Third

Common Review Mission

State Report

Dadra & Nagar Haveli

National Rural Health Mission (NRHM)

Common Review Mission 3

Dadra & Nagar Haveli
November 2009

Ministry of Health & Family Welfare
Government of India

1. Team for CRM 3

A six member diverse team was constituted for the Common Review Mission (CRM) to visit the Union Territories (UT) of Dadra & Nagar Haveli. And Daman & Diu . The details of the team members are as follows:

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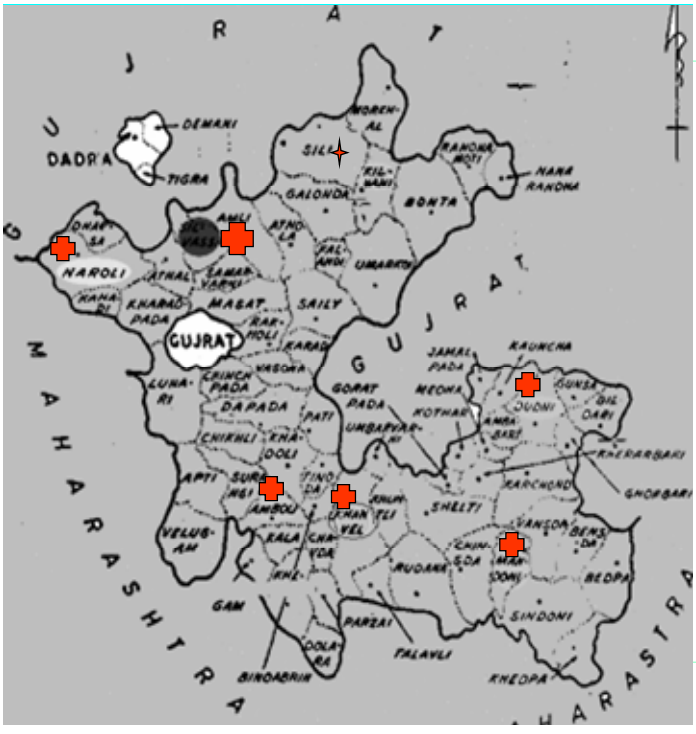
The team after the initial briefing at the two UTs divided into two groups. Team A of two members (Mr. Kal Singh and Dr. Dinesh Agarwal) reviewed the UT of Dadra & Nagar Haveli. and Team B four members (Dr. Sunil D. Khaparde, Dr AT Kannan, Dr.G.S.Meena and Mr Prateek Goel) reviewed UT of Daman & Diu.The two teams made separate presentations to the respective UT officials and have prepared separate report for respective UT. This report focuses on the UT of Dadar & Nagar Haveli.

2. Introduction to the State

1 The Union Territory of Dadra and Nagar Haveli is situated on the western coast of India. The territory is surrounded on the west, north and east by Valsad district of Gujarat and in the south, and south east by Thana and Nasik districts of Maharashtra.The district has a hilly terrain specially towards the north-east where it is surrounded by the ranges of Sahyadri mountains (western ghats). The central region of the land is almost plain and the soil is rich and fertile.

The UT of Dadar & Nagar Haveli has an area of 491 sq. km. and a population of 0.22 million. There is 1 district, 1 block and 70 villages. The UT has population density of 449 per sq. km. (as against the national average of 312). The decadal growth rate of the state is 59.22% (against 21.54% for the country) and the population of the UT continues to grow at a much faster rate than the national rate.



HEALTH INDICATORS OF DADAR & NAGAR HAVELI

The Total Fertility Rate of the State is NA. The Infant Mortality Rate is 34 and Maternal Mortality Ratio is NA (SRS 2004 - 06). The Sex Ratio in the State is 812 (as

compared to 933 for the country). Comparative figures of major health and demographic indicators are as follows:

Table I: Demographic, Socