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| **IDCF 2016 Intensified Diarrhoea Control Fortnight 11th July -23th July 2016** |
| OPERATIONAL GUIDELINES |
| **Ministry of Health & Family Welfare,**  **Government of India** |

***Intensification of efforts towards “zero” childhood deaths due to Diarrhoea across all States & UTs of India***

 

5/10/2016

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# Introduction & rationale

Reduction of childhood mortality is one of the prime goals of National Health Mission. Childhood diarrhoeal diseases continue to be a major killer among under-five children in many states, contributing to 10% of under five deaths in the country. Around 1.2 lakhs children die due to diarrhoea annually in the country. Diarrhoeal deaths are usually clustered in summer and monsoon months andthe worst affected are children from poor socio-economic situations.

Diarrhoea is considered when the stools have changed from usual pattern and are many and watery (more water than faecal matter). Almost all the deaths due to diarrhoea can be averted by preventing and treating dehydration by the use of ORS (Oral Rehydration Solution) and administration of Zinc tablets along with adequate nutritional intake by the child during diarrhoea. Diarrhoea can be prevented with use of safe drinking water, hand-washing, sanitation, immunization and breastfeeding / appropriate nutrition.

The effect of diarrhoeal mortality remains high in children and hence in continuation of the efforts in 2014 and 2015, it has been decided to organise an Intensified Diarrhoea Control Fortnight (IDCF) this year from 11 to 23 July 2016, with the ultimate aim of zero child deaths due to childhood diarrhoea.

Intensified Diarrhoea Control Fortnight (IDCF) is a set of activities to be implemented in an intensified manner from 11 to 23 July 2016 for prevention and control of deaths due to dehydration due to Diarrhoea across all States & UTs, these activities mainly include- intensification of advocacy & awareness generation activities for diarrhoea management, strengthening service provision for diarrhoea case management, establishment of ORS-Zinc corners, prepositioning of ORS by ASHA to households with under-five children and awareness generation activities for sanitation & hygiene.

# Objective and Strategy

## 2.1 Goal of IDCF

**The goal of IDCF is attain zero child deaths due to childhood diarrhoea.**

The overall objective of IDCF is to ensure high coverage of ORS and Zinc use rates in children with diarrhoea throughout the country along with inculcating appropriate behaviour in care giversfor diarrhoea prevention & management of under-five children, with emphasis on the high priority areas and vulnerable communities.

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## 2.2 Specific objectives of IDCF

* To improve awareness on use of ORS and zinc for childhood diarrhoea.
* To complement awareness activities for prevention and management of diarrhoea in under-five children.

The diarrhoeal mortality in India still remains high in under-five children, especially in children under 24 months of age. The ORS and zinc use rate remains low in many states and districts. Effort was made in year 2014& 2015 through intensified diarrhoea control fortnight to position ORS and Zinc at the community level and raise awareness at the household and community level. **Intensified Diarrhoea Control Fortnight (IDCF) as a continued activity in 2016,will be held from 11th July to 23th July 2016.**

## 2.3 Strategy for the IDCF

The focus of IDCF is on delivery of simple proven interventions that have large impact towards control of childhood diarrhoeal morbidity and mortality. The IDCF strategy is three folds, as below:

1. Improved availability and use of ORS and Zn at the community
2. Facility level strengthening to manage cases of dehydration
3. Enhanced advocacy and communication on prevention and control of diarrhoea through IEC campaign.

# Pre- campaign planning

## 3.1 Setting up of the committees

### 3.1.1 IDCF coordination committee

IDCF coordination committee has been established at the MoHFW, Government of India to oversee the implementation of this fortnight. Similar committee should to be established at State and District level. At the State level, Principal Secretary Health or MD – NHM should preferably be leading the IDCF Steering Committee with support from key staff from Directorate of Health and Family Welfare. At the District level IDCF committee should be formed, preferably led by District Magistrate and with support from Chief Medical and Health Officer of the district. At both the State and District level, Program Officer for Child Health and IEC Officer should be included in the Committee.

* **3.1.1a IDCF Steering Committee meeting**: The lead official from State and District shall call a meeting of the Committee *before, during and after* the fortnight to ensure effective implementation of the IDCF.
  + **Departments to be invited for the meeting:** Health and Family Welfare, State Health Resource Centre / ASHA Resource Centre, Department of Women and Child Development, Dept. of Panchayati Raj, Dept. of Water and Sanitation, Dept. of Tribal Welfare, Municipalities, State / District IEC Department / Publication Bureau, song and drama division etc.
  + **Partners to be invited for the meeting:** IAP, IMA, UNICEF, WHO, CHAI, MI and Lead Development Partners of the State in supportive supervision of RMNCHA activities. To improve the support to States, it is proposed that Lead Development Partners may work closely with the State Government during the State level briefing of Districts RMNCHA partners to support respective state to plan, capacity build and monitor activities for the fortnight.
* **3.1.1b Video conference**: Continuous efforts of communication with District through video conference to be conducted by State NHM to sensitize for planning of IDCF. Similarly VC would be undertaken by National coordination committee with States Annex 1 provides suggested agenda items to be covered during meeting/ VCs (*Suggested agenda points for meeting:(Annexure I)*

## 3.2IDCF orientation

One day orientation workshops of various categories of stakeholders need to be carried out.Refer the table below for details of the orientation.

|  |  |  |  |
| --- | --- | --- | --- |
| **Location** | **Participants** | **Contents of orientation** | **Timeline** |
| **State/Regional level** | RDD, CS, DIO, RPM, DPM, DCM, DSO, PO - ICDS | Managerial aspects of IDCF and planning, monitoring and IEC of IDCF. | 15-27 June 2016 |
| **District level** | BPO/ MOs / BCM / BHM/MO- CHC/PHC etc. |
| **Block/PHC level** | AYUSH Medical Officer, Nursing staff, ANM, ASHA& AWW | Technical orientation on diarrhoea management along with programme orientation of IDCF which involves their roles and activities during IDCF. | 27th June-8 July 2016 |

**Important Note: During the capacity building exercise, distribution of ORS and zinc tablets, supportive supervision formats and IEC material should take place and plan of activities should be explained to all frontline workers. Module for technical orientation on diarrhoea management is available in IDCF toolkit**

## 3.3 Need assessment and planning for the supplies and logistic

Special attention to availability of supplies and logistics for the campaign is critical to achieve high coverage. It is important to forecast procurement well in advance and plan made for distribution of ORS and zinc supplies.

**District requirement:**

On an average, one under-five child suffers from 2.44 episodes of diarrhoea per year. Each episode requires ORS and Zinc treatment. This should be taken into account for calculating budget for the District for regular supply.

Therefore, for a district of 20 lakhs population, the following will be required

# 2 lakh ORS sachets for distribution during IDCF (as estimated 2 lakh children

require 1 ORS per family)

# 20,000 ORS sachets and 2,80,000 Zn tablets for ORS-Zn corners

# 60,000 ORS packets and 400,000 Zinc tablets for ASHA / ANM (for treatment of

diarrhoea cases whenever required, minimum of 20 ORS packets and 140 Zinc

tablets with each ASHA / ANM)

**State forecast should be based on cumulative demand of each district in the state.**

In case sufficient stocks are not avaibale, the District or State should undertake procurrmentof ORS and zinc on an urgent basis, but as per rate Contracts and qualified vendors, maintaining quality of supplies.

## 3.4Strengthen and gear up facilities for the IDCF

* Health Facilities to be equipped to provide both OPD and inpatient diarrhoea management.
  + Establishing ORS – Zinc corners for ambulatory care for some dehydration
  + Inpatient care for severe dehydration in diarrhoeal cases
  + Ensure standard treatment protocols for management are available at all facilities
* Cleaning of water tanks in health facilities and overall sanitation and hygiene to be undertaken.
* Schools should be geared up for hand washing demonstration.
* AWCs should be equipped with ORS-zinc corner and demonstration site for hand-washing.

## 3.5 Planning for IEC for the fortnight

The District IDCF committee would undertake:

1. Assessment of available IEC materials such as videos, hoardings, posters, pamphlets and IEC material for free distribution at ORS – Zinc Corners for placement at strategic locations, prior to the Fortnight.
2. IEC material would be provided by National level to State offices and also available on NRHM website[www.nrhm.gov.in](http://www.nrhm.gov.in).
3. Prototypes of additional IEC material are available on the website [www.nrhm.gov.in](http://www.nrhm.gov.in). States are encouraged to use these materials widely for the IDCF campaign. If necessary, adaptation and translation/dubbing in regional language may be carried out at the local level for better awareness generation in the communities.
4. Any other media and mid-media planning for reinforcement of messages on diarrhoea prevention and control

5. However States mayalso use available material with the State that is technically sound material.

# IDCF Campaign

## 4.1 Target beneficiaries

The target beneficiaries for the campaign include:

1. All under-five children ( includes all household members especially caregivers/mothers for community mobilization\*)
2. Under 5 years children suffering from diarrhoea

**\*However, for involvement of this core audience, a large number of secondary audiences that influences them would be involved such as School teachers/children, PRI members, Health & ICDS functionaries, private practitioners etc.**

## 4.2Priority populations

IDCF is a nationwide drive; however the focus should be to saturate the underserved and vulnerable communities.

Key locations reached through ICDF should include:

1. Areas with vacant sub-centres: No auxiliary nurse midwife (ANM) posted for more thanthree months
2. Villages/areas with ANMs on long leave or other similar reasons.
3. High risk areas (HRAs) with populations living in areas such as:
   1. Urban slums with migration
   2. Underserved and hard to reach populations (forested and tribal populations, hillyareas etc.).
4. Other migrant settlements (fisherman villages, riverine areas with shifting populations)
5. Nomadic sites
6. Brick kilns
7. Construction sites
8. Orphanage
9. Street children
10. Areas known for or with diarrhoeal outbreaks, in last two years.
11. Areas known for poor sanitation and water supply.
12. Small villages, hamlets, dhanis, purbas, basas (field huts), etc.

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# Micro-plans at the village level to be compiled by ANMs and block level by Medical Officer Incharge and District level by CMO. Template for the micro-plan is *annexed(AnnexureV,VI)*

# Activities during IDCF 2016

The following activities to be undertaken during the fortnight:

## 5.1 At the community / village level

### 5.1.1 Distribution of ORS and demonstration at the household level

* Every ASHA to distribute ORS sachets to all families with under five children.
* During the household visit ASHA will deliver the key messages to the mothers / families (Key messages in box on Page 14).
* A group demonstration for the preparation of the ORS solution will be conducted by ASHA. It will involve gathering of members from 4-8 households and demonstrating the steps for preparation of ORS solution. Understanding of the caregivers same must be checked after the demonstration.
* ASHAs will also educate families on the importance of hygiene and sanitation.
* ASHA will undertake identification and referral of diarrhoeal cases to ANM/ health facilities and also educate mothers on the danger signs.
* ASHA will report all diarrhoeal deaths during the fortnight.
* At the end of Fortnight a report will be submitted by ASHA→ANM→BCM (Block DEO will compile the data)→ DCM (DM&E will compile the data)→State Health Society.
* The activity of the village to be monitored by ANMs

**Note: ASHA should distribute her workload in such a way that she covers all the households of under-five children in 15days. On an average there will be 100-130 under-five children in a village, so the ASHA will visit 10 under-five children in a day that implies 4-8 households. Every ASHA would be provided an incentive of Rs. 1 per ORS packet distributed to a family with under five children.**

**Special emphasis need to be given to remote areas and marginalized populations, enlisted areas, areas under Polio micro-plan,flood prone districts/areas.**Community level activities provide the last mile connectivity and complete execution of the programme and hence must be implemented effectively.

### 5.1.2 IPC activities by ANM on sanitation & hygiene along with management of diarrhoea.

1. During the fortnight,ANM should conduct IDCF meeting in her Sub centre village and VHNDs (as per her existing micro-plan)to disseminate information on prevention & control of diarrhoea, esp. involving care givers of under-five children.
2. ANM should start the session with key message of the IDCF campaign highlighting importance of ORS and Zinc, continued feeding, hand-washing in control of childhood diarrhoea.
3. ANM should carry out Participatory learning technique on sanitation & hygiene, as per Annexure XI. Active participation of Dept. Of Water and Sanitation at States/District level may be taken to carry out this activity.

### 5.1.3 Hand-washing demonstration in schools

1. This activity needs to be carried out in all primary and middle schools.
2. Each school should have poster pasted at the hand washing area on steps for effective hand washing.
3. After the morning assembly / prayers, message on importance of hand washing should be delivered to all the students.
4. Before mid-day-meal, all children should be taught to wash hands following the steps in the poster with water and soap.
5. Prabhat pheri or rally by school children on topic of hand-washing to be carried out.

**5.1.4 Mobile health teams for urban areas**to cover children in urban slums, migrant population & street children.

1. Mobile teams should be formed, with the cooperation from Municipalities, for visiting slums, floating population etc.
2. There should be high visibility of activities through posters, banners, FM radio should be undertaken.
3. ORS – Zinc corners should be established in medical colleges, district hospital, Urban Health Post / Urban Primary Health Centres.
4. The private paediatricians / medical practitioners through IAP / IMA should be involved for setting up of ORS – Zinc corners in their clinics and wards.
5. Urban ASHA (USHA), wherever available will work as outlined for rural ASHA.

## 5.2 At the facility level

### 5.2.1 Establishment of ORS- Zinc corners for treatment of diarrhoea:

1. ORS- Zinc corner should be established for treatment of diarrhoea in OPD and paediatric ward and for promotion in a easily noticeable area on entrance of hospital in following health facilities/Anganwadis:
   1. Medical Colleges
   2. District Hospital
   3. Block CHC / PHC
   4. Subcentre
   5. Anganwadi centres
   6. Private medical practitioners

**ORS- zinc corners to be set up at Anganwadi centres in each village, so that effective ORS demonstration for care givers of under-five children takes place in each village. Active involvement of WCD department at State/District/Block is needed to implement this activity.**

1. At these corners, demonstration of ORS preparation along with Zinc regimen will be done along with display of IEC material for awareness generation for all patients attending OPD for any ailment. In order to establish ORS- Zinc corner, refer to Annexure X.
2. During the IDCF, all facilities should have sufficient availability of ORS and Zinc dispersible tablets at all Health facilities.
3. Tertiary level facilities with Nutritional Rehabilitation Centres must be geared up for management of SAM children with diarrhoea as per GoI NRC guidelines.
4. Arrangements for management of severely dehydrated cases as per IMNCI Plan C.
5. Pasting and display of facility appropriate treatment protocols in OPD and paediatric ward/General IPD.Promoting prescription of ORS along with Zinc dispersible tablets for childhood diarrhoea by all healthcare providers.

### 5.2.2 Promote standard case management of diarrhoeal cases

The standard treatment protocol for management of childhood diarrhoea is as below. For Plan A,B,C refer to IDCF toolkit.

1. Diarrhoea cases with no dehydration will be treated with ORS, extra oral fluids and Zinc as per IMNCI Plan A.
2. Diarrhoea cases with some dehydration will be managed for rehydration with ORS under observation as per IMNCI Plan B; then shifted either to IMNCI Plan A to C.
3. Diarrhoea cases with severe dehydration will be admitted and rehydrated with IV Ringer Lactate in wards (IMNCI Plan C), once rehydrated will shift to Plan A (ORS, extra oral fluids and Zinc).
4. The above recommendation will be for treatment of all diarrhoea cases managed by both the government health staff and private medical practitioners- in routine system and during IDCF.
5. Medical officers and nursing staff at health facilities to be oriented on the treatment plan.(Ref.-IDCF toolkit).
6. Pasting and display of facility appropriate treatment protocols in OPD and paediatric ward/General IPD:• Plan A and B in OPD• Plan C in wards

## Intensive Awareness generation

5.3.1 State level Launch: The IDCF Fortnight should be launched by a Minister at State level and by noted political member at District and Sub District level. Raise visibility of the Fortnight by involving Chief Ministers/MPs/MLAs/PRI members. CMs may be asked to lead the movement and address the public through media with the message that No Child Should Die in the State due to Diarrhoea.

