) : Confirmed Malaria Cases annually per 1000 population under surveillance. This is calculated as :

$$\frac{\text{Number of confirmed malaria cases in the Year}}{\text{Population under surveillance}} \times 1000$$

25. FILARIA

The indicator for elimination of Lymphatic Filarisis is the 'coverage of eligible people under Mass Drug Administration' (MDA)

This is calculated as :

$$\frac{\text{Number of people administered with anti-filarial drugs during MDA}}{\text{Eligible population at the risk of filarial}} \times 100$$

26. KALA AZAR

The indicator used for Kala-azar detection is annual new case detection of Kala-azar per 10,000 population.

$$\frac{\text{Number of Kala-azar cases in the Year}}{\text{Kala-azar Endemic Population}} \times 10000$$

27. LEPROSY:

Annual New Case Detection Rate (ANCDR) =

$$\frac{\text{Number of new cases detected during the year}}{\text{Population as on 31st March}} \times 100000$$

28. HIGH BURDEN DISTRICTS

209 High burdened districts have been identified with annual prevalence rate of <10 per lakh population for eradication of Leprosy through focused attention. Prevalence Rate (PR) is 3.74/10,000 population (March 2001) which was 57/10,000 in 1981. Elimination level <1/10,000) achieved in 13 states. 4 State close to achieve elimination Leprosy is endemic mainly in states of Bihar, Jharkhand, Chattisgarh, U.P., West Bengal, Orissa and M.P. where 64^% are found. Bihar has 24% of recorded leprosy cases in India. A total of 5.59 lakh cases were detected in India by 2000-2001 due to intensification of the programme, the highest number of cases detected in any year. Annual new cases detected were 4 to 7.8 lakh. Out of the total 18.5 % were children. Deformity cases (Grade-II and above) amount new cases were 2.7%. MB cases among new cases were 34%. Single lesion cases among new cases were 10% but vary from area to area. It varies from 22% in Wardha to more than 80% in Tamil Nadu, India.

23 TUBERCULOSIS

The term "case detection" denotes that TB is diagnosed in a patient and is reported within the national surveillance system. Smear-positive is defined as a case of TB where Mycobacterium tuberculosis bacilli are visible in the patient's sputum when properly stained and examined under the microscope.

'New Case' denotes a patient who has never taken TB treatment in the past or has taken anti TB treatment, but for less than 1 month.

New Smear positive case detection rate is calculated by dividing the number of new smear positive cases notified in the specific cohort (quarter/year) by the estimated number of new smear positive cases in the population for the same quarter/year expressed as a percentage.

The term new smear positive treatment success rate denote the proportion of new smear positive TB cases cured or treatment completed to the total number of new smear positive TB cases registered in the specific cohort (quarter/year).

24. CATEGORY II TREATMENT UNDER TUBERCULOSIS PROGRAMME

Management of patients who have been previously treated for tuberculosis (TB) has been a cause of much debate.1 In 1991, the World Health Organization (WHO) recommended the use of the "category II retreatment regimen" for all patients with a prior history of TB treatment. The category II regimen added streptomycin to the first-line agents and extended treatment to 8 months. Multiple observational studies have examined outcomes among individuals receiving category II treatment and shown mixed results. Overall success rates are in the 60–80% range, with notably worse outcomes seen among patients who failed or relapsed after their initial treatment episode.

25. MULTI-DRUG-RESISTANT TUBERCULOSIS (MDR-TB)

Multi-drug-resistant tuberculosis (MDR-TB) is defined as tuberculosis that is resistant to at least isoniazid (INH) and rifampicin (RMP), the two most powerful first-line treatment anti-TB drugs. Isolates that are multiply resistant to any other combination of anti-TB drugs but not to INH and RMP are not classed as MDR-TB. MDR-TB develops in otherwise treatable TB when the course of antibiotics is interrupted and the levels of drug in the body are insufficient to kill 100% of bacteria. This can happen for a number of reasons: Patients may feel better and halt their antibiotic course, drug supplies may run out or become scarce, patients may forget to take their medication from time to time or patients do not receive effective therapy. Most tuberculosis therapy consists of short-course chemotherapy which is only curing a small percentage of patients with multi-drug resistant tuberculosis. Delays in second line drugs make multi-drug resistant tuberculosis more difficult to treat. MDR-TB is spread from person to person as readily as drug-sensitive TB and in the same manner. Even with the patent off second line antituberculosis medication the price is still high and therefore a big problem for patients living in poor countries to be treated..

26. NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

The National Programme for Control of Visual Impairment and Blindness was launched in 1976 as a 100% centrally sponsored and incorporates the earlier Trachoma Control Programme that was started in 1963 to reduce the prevalence of blindness (1.49% in 1986-89) to less than 0.3%; and to establish an infrastructure and efficiency levels in the programme to be able to cater new cases of blindness each year to prevent future backlog with the objectives :-

1.To establish eye care facilities for every 5 lakh population,

2. To develop human resources for eye care services at all levels the primary health centres, CHCs, sub-district levels,

3. To improve quality of service delivery and

4. To secure participation of civil society and the private sector.

27. CATARACT

A cataract is a clouding of the lens inside the eye which leads to a decrease in vision. It is the most common cause of blindness and is conventionally treated with surgery. Visual loss occurs because opacification of the lens obstructs light from passing and being focused on to theretina at the back of the eye. It is most commonly due to biological aging but there are a wide variety of other causes. Over time, yellow-brown pigment is deposited within the lens and this, together with disruption of the normal architecture of the lens fibers, leads to reduced transmission of light, which in turn leads to visual problems.Those with cataract commonly experience difficulty appreciating colors and changes in contrast, driving, reading, recognizing faces, and experience problems coping with glare from bright lights

28. NATIONAL CANCER CONTROL PROGRAMME

In India it is estimated that there are 2 to 2.5 million cancer patients at any given point of time with about 0.7 million new cases coming every year and nearly half die every year. Two-third of the new cancers are presented in advance and incurable stage at the time of diagnosis. More than 60% of these affected patients are in the prime of their life between the ages of 35 and 65 years. With increasing life expectancy and changing life styles concomitant with development, the number of cancer cases will be almost three times the current number. It has long been realised that cancers of the head and neck in both sexes and of the uterine cervix in women are the most common malignancies seen in the country. The age adjusted incidence rate per 100,000 for all types in India in urban areas range from 106-130 for men and 100-140 for women but still lower than USA, UK and Japan rates. 50% of all male cancers are tobacco related and 25% in female (total 34% of all cancers are tobacco related). There are predictions of incidence of 7 fold increase in tobacco related cancer morbidity in between 1995-2025. To control this problem the Govt. of India has launched a National Cancer Control Programme in 1975 and revised its strategies in 1984-85 stressing on primary prevention and early detection of cancer with goals

1.The primary prevention of tobacco related cancers.

2.Secondary prevention of cancer of the uterine cervix, mouth, breast etc.; and

3.Tertiary prevention includes extension and strengthening of therapeutic services including pain relief on a national scale through regional cancer centres and medical colleges (including dental colleges).

District Cancer Control Programme

This programme was launched in 1990-91 and under this programme each state and union territory has advised to prepare their projects on health education, early detection, and pain relief measures. For this they can get up to Rs. 15 lakh one time assistance and Rs. 10 lakh for four years recurring assistance. The district programme has five elements: 1.Health education; 2.Early detection;

3.Training of medical & paramedical personnels. 4.Palliative treatment and pain relief. 5.Coordination and monitoring. The District programmes are linked with Regional Cancer Centres/ Government Hospitals/ Medical Colleges. For effective functioning each district where programme is started have one District Cancer Society that is chaired by local Collector/Chief Medical Office. Other members are Dean of medical college, Zila parishad representative, NGO representative etc.

29. NATIONAL MENTAL HEALTH PROGRAMME

The Government of India has launched the National Mental Health Programme (NMHP) in 1982, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental health care infrastructure in the country to deal with it aiming for Prevention and treatment of mental and neurological disorders and their associated disabilities; Use of mental health technology to improve general health services and application of mental health principles in total national development to improve quality of life with following objectives:-

1. To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population.
2. To encourage application of mental health knowledge in general health care and in social development.
3. To promote community participation in the mental health services development and to stimulate efforts towards self-help in the community.

30. NATIONAL DIABETES CONTROL PROGRAMME

Diabetes is a chronic disease caused by inherited and /or acquired deficiency in production of insulin by the pancreas or in its effects. As a result of this there is increased concentration of glucose in the blood. In one form, the pancreas fails to produce the insulin that is essential for survival. However, noninsulin-dependent diabetes is much more common. This form of diabetes occurs principally in adults and results from the body's inability to respond properly to the action of insulin. Malnutrition-related diabetes has also been described from some developing countries, like India.

Burden of Disease

The worldwide prevalence of diabetes is 4% (1995) which will be 5.4% in 2025. Prevalence in most Western communities is estimated as 2% - 5%. It is now known that some developing countries it may reach 10% or even 20%. Indian studies showed prevalence of diabetes mellitus ranging from 2.1% in New Delhi to 12.4% in Kerala and rural areas showed lower rates. As diabetes is a chronic disease and need life long treatment causing economic burden on patients and family. The most important aspect of diabetes is occurrence of complications that increases the cost of management. Heart disease in diabetes is 21.4%, neuropathy 17.5%, peripheral vascular disease 6.3%-30%,

Retinopathy 19.0%, and Microalbumina 26.3% . Based on these alarming figures Government of India started National Diabetes Control Programme on pilot basis in 1987 in some districts of Tamil Nadu, J & K and Karnataka with following objectives:-

1. Prevention of diabetes through identification of high risk subjects and early intervention in the form of health education;
2. Early diagnosis of disease and appropriate treatment morbidity and mortality with reference to high risk group;
3. Prevention of acute and chronic metabolic, cardiovascular, renal and ocular complication of the disease;
4. Provision of equal opportunity for physical attainment and scholastic achievement for the diabetic patients; and
5. Rehabilitation of those partially or totally handicapped diabetes people.