5.3.2 District level launch: The Fortnight should be launched at District level by MLA/MP which may be facilitated by IAP. The launch should be widely publicised

5.3.3 Media and mid-media campaign:Awareness generation fortnight using mass and mid media along with folk lore and other means of communication as per population needs should be undertaken in local language.

1. Television and Radio is used to increase reach of the messaging among the target audience, mid media and outreach provide depth to the messaging but have limited reach. Involve Doordarshan with clear messages.
2. Posters, banners, hoardings to be put at strategic locations
3. All the IEC materials & reporting formats should be available with the stake holders 3 days before the Fortnight, or preferably distributed during orientation meeting.
4. Such material has also been developed at National level and would need to be printed at State level and distributed to all health facilities. TV and Radio spots are available on MoHFW website <http://nrhm.gov.in>

5.3.4 Matrix of IEC activities:

|  |  |  |
| --- | --- | --- |
|  | **IEC activity to be undertaken** | **Key person** |
| **State level** | 1. T.V/ radio advertisements 2. State level launch of IDCF by CM/ HM by inaugurating activities in a noted General Hospital 3. Facilitation of Districts by providing IEC material prototypes shared by GoI 4. Facilitation of Districts by providing other printed material- orientation material, FAQs, IDCF guidelines, supportive supervision formats 5. State level monitors to be sent to each District for observation of activities 6. SMS delivery on diarrhoea control through MCTS. | MD(NRHM) |
| **District Level** | 1. Launch of IDCF to be organised jointly by CMO office and Indian Academy of Paediatrics 2. Launch of IDCF by MP/MLA 3. Placing Banners/Posters at Strategic locations 4. Celebrating ORS Day on 29th July | CMO |
| **Schools /Colleges** | Schools:   1. Organise WASH Fortnight in which soap, clean water is provided and hand-washing is observed before Mid Day Meal / School lunch ; Posters on Hand washing to be put in hand washing area 2. Organise Speech/painting competition on diarrhoea and use of ORS and Zinc followed by a lecture by BMO/MO on Diarrhoea and ORS and Zinc use Colleges 3. Organise Speech competition on Diarrhoea and use of ORS and Zinc followed by a lecture by BMO/MO on Diarrhoea and ORS/Zinc use | BMO/Active MO of CHC,PHC |
| **Block Level** | 1. Special session on Childhood Diarrhoea- ORS/Zinc in meeting of Block PRI members (Funds from RPI system) 2. Similar session in BDC meeting 3. Daily miking for key messages 4. Placing Banners/Posters at Strategic locations | BMO/BHO |
| **Village level** | Wall Painting in each village on use of ORS/zinc, WASH | PHC MO |
| Goshthi/village level discussion on Diarrhoea management | ANM/ MO |
| Daily Miking | PHC MO |
| **Others** | Messaging about ORS and Zinc through Munadis/Nukad Natakas/ Folk lore | MO |

## 5.4 Multi-sectoral involvement

Multi-sectoral involvement is essential for activities that generate momentum and awareness such as carrying out rallies & competitions at Schools, conducting meetings with Panchayati Raj at District/Block level, awareness generation in remote areas by involving tribal department, State and District level launch by leaders, involvement of IAP, mother meetings and demonstrations at Anganwadi Centres.

1. All line Departments for Launch activity: Departments such as WCD, Drinking water and sanitation, Rural development, Panchayati Raj and Education along with IAP, development partners should be invited and commitment should be extracted for IDCF.
2. Department of WCD, for establishing ORS-zinc corners In AWCs: Instruction to be issued by the department to their staff informing the IDCF activities and their role.
3. Education department, for handwashing demonstration and competitions at schools: Instruction to be issued by the department to their staff informing the IDCF activities and their role.
4. Panchayati Raj: For assistance in ORS corners in AWCs and dissemination of key messages through Meetings in Panchayati Raj Institution meetings, block development meetings.
5. Involvement of Indian Academy of Paediatrics (IAP) / Indian Medical Association (IMA) / other NGOs: IAP may be involved in this fortnight. The various activities proposed are :

• Facilitating launch though State and District Health Mission

• Organising sensitisation meeting of Chemists, local Practitioners regarding ORS and Zinc use and rational use of antibiotics in case of diarrhoea.

# Key messages for awareness generation to be used during fortnight

**To be used by DDO/CMO/BMO/BHO/MO/Managers/ANM/ASHA/AWW**

* Give ORS and extra fluids to child immediately at the onset of diarrhoea (3 or more loose stools in one day) and continue till diarrhoea stops.
  + Giving Zinc for 14 days for children suffering from diarrhoea , even if diarrhoea stops.
  + Use of ORS and Zinc during diarrhoeal episodes among children is a safe treatment which makes the child recovers from diarrhoea faster.
  + Safe and quick disposal of child’s faeces.
  + Continue feeding, including breastfeeding in those children who are being breastfed & give extra feeds during and after illness.
  + Use clean drinking water after safe handling.
  + Mother should wash with soap before preparation of food, before feeding the child and after cleaning stool of child.
  + Return to the health worker / centre if the child develops the following during treatment:
  + *Childbecomessicker*
  + *Notabletodrinkorbreastfeed*
  + *Bloodinstool*
  + *Drinkingpoorly*
  + *Developsa fever*
  + Contact your ASHA or ANM on any advice on diarrhoea.

# 6. Supportive supervision and monitoring

* National level teams will be carrying out supportive visits to oversee the implementation of fortnight and similarlythe State would monitor IDCF activities by sending dedicated personnel to monitor activity at district level. NPMU would carry out IDCF monitoring in high priority districts.
* The district IDCF committee will act as a nodal committee for all supportive supervision activities at sub-district level. They will plan for their own supervisory visit during the fortnight and also guide Block PHCs for developing supervisory plan and its proper implementation. Dedicated funds are provided for mobility support per district.
* The block supervisors include BMO/BHO, BHM, BCM, AYUSH, MOIC and others. They will visit at least 10% of the AWW, ORS-Zinc corners and 2% of households provided with ORS for confirmation during the Fortnight period.
* The overall community mobilisation and the IEC activities should be monitored.
* Under RMNCH+A intensification, the lead agency will monitor its implementation through District coordinators placed in 184 HPDs.
* **Involvement of development partners and NGOs and reaching for poor performing districts**: Special focus should be provided to High Priority Districts, other poor performing areas, remote and tribal blocks, slums, areas prone to Diarrhoeal outbreaks based on previous year’s data. Development partners and other NGOs working in field of diarrhoea management should also be roped in for better coverage and quality of Fortnight. Technical expertise available with major development partners can be used to orient State and District Health Officials to conduct the programme. Involve NGOs (eg Rotary) for reaching out in marginalised communities.

(Refer Monitoring guidelines Annexure XII)

# Reporting

* Each ASHA shall provide the filled monitoring formats at the end of the IDCF to the ANM (Within first two days of post Fortnight) i.e. by July 23.
* ANM will submit the compiled report to the Block within the next two days of receiving from ASHA i.e by July 25
* The Block DEO will collate the reports and submit it to the district M and E in another 2 days i.e. by July 27
* The district M&E will submit the compiled duly signed copy to the State level in another 2 days after receiving from the Block by July 29
* State IDCF reports would be sent to National level by 3rd August 2016.

(Reporting formats are in Annexures VI-IX)

# Financial guidelines

Following is only a suggestive structure for expenditure for one District of population of 20 lakh. However, many States have made a lower estimate due to variation in population size of district; hence the approvals would be provided as per actual population and actual no. of ASHAs.

|  |  |  |
| --- | --- | --- |
| **S. No.** | **Activity** | **Estimated expenditure per District (Rs.)** |
| 1. | **ASHA incentive** for prophylactic distribution of ORS @ Rs. 1 per ORS packet delivered to family with under-five children.  [For 100 under-five children per village and approximate 2000 ASHA funds are Rs. 2 lakhs]  **Budget Line: B.1.1.3.5** | **Rs. 2,00,000 \*** |
| 2. | **Printing Costs:**  - monitoring formats  - printing of training material (as in toolkit)  **Budget Line: B.10.3.5** | **Rs. 18,000 \*(Training material printing to be given only to ANM/MO/BMO. ASHA to use her module 6 & 7)** |
| 3. | **Procurement of ORS- for prophylactic distribution:**  [For a district with 20 lakhs population—around 2 lakh under-five children requiring 1 packet@ Rs. 2 (suggestive price per packet)**Budget Line:B.16.2.5** | **Rs. 4,00,000 \*** |
| 4. | **Daily Mobility Support** for field level monitoring- 2 hired vehicles from for two weeks: 2 Vehicle per district  (Rent per day Rs. 1000/vehicle; Fuel Rs.1000/day/vehicle)  =Rs. 2000\*10 days  **Budget Line: A.10.7** | **Rs. 40,000** |
| 5. | **WASH activities in Schools**. **Budget Line: A.4.5** | **Rs. 50,000** |
| 6. | **IEC material printing:** Banners/Posters/Pamphlets for ASHA, Munadi, Nataks **This budget may be expended at State level as printing/Audio visual Airtime cost takes place at State level. Otherwise District may use this fund for printing. Dedicated funds should be provided for village level miking and wall paintings). Budget Line: B.10.3.5** | **Rs. 1,00,000** |
| 7. | **One day orientation meeting** at PHC/Block levels @Rs. 50/ participants for around 3000 health care providers (apart from printing of training material. **Budget Line: A.9.11.3** | **1,50,000\*** |
|  | Total | **Rs. 9.5 lakh per district (approx.)\*** |

**\* This amount is for estimated population of 20 lakh for district. Approval for expenditure would be provided for actual expenditure on reported population and actual number of ASHAs.**

# District Operational plan/Timelines

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl No.** | **Activity** | **Person Responsible** | **Terms of Reference/ Activities** | **Output** | **Timeline** |
|  | **Formation of District IDCF steering committee** | **CMHO** | * **Constitution of IDCF Steering Committee** chaired by District Collector to oversee the implementation * **Regular meetings of Steering Committee** before, during and after the fortnight for oversight, inter-sectoral coordination and reviewing progress | District IDCF Steering Committee functional | By 10th June 2016 |
|  | **Identification of IDCF District Nodal person** | **District Steering committee** | * The nodal person identified for IDCF will be responsible for overall planning and implementation of IDCF activities in the district * S/he will be responsible for organizing Steering Committee meeting, assessing and ensuring the supply of ORS-Zinc in the district, planning and organising District & Block sensitization workshop, development of proper micro-plans, identification of monitors and finalization of supportive supervision plan, ensuring timely availability & distribution of recording, reporting & supportive supervision formats and IEC materials | District Nodal Officer identified | By 13rd June 2016 |
|  | **Assessment of ORS and Zinc Supply and requirement** | **District Nodal person**  **District Nodal person with district pharmacist & Block MO I/c** | 1. **District Nodal person shall assess the requirement of the ORS and Zinc supply for pre-positioning and treatment.**   **Calculation:**  No. of ORS Packets: Total Number of under five children in the district X 1 packet (for pre-positioning[[1]](#footnote-2)) + 20,000 packets (for ORS – Zinc corners) + 60,000 packets for ASHA / ANM  No. of Zinc tablets: 280,000 for ORS – Zinc corners + 400,000 for ASHA / ANM  Example:  For a district of 20 lakhs population the following will be required,   * 2 lakhs ORS packets for distribution * 20,000 ORS packets and 280,000 Zinc tablets for ORS-Zinc corners * 60,000 ORS packets and 400,000 Zinc tablets for ASHA / ANM (for treatment of diarrhoea cases whenever required, minimum of 20 ORS packers and 140 Zinc tablets with each ASHA / ANM)   Thus an estimated **3 lakh ORS packets and 7 lakhs Zinc tablets for district of 20 lakhs population**   1. **Assessing Stock position of ORS and Zinc at district and replenishing the stock based on the requirement** 2. **Replenishing ORS and Zinc stocks at Block (both facility & community level)** 3. **Distribution of ORS to ASHAs based on micro plan provided by ASHA** | 1. Requirement of ORS and Zinc tablet for IDCF 2. Stock position and estimated requirement 3. Blocks have sufficient supply of ORS and Zinc 4. ASHAs have sufficient ORS supply for distribution | By 15th June 2016  By 17th June 2016  By 20th June 2016  By 21st June 2016 |
|  | **Sensitization workshop** | **District Nodal person** | 1. **Planning & organising District sensitization workshop**     1. Block Health officials(BMOs, MOs, BPM / BHM, BCM) Representation from ICDS(CDPO), Education, PRI, local IAP, PHED and NGOs    2. Orientation on activities to be implemented micro planning and reporting & monitoring mechanisms    3. Sensitization on Diarrhoea prevention & management    4. Planning for Block level sensitization meeting    5. Orientation & Distribution of reporting & monitoring formats    6. Development of Monitoring Plan    7. Distribution of IEC materials 2. **Planning and organising Block Orientation workshop**    1. CHC/PHC MOs, LHVs, AYUSH doctors, ICDS Supervisor, ANMs, ASHAs    2. Orientation on activities under IDCF and microplanning    3. Orientation on Diarrhoea prevention & management    4. Distribution of IEC materials | 1. Block level sensitization meeting plan | By 25th June 2016  By 30th June 2016 |
|  | **Operationalizing ORS-Zn Corners at selected health facilities** | **District Nodal person & Facility In-charges of selected facilities** | 1. **Selection of public health facilities –** District Hospitals, Sub divisional Hospitals/Civil Hospitals, CHCs, High case load PHCs 2. **Selection of private nursing homes/clinics in consultation with local IAP/IMA branches** 3. **Ensuring space, necessary infrastructure and logistics**( table/chairs, one bench/bed, ORS, Zn tablets, supply of safe drinking water, necessary utensils like one litre vessel, spoons, glasses, bowls& cups, treatment protocols, IEC materials for display and distribution, nearby toilet & handwashing facilities), **trained staff** for fully functional ORS-Zn corners 4. **Orientation of service providers –**MOs and Staff nurses to manage the ORS-Zn corners | No of operational ORS-Zn corners at health facilities | 1st July onwards |
|  | **Printing of formats-Recording, Reporting format** | **District Nodal person** | 1. **Printing of recording, reporting & monitoring formats** 2. **Distribution of formats during orientation of service providers** | * Recording formats * Reporting formats * Monitoring formats | By 27th June 2016 |
|  | **Micro-planning** | **District Nodal person, District ASHA nodal person & Block Medical Officer** | 1. Orientation of Block health officials on importance /need of micro-planning during district sensitization meeting 2. Orientation of ASHAs on micro-planning during Block Sensitization Workshops and finalizing timeline for submission of micro-plans by ASHAs 3. ASHAs to prepare and submit micro-plan to Block in-charge 4. Block In-charge to submit compiled micro-plans to District Nodal officer 5. Review of all micro-plans | Microplans developed and reviewed | By 2nd July 2016  By 3rd July 2016  By 4th July 2016  By 6th July 2016 |
|  | **IEC activities** | **District Nodal person & District IEC Officer** | 1. Printing of IEC material- Posters/Leaflets (District should also utilise existing IEC material on Diarrhoea along with newly printed IEC material. 2. Distribution of IEC material to Blocks | Printed IEC material distributed | By 27th June 2016  By 1st July 2016 |
|  | **IDCF Supportive supervision** | **District Nodal person** | 1. Preparation of supportive supervision plan at district & Block level    1. Identification of District and Block level monitors    2. Preparation of supportive supervision plan    3. Sharing of supportive supervision formats 2. Supportive supervision of community and facility level activities 3. Sharing of supportive supervision reports /feedback for necessary facilitative actions on daily basis and setting up troubleshooting mechanisms | Monitoring Plan developed and Monitors identified | By 28th July 2016  During the Fortnight |
|  | **Recording and reporting** | **District Nodal Officer, District M&E Officer, District/Block Entry Operators, District ASHA Coordinator /BCM** | 1. Recording and reporting formats distributed to Blocks and ASHAs 2. Orientation on reporting formats and submission instructions 3. ASHAs to submit reports to ANM who submits compiled reports at Block level 4. Block DEO collates and compile block report and Block In-charge shares the compiled report with district 5. CMO shares complied district report with State | Distribution of all recording, reporting and monitoring formats | By 6th July 2016 |
|  | **District Launch Meeting** | **CMO & District Nodal Officer** | 1. Organising District IDCF Launch preferably inauguration by local MLA/MP 2. Representation from ICDS, Education, PRI, IAP, IMA, NGOs | District IDCF launch | 11th July 2016 |