LIST OF ABBREVIATIONS		
Sl.No.		
1	ANM	Auxiliary Nurse Midwife
2	API	Annual Parasite Incidence
3	ASHA	Accredited Social Health Activist
4	AYUSH	Ayurveda Yoga-Naturopathy Unani Siddha & Homoeopathy
5	BPHCs	Block Primary Health Centres
6	CHC	Community Health Centre
7	DPMR	Disability Prevention and Medical Rehabilitation
8	FRU	First Referral Unit
9	IMR	Infant Mortality Rate
10	IUD	Intra Uterine Devices
11	MDR-TB	Multi Drug Resistance - Tuberculosis
12	MMR	Maternal Mortality Ratio
13	MMU	Mobile Medical Unit
14	NACO	National AIDS Control Organization
15	NCD	Non Communicable Diseases
16	NIPS	National Institute of Paramedical Sciences
17	PHC	Primary Health Centre
18	PRI	Panchayati Raj Institutions
19	RNTCP	Revised National Tuberculosis Control Programme
20	SC	Sub Centre
21	TB	Tuberculosis
22	TFR	Total Fertility Rate
23	VHSNC	Village Health, Sanitation and Nutrition Committee

Section: 5

SPECIFIC PERFORMANCE REQUIREMENTS FROM OTHER DEPARTMENTS

Section-5
Specific Performance Requirements from other Departments

Department / Ministries	Relevant Success indicator	What do you need?	Why do you need it?	How much you need ?	What happens if you do not get it ?
• Panchayati Raj • Women & Child, • HRD, • Drinking Water • Sanitation • Tribal Affairs, • Home, • Defence, • Youth affairs, • NACO, • AYUSH, • Health Research, • Medical Council of India, • Dental Council of India, • Pharmacy Council of India, • Indian Nursing Council	• Numbers of persons trained under main-streaming training. • Increasing scope & coverage of programmes of the Departments/institutions to promote quality of life impacting health care of citizens of this country. • Numbers of persons trained for providing health services (medical, paramedical & managerial) with adequate skill mix at all levels .	• Guidelines for incorporating various Health & Family Welfare schemes and training programmes, • Constant monitoring to promote quality Health & Family welfare services in the country.	• To strengthen the national response to promote health care of fellow citizens.	• Full support and commitment.	• It would hamper the achievement of National targets and programme outcomes.
• All State Governments	• Number of persons provided quality healthcare services with special focus on under-served and marginalized-group. • Number of comprehensive primary healthcare delivery system established & their well-functioning linkages with secondary & tertiary care health delivery system. • Majority Health related parameters.	• Implement-ation and timely reporting the progress of various Health & family welfare programmes and outcomes.	• To enhance the quality of life of fellow citizens in the country with thrust on health care.	• 100% commi-tment & support for effective implem-entation with constant monito-ring.	• The progress of implementati-on will slow down availability of quality healthcare on equitable accessible and affordable basis across regions & communities with special focus on under-served population & marginalized groups.

Section: 6

Outcome/Impact of Department/Ministry

SECTION 6- OUTCOME /IMPACT OF ACTIVITIES OF THE MINISTRY/DEPARTMENT
Department of Health & Family Welfare 2013-14

Sr. No.	Outcome/Impact of Ministry/Department	Jointly with	Success Indicator	Unit	2011-12	2012-13 (Anticipated)	2013-14 (Projected)	2014-15 (Projected)	2015-16 (Projected)
1	Improved access to health care services	States/UTs	Average number of primary health care centres per 1000 population.	Number	0.0201	0.022	0.0199	0.0198	0.0197
			Average number of primary health care centres per district	Number	37.32	37.45	37.89	38.33	39.03
2	Reduction in Mortality Rate	States/UTs	Infant mortality rate	Per 1000 live births	43	39	35	31	27
			Crude death rate	Per 1000 population	7.1	7.0	7.0		
3	Improvement in Maternal Health	States/UTs	Institutional Deliveries as a % of Total deliveries	%	82	82	75	75	75
			Full Immunization (age group 0-12 Month)	%	87	85	85	86	87
4	Reduction in growth rate of population	States/UTs	Total Fertility Rate	children born per woman	2.5	2.4	2.4	2.3	2.3
5	Reduction in the burden of communicable and non-communicable diseases	States/UTs	Annual Parasite Incidence (Malaria)	Per 1000 population	1.10	0.85	1.10	< 1.0	< 1.0
			Annual prevalence rate of Leprosy < 10 per Lakh population in High burden Districts (209)	Number of Districts	-	-	70	70	70
			Reconstructive Surgeries (Leprosy) performed	Number	2570	2548	2700	2700	2700
			New Sputum positive (NSP) Success rate	%	88	90	92	92	92
6	Development of human resources	States/UTs	Number of doctors per 1000 population	Number	0.074	0.075	0.076	0.077	0.078

Note: 1.The indicator Crude death rate - Point decline over per 1000 population; 2. Leprosy prevalence rates are available from year 2013-14 onwards.

3. The indicator **Infant Mortality Rate** (IMR)- Point decline over per 1000 live births