# 

# Annexure I. Agenda for the IDCF planning meeting

1. Review progress / achievement of IDCF 2015.
2. Clarity on role of each department to make IDCF a success.
3. Selection and role clarity of nodal officer from each department to coordinate with other departments.
4. Micro planning: Micro plan has to be prepared to facilitate ASHA visits during the fortnight. Line list available at the village level with ASHA and AWW can be used to identify the houses of under five children and prepare the visit plan during the fortnight.
5. District level plan: Should contain details on ORS – Zinc Corners/ Health Facilities/ Schools, etc which are part of the IDCF Fortnight.
6. Stock assessment of essential commodities viz: ORS sachets and Zinc dispersible tablets
7. Stock assessment of IEC materials: already available materials on ORS – Zinc use, hand washing etc. should be listed and distribution plan prepared. Additional materials should also be used after replication and adaptation to local context. Prototypes of additional IEC materials are available on the website **www.nrhm.gov.in**
8. Involvement of mass media e.g. TV, radio, etc.
9. Mechanism for involvement of other sectors- WCD, Education, PRI, Water & Sanitation, IAP, private practitioners, noted NGOs
10. Chalk out daily supportive supervision and troubleshooting mechanism
11. Plan for State/District level inauguration of the IDCF by elected representatives in a prominent general hospital.

# Annexure II : State operational plan - IDCF 2016

**(to be filled by State IDCF officer that help him/her to take comprehensive preparations)**

**State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total under five population of the district: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nodal Officer of the State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IDCF Secretariat**

|  |  |  |  |
| --- | --- | --- | --- |
| **Names** | **Designation** | **Phone No** | **Responsibility in IDCF** |
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**Supply plan for State**

|  |  |  |  |
| --- | --- | --- | --- |
| **District** | **Commodity** | **Current stock in the district** | **Supply required by district** |
| **A** | ORS |  |  |
| Zinc |  |  |
| **B** | ORS |  |  |
|  | Zinc |  |  |
|  |
| **Total** |  |  |  |
|  |

|  |  |  |
| --- | --- | --- |
| **Commodity** | **Total available Stock in State** | **Total required by districts** |
| ORS |  |  |
| Zinc |  |  |

**Date of IDCF steering committee meeting**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**State level orientation plan**

**Venue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Participants from** | **Number** |
| Health dept (district & block level) |  |
| WCD (district & block level) |  |
| IAP |  |
| Development partners |  |
| Others |  |

**Supply plan:**

**Supply plan:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Commodities** | **For distribution by ASHA** | **For ORS – Zinc corners** | **For treatment by ANM** | **For treatment by ASHA** | **For mobile teams** | **Requirement for IDCF** | **Current stock in block** | **To indent** |
| **A** | **B** | **C** | **D** | **E** | **C = A + B + C + D** | **E** | **F = E– C** |
| ORS  (formula for calculation) | Under 5 population X 1 | No. of ORS Zinc corners X 100 | No. of ANM X 20 | No. of ASHA X 20 | No. of mobile teams X 200 |  |  |  |
| ORS (calculate) |  |  |  |  |  |  |  |  |
| Zinc (formula for calculation) |  | No. of ORS Zinc corners X 700 | No. of ANM X 140 | No. of ASHA X 140 | No. of mobile teams X 140 |  |  |  |
| Zinc (calculate) |  |  |  |  |  |  |  |  |

**ORS – Zinc corners plan:**

|  |  |  |
| --- | --- | --- |
| **Facilities** | **Number** | **Planned ORS – Zinc corners** |
|
| Medical College (OPD) |  |  |
| Medical College (ward) |  |  |
| District Hospital (OPD) |  |  |
| District Hospital (ward) |  |  |
| Block CHC / PHC (OPD) |  |  |
| Block CHC / PHC (ward) |  |  |
| Additional PHC (OPD) |  |  |
| Additional PHC (ward) |  |  |
| Sub-center (OPD) |  |  |
| Private clinics (OPD) |  |  |
| Private clinics (ward) |  |  |

**Number of special VHND / RI session to be conducted by ANM during IDCF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IEC plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sr. No.** | **Materials available in district and block** | **Number required** | **Number already available** | **Number to be printed (national materials)** |
| 1 | ORS – Zinc poster |  |  |  |
| 2 | Hand-washing poster |  |  |  |
| 3 | Leaflet on ORS – Zinc |  |  |  |
| 4 | Leaflet breastfeeding |  |  |  |
| 5 | Leaflet on complimentary feeding |  |  |  |
|  |  |  |  |  |

**Printing of formats**

|  |  |  |
| --- | --- | --- |
| **Sr. No** | **Formats** | **Number** |
| 1 | ASHA planning cum tally sheet |  |
| 2 | Diarrhoea cases line list (ASHA) |  |
| 3 | Block reporting format |  |
| 4 | District reporting format |  |

**Mobile team plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Sr. No.** | **District** | **No. of slums / hard-to-reach areas** | **No. of vehicles / teams** |
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**Supportive supervision from State level**

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| --- | --- | --- | --- | --- | --- |
| **Sr. No** | **Names** | **Designation** | **Phone No** | **District to be visited** | **Date of visit** |
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**Signature of MD – NHM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Annexure III: District operational plan

IDCF 2016 (to be filled by District Health officer that help him/her to take comprehensive preparations)

**District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total under five population of the district: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nodal Officer of the district: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IDCF Secretariat**

|  |  |  |  |
| --- | --- | --- | --- |
| **Names** | **Designation** | **Phone No** | **Responsibility in IDCF** |
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**Date of IDCF steering committee meeting**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**District level orientation plan**

**Venue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Participants from** | **Number** |
| Health dept (district & block level) |  |
| WCD (district & block level) |  |
| IAP |  |
| Development partners |  |
| Others |  |

**Block level orientation plan (Copy and paste as per number of blocks)**

**Name of block: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Venue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Participants** | **In position** | **To be trained** |
| ASHA |  |  |
| ANM |  |  |
| AWW |  |  |
| Staff nurse |  |  |
| MO |  |  |

**Supply plan(compiled from block plans)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Commodities** | **For distribution by ASHA** | **For ORS – Zinc corners** | **For treatment by ANM** | **For treatment by ASHA** | **For mobile teams** | **Requirement for IDCF** | **Current stock in district** | **To indent** |
| **A** | **B** | **C** | **D** | **E** | **C = A + B + C + D** | **E** | **F = E– C** |
| ORS  (formula for calculation) | Under 5 population X 1 | No. of ORS Zinc corners X 100 | No. of ANM X 20 | No. of ASHA X 20 | No. of mobile teams X 200 |  |  |  |
| ORS (calculate) |  |  |  |  |  |  |  |  |
| Zinc (formula for calculation) |  | No. of ORS Zinc corners X 700 | No. of ANM X 140 | No. of ASHA X 140 | No. of mobile teams X 140 |  |  |  |
| Zinc (calculate) |  |  |  |  |  |  |  |  |

**ORS – Zinc corners plan:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facilities** | **Number** | **Planned ORS – Zinc corners** | **For display** | | |
| **Plan A protocol** | **Plan B protocol** | **Plan C protocol** |
| Medical College (OPD) |  |  |  |  |  |
| Medical College (ward) |  |  |  |  |  |
| District Hospital (OPD) |  |  |  |  |  |
| District Hospital (ward) |  |  |  |  |  |
| Block CHC / PHC (OPD) |  |  |  |  |  |
| Block CHC / PHC (ward) |  |  |  |  |  |
| Additional PHC (OPD) |  |  |  |  |  |
| Additional PHC (ward) |  |  |  |  |  |
| Sub centre (OPD) |  |  |  |  |  |
| Private clinics (OPD) |  |  |  |  |  |
| Private clinics (ward) |  |  |  |  |  |

**Number of special VHND / RI session conducted by ANM during IDCF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IEC plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sr. No.** | **Materials available in district and block** | **Number required** | **Number already available** | **Number to be printed (national materials)** |
| 1 | ORS – Zinc poster |  |  |  |
| 2 | Hand-washing poster |  |  |  |
| 3 | Leaflet on ORS – Zinc |  |  |  |
| 4 | Leaftlet breastfeeding |  |  |  |
| 5 | Leaflet on complimentary feeding |  |  |  |
|  |  |  |  |  |

**Printing of formats**

|  |  |  |
| --- | --- | --- |
| **Sr. No** | **Formats** | **Number** |
| 1 | ASHA planning cum tally sheet |  |
| 2 | Diarrhoea cases line list (ASHA) |  |
| 3 | Block reporting format |  |
| 4 | District reporting format |  |
| 5 | Supportive supervision format |  |

**Mobile team plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Sr. No.** | **Block** | **No. of slums / hard-to-reach areas** | **No. of vehicles / teams** |
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**Supportive supervision from district level**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sr. No** | **Names** | **Designation** | **Phone No** | **Blocks / urban area** | **Date of visit** |
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Signature of District Collector:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Annexure IV: Block operational plan

**IDCF 2016 (to be filled by Block Health officer that help him/her to take comprehensive preparations)**

**Block: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total under five population of the block: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Officer of the block: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Block level orientation plan**

**Venue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Participants** | **In position** | **To be trained** |
| ASHA |  |  |
| ANM |  |  |
| AWW |  |  |
| Staff nurse |  |  |
| MO |  |  |

**Supply plan (Compiled from all PHCs):**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Commodities** | **For distribution by ASHA** | **For ORS – Zinc corners** | **For treatment by ANM** | **For treatment by ASHA** | **For mobile teams** | **Requirement for IDCF** | **Current stock in block** | **To indent** |
| **A** | **B** | **C** | **D** | **E** | **C = A + B + C + D** | **E** | **F = E– C** |
| ORS  (formula for calculation) | Under 5 population X 1 | No. of ORS Zinc corners X 100 | No. of ANM X 20 | No. of ASHA X 20 | No. of mobile teams X 200 |  |  |  |
| ORS (calculate) |  |  |  |  |  |  |  |  |
| Zinc (formula for calculation) |  | No. of ORS Zinc corners X 700 | No. of ANM X 140 | No. of ASHA X 140 | No. of mobile teams X 140 |  |  |  |
| Zinc (calculate) |  |  |  |  |  |  |  |  |

**ORS – Zinc corners plan:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facilities** | **Number** | **Planned ORS – Zinc corners** | **For display** | | |
| **Plan A protocol** | **Plan B protocol** | **Plan C protocol** |
| Block CHC / PHC (OPD) |  |  |  |  |  |
| Block CHC / PHC (ward) |  |  |  |  |  |
| Additional PHC (OPD) |  |  |  |  |  |
| Additional PHC (ward) |  |  |  |  |  |
| Subcenter (OPD) |  |  |  |  |  |
| Private clinics (OPD) |  |  |  |  |  |
| Private clinics (ward) |  |  |  |  |  |

**Number of special VHND / RI session conducted by ANM during IDCF: ………………..**

**IEC plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sr. No.** | **Materials available in district and block** | **Number required** | **Number already available** | **Number to be printed (national materials)** |
| 1 | ORS – Zinc poster |  |  |  |
| 2 | Hand-washing poster |  |  |  |
| 3 | Leaflet on ORS – Zinc |  |  |  |
| 4 | Leaftlet breastfeeding |  |  |  |
| 5 | Leaflet on complimentary feeding |  |  |  |

**Requirement of formats**

|  |  |  |
| --- | --- | --- |
| **Sr. No** | **Formats** | **Number** |
| 1 | ASHA planning cum tally sheet |  |
| 2 | Diarrhoea cases line list (ASHA) |  |
| 3 | Block reporting format |  |
| 4 | District reporting format |  |

**Mobile team plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sr. No.** | **Name of slum or hard-to reach area** | **No. of vehicles / teams** | **Name of team members** | **Date of visit** |
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**Supportive supervision from block level**

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| --- | --- | --- | --- | --- | --- |
| **Sr. No** | **Names** | **Designation** | **Phone No** | **Village / slum / hard – to- reach** | **Date of visit** |
|  |  |  |  |  |  |
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Signature of Block Medical Officer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Annexure V: Village level plan for IDCF and implementation checklist

**(For ANM)**

(MOIC to ensure this format is filled for all sub-centres including vacant sub-centres)

Name of the sub-centre:\_\_\_\_\_\_\_\_\_\_\_ Block: \_\_\_\_\_\_\_\_\_\_\_ Name & Mobile no of ANM:\_\_\_\_\_\_\_\_\_\_

ANM roster

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ANM visit plan | | | | | | |
|  | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| Village/ urban area |  |  |  |  |  |  |  |
| Sub Centre |  |  |  |  |  |  |  |
| VHND village(as per routine microplan) |  |  |  |  |  |  |  |
|  | Day 8 | Day 9 | Day 10 | Day 11 | Day 12 | Day 13 | Day 14 |
| Village/ urban area |  |  |  |  |  |  |  |
| Sub Centre |  |  |  |  |  |  |  |
| VHND village(as per routine microplan) |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
|  | List of Vulnerable area to be covered (nomadic/tribal/brick kiln, tea garden etc) |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |

# Annexure VI: Village level plan cum monitoring format for IDCF and implementation checklist

**(For ASHA)**

**District: \_\_\_\_\_\_\_\_\_\_\_\_ Block:\_\_\_\_\_\_\_\_\_\_\_\_\_ Village: \_\_\_\_\_\_\_\_\_\_\_\_\_ Total population:\_\_\_\_\_\_\_\_\_\_\_\_\_Families with under 5 children: \_\_\_\_\_**

**ASHA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mob. No. :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total under five children:** \_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Listing of children (to be done before the campaign i.e. 27-10June)** | | | | | | | **Home visit (11 July – 23July) to be filled during the camapign** | | | | |
| Sr. No | Father name | Mother name | **Child detail** | | | | **Day of visit (Mon / Tue / Wed / Thurs / Fri)** | **Prophylactic distribution of**  **ORS with demonstration**  **(✓ if yes)** | **Does the child suffer from diarrhoea**  **(✓ if yes)** | **ORS & zinc given to the child with diarrhoea**  **(✓ if yes)** | Whether danger sign and referred  **(✓ if yes)** |
| Name | Age | Gender (✓ wherever applicable) | |
| M | F |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Total | | | | |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
|  | List of Vulnerable area to be covered (nomadic/tribal/brick kiln, tea garden etc) |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |

Signature of ASHA: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ SIgnature of ANM:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Annexure VII: Sub-centre reporting format

**District: \_\_\_\_\_\_\_\_\_\_\_\_ Block:\_\_\_\_\_\_\_\_\_\_\_\_\_ Subcenter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ANM Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mob. No. :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Sr. No.** | **Week 1 reporting** | **Number** |
| 1 | Total No. of villages |  |
| 2 | No of villages where ORS was distributed |  |
| 3 | No. of under five children in the villages |  |
| 4 | No. of children distributed with ORS |  |
| 5 | No. of children reported with Diarrhoea during IDCF |  |
| 6 | No. of children with Diarrhoea provided with ORS |  |
| 7 | No. of children with Diarrhoea provided Zinc for 14 days |  |
| 8 | No. of children detected with Danger signs and referred by ASHA |  |
| 9 | No. of villages where VHNSC session on sanitation was conducted |  |
| 10 | Whether ORS – Zinc corner established at subcenter (Yes / No) |  |
| 11 | No. of schools where handwashing demonstration was carried out |  |

**Signature of ANM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Annexure VIII: Block reporting format

|  |  |  |
| --- | --- | --- |
| **Sr. No.** | **Week 1 reporting** | **Number** |
| 1 | Total No. of villages |  |
| 2 | No of villages where ORS was distributed |  |
| 3 | No. of under five children in the villages |  |
| 4 | No. of children distributed with ORS |  |
| 5 | No. of children reported with Diarrhoea during IDCF |  |
| 6 | No. of children with Diarrhoea provided with ORS |  |
| 7 | No. of children with Diarrhoea provided Zinc for 14 days |  |
| 8 | No. of children detected with Danger signs and referred by ASHA |  |
| 9 | No. of villages where VHNSC session on sanitation was conducted |  |
| 10 | No. of ORS – Zinc corner established (including block level) |  |
| 11 | No. of ORS – Zinc corner established in private medical practitioners |  |
| 12 | No. of schools where handwashing demonstration was carried out |  |
| 13 | No. of slums / hard-to-reach areas |  |
| Performance of Mobile teams | |  |
| 14 | No. of mobile teams formed |  |
| 15 | No. of children received ORS from mobile teams |  |
| 16 | No. of children with Diarrhoea provided with ORS |  |
| 17 | No. of children with Diarrhoea provided Zinc for 14 days |  |
| 18. | No. of one day orientation meeting conducted at PHC |  |
| 19. | No. of one day orientation meeting held at block level |  |
| 20. | Cost incurred for meetings |  |
| 21 | No. of IDCF toolkit printed |  |
| 22 | No. of monitoring formats printed |  |
| 23 | Cost incurred on printing |  |
| 24 | Cost of local purchase of ORS and zinc (if any) |  |

# Annexure IX: District and State reporting format

|  |  |  |
| --- | --- | --- |
| 1 | Name of District / State: |  |
| 2 | Name of Nodal Officer Implementing IDCF  Email:  Phone: | ………….  ………….  …………... |
| 3 | No. of Districts conducted IDCF 2016/Total No. of Districts | …../……. |
| 4 | State launch undertaken as per guidelines (Yes/No) |  |
| 5 | No. of Districts where District launch was undertaken |  |
| 6 | No. of ASHAs oriented on IDCF/ No. of ASHA | .…../…….. |
| 7 | No. of ANMs oriented on IDCF/ No. of ANMs | ……/…… |
|  | No. of MO’s oriented on IDCF / No. of MOs | ……/…… |
| 8 | No. of Staff Nurses oriented on Diarrhoea management/ No. of Staff Nurses | ……/…… |
| 9 | Dates of IDCF observation: |  |
| 10 | No. of vehicles hired for field supportive supervision |  |
| 11 | No. of HPDs where supportive supervision was undertaken by DPs/Total no. of HPDs | …../……. |
| 12 | Total No. of villages |  |
| 13 | No of villages where ORS was distributed |  |
| 14 | No. of under five children in the villages |  |
| 15 | No. of children distributed with ORS |  |
| 16 | No. of children reported with Diarrhoea during IDCF |  |
| 17 | No. of children with Diarrhoea provided with ORS |  |
| 18 | No. of children with Diarrhoea provided Zinc for 14 days |  |
| 19 | No. of children detected with Danger signs and referred by ASHA |  |
| 20 | No. of villages where VHNSC session on sanitation was conducted |  |
| 21 | No. of ORS – Zinc corner established (including block level) |  |
| 22 | No. of ORS – Zinc corner established in private medical practitioners |  |
| 23 | No. of schools where hand-washing demonstration was carried out |  |
| Performance of Mobile Teams | | |
| 24 | No. of slums / hard-to-reach areas |  |
| 25 | No. of mobile teams formed |  |
| 26 | No. of children received ORS from mobile teams |  |
| 27 | No. of children with Diarrhoea provided with ORS |  |
| 28 | No. of children with Diarrhoea provided Zinc for 14 days |  |
| 29 | No. of one day orientation meeting conducted at PHC |  |
| 30 | No. of one day orientation meeting held at block level |  |
| 31 | No. of one day orientation meeting held at district level |  |
| 32 | Cost incurred for one day meetings |  |
| 33 | No. of IDCF toolkit printed |  |
| 34 | No. of monitoring formats printed |  |
| 35 | Cost incurred on printing |  |
| 36 | Cost of local purchase of ORS and zinc (if any) |  |

# Annexure X : Set up of ORS – ZINC CORNER

ORS - Zinc Corners are usually meant for childhood diarrhoea with **some dehydration** to be administered ORS under supervision for **4 hours**. Also no-dehydration cases that come directly to facilities could be treated at the ORS – Zinc corners. When there are no diarrhoea cases using the ORS – Zinc corner, the area can be used for treating other problems

**Location**:

ORS – Zinc corners should be permanently at **health facilities** like Medical Colleges, District Hospitals, Block health facilities, sub-centres, private paediatrics facilities etc. Earmark a suitable area in the health facility for the corner. A small corner in the OPD or ward or any other suitable area in the health facility is generally enough for this purpose. The space required would depend on the case load. While earmarking such an area it should be ensured that:

* In case of hospital, the area is close to the workplace of the Doctor so that assessment of the child can be carried out frequently.
* The area is near a toilet or a washing facility, where mothers can clean the child and wash their hands before feeding them.
* Mothers can sit comfortably while administering ORS to their child.
* Pleasant and well-ventilated.

**Timings:**

The ORS – Zinc corners should be functional during OPD timings and 24 hours in paediatrics ward. A health worker who is trained in preparation of ORS solution and Zinc solution, should be posted to manage the corner. The corner should be prominently labeled as *“ORS – Zinc Corner for treatment of diarrhoea”*

**Materials required for management of ORS – Zinc corner**

* One table and two chairs / one bench with a back where the mother can sit comfortably while holding the child should constitute the corner
* Shelves to hold supplies
* Sufficient ORS and Zinc tablets with potable drinking water in a clean container, five glasses (200 ml), bowl / cup, soap, waste-backet, one litre vessel, clean spoons and leaflets should be on the table.

**Counseling at the ORS – Zinc corners:**

* The doctor / staff should counsel the mother in person using MCP card and administration of Zinc for 14 days.
* ORS – Zinc corner is a good place to display informative materials. Banner and poster on ORS – Zinc, hand washing and continued feeding should be displayed at the corner.

**Activities:**

* At least one litter of ORS solution should be prepared daily after washing hands with soap and water. The solution should be kept at the ORS – Zinc corner. It should be readily available to the mother when required. Replenish the solution whenever required. More than 24 hours prepared solution should be discarded and not be used. After the mother has washed her hands thoroughly with soap and water, provide the ORS solution in bowl / cup or glass with spoon to enable her to administer the solution.
* In case of a diarrheal episode during ORS administration, the child and mother and the area should be thoroughly cleaned. After washing hands again with soap and water the mother should administer ORS.
* If the child vomits, the child and mother and the area should be thoroughly cleaned. After washing hands again with soap and water the mother should administer ORS more slowly.
* In case of no-dehydration diarrhoea,
  + Administer ORS solution at the corner for some time till the child is comfortable.
  + Explain the mother on how to prepare the ORS solution, if possible demonstrate.
  + Demonstrate on how to prepare age appropriate Zinc tablet solution in a spoon.
  + Administer the first dose of Zinc tablet solution.
  + Explain when to administer ORS and Zinc.
  + Provide at least one ORS sachet and 13 tablets of Zinc to take home.
  + Advice on age appropriate feeding during diarrhoea
  + Advice when to return
* In case of some-dehydration diarrhoea,
  + Administer ORS solution at the corner for 4 hours
  + Re-asses the child for status of dehydration.
  + In case of no dehydration, follow the above steps for no-dehydration diarrhoea.
  + In case of severe-dehydration, the child needs to be admitted for Plan C treatment.

# Annexure XI: Content for VHSNC meeting to be conducted during IDCF.

ANM should carry out IDCF meeting with VHSNC members in her subcentre village and those villages where her VHND workplan falls in the IDCF weeks. ASHA will mobilize all families with under-five children for the session as well as VHSNC members.

1. ANM should start the session with key message of the IDCF campaign highlighting importance of ORS and Zinc, hand-washing and importance of Sanitation & hygiene in control of childhood diarrhoea.

a. After highlighting importance of hygiene and sanitation, ANM and or ASHA would demonstrate hand-washing with soap and water.

b. ANM will demonstrate preparation of ORS and Zinc, importance of safe water, hand-washing.

c. ANM will communicate on danger signs of diarrhoea.

d. ASHA would distribute ORS to each family with under-five child who are present during the session.

e. If there are cases of diarrhoea then ANM or ASHA will assess the child and provide ORS – Zinc. If child is severely dehydrated then referral will be ensured.

2. PLA technique to be used for advocacy around sanitation & hygiene: PLA (Participatory Learning Approach) techniques should be carried out such as mapping of open defecation areas in and surrounding the village and plan for stopping open defecation should be chalked out, with active participation of VHSNC members and representatives from Department of Drinking Water and Sanitation.

2.1 The ASHA / ANM will ask the participants to say the ailments caused due to water contamination. This could be Diarrhea, Typhoid, Intestinal worms, Abdominal pains, Vomiting etc.

2.2 The ASHA / ANM will ask participants to say what contaminates the water to cause these diseases. A relationship between human faeces, water and the diseases will be established. Focus on how faecal matter slowly recedes into the soil. She will explain how contaminated human faeces get into water and food from open defecation through flies.

2.3 The ASHA / ANM will ask one of the participant’s who had suffered from Diarrhea, about the suffering and cost involved for treatment.

2.4 A calculation of quantity of faeces will be done. For this The ASHA / ANM will ask the participants the average percentage of households that do not have a toilet.

* Average percentage of households that do not have toilet X Total population of the village = No. of people defecating in the open.

• No. of people defecating in the open. X 0.3 kg (average faeces excreted per person per day) = Daily quantity of faeces excreted in open (in kg).

• Daily quantity of faeces excreted X 30 = Monthly quantity of faeces excreted in open (in kg).

• Monthly quantity of faeces excreted per day X 12 = Annual quantity of faeces excreted in open (in kg).

2.5 The importance of use of toilet for defecation will be emphasised.

2.6 A rough map of the village will be drawn on the ground using a stick or stone.

2.7 Geographical areas within the village and it’s vicinity that are used for open defecation (i.e. toilets not used for defecation) will be marked in the map. She will explain how contaminated human faeces get into water and food from open defecation through flies.

2.8 A plan will be made / updated on construction of toilets in the households of the

village.

3. For the above exercise, ASHA may test water from it’s source using the field test kit (H2S vials) that is with the gram panchayats. The result of the test is available in 24 hours. The result can be declared during the above exercise.

# Annexure XII: Monitoring guidelines for IDCF

**State level monitors:**

* The state monitors need to prioritize districts for monitoring IDCF. Priority may be accorded to HPDs, districts that have more hard-to-reach areas, slums, migration points, flood prone, have out-break of diarrhea in last three years.
* A supportive supervision plan needs to be chalked out at the state level for daily monitoring of the chosen districts.
* Carry enough supportive supervision formats with you. Formats to carry are:
  + District level Supportive Supervision Checklist (one for each district)
  + Block / urban level Supportive Supervision Checklist (one per block / urban area)
* During the meeting with district health officials, review the preparedness in terms of District level steering committee meetings (were they chaired by District Magistrate / Collector), stock position of ORS and Zinc, IEC materials, ORS – Zinc corners in OPD and wards, trainings, formats, involvement of WCD & PRI, mobile teams.
* On a daily basis visit, one block or urban area.
  + Prioritize visit to those block / urban areas that have more hard-to-reach areas, slums, orphanages, migration points (railway station, bus stops, taxi stops), flood prone, have out-break of diarrhea in last three years.
  + Meet the Block Medical Officer / Municipal Medical Officer
  + For ORS – Zinc corner prioritize visit to those health facilities that have high patient load viz: Medical college, district hospital, children hospital, block level health facilities etc
  + Visit those villages where VHNSC meeting is planned on the day of visit. Visit the schools of those villages too.
* The monitor needs to apprise the District Magistrate / District Collector of their findings. During the meeting with the DM / DC, highlight 2-3 key actions that the DM / DC needs to ensure to make IDCF a success with the goal of not a single diarrhea death throughout the year.
* Submit the filled formats to National and State IDCF secretariat.

**District level monitors:**

* Prioritize visit to those block / urban areas that have more hard-to-reach areas, slums, migration points (railway station, bus stops, taxi stops), flood prone, have out-break of diarrhea in last three years.
* Carry enough supportive supervision formats with you. Formats to carry are:
  + Block / urban level Supportive Supervision Checklist (one per block / urban area)
* Meet the Block Medical Officer / Municipal Medical Officer to review the preparedness
* For ORS – Zinc corner prioritize visit to those health facilities that have high patient load viz: Medical college, district hospital, children hospital, block level health facilities etc
* Visit those villages where VHNSC meeting is planned on the day of visit. Visit the schools of those villages too.
* The monitor needs to apprise the BMO / Municipal Medical Officer of their findings. During the meeting, highlight 2-3 key actions that the BMO / Municipal Medical Officer needs to ensure to make IDCF a success with the goal of not a single diarrhea death throughout the year.
* Submit the filled format to State IDCF secretariat

**Block level supervisors:**

* As per the supportive supervision planprioritize visit to those villages / areas that have more hard-to-reach areas, slums, orphanages, migration points (railway station, bus stops, taxi stops), flood prone, have out-break of diarrhea in last three years.
* Carry one Village level Supportive Supervision Checklist
* Visit those villages where IDCF - VHNSC meeting is planned on the day of visit. Visit the schools of those villages too.
* Assess the IDCF activities by visiting houses and schools.
* For community level monitoring, the supervisors should hold a quick interaction with a minimum of five respondents in the village to understand the exposure to and understanding of IEC materials.
* The monitor needs to apprise the BMO / Municipal Medical Officer of their findings on a daily basis. During the meeting, highlight 2-3 key actions that the BMO / Municipal Medical Officer needs to ensure to make IDCF a success with the goal of not a single diarrhea death throughout the year.
* Submit the filled format to District IDCF secretariat

**IDCF Toolkit**

Contents:

1. Orientation module
2. Communication Kit for Awareness campaign

(IDCF toolkit is a separate document provided with these guidelines)

**IDCF Secretariat**

**In case of any further information may contact:**

1. **Dr.VandanaGurnani, Joint Secretary (RCH)**

**Email:** [**vandana.g@nic.in**](mailto:vandana.g@nic.in)

**Telefax: 011-23061706**

1. **Dr. Ajay Khera, Deputy Commissioner (Child Health & Immunization)**

**Email:** [**ajaykheramch@gmail.com**](mailto:ajaykheramch@gmail.com)

**Telefax: 011-23061281**

1. **Dr. Sila Deb, Deputy Commissioner (Child Health)**

**Email:** [**drsiladeb@gmail.com**](mailto:drsiladeb@gmail.com)

**Telefax: 01123061218**

1. [↑](#footnote-ref-2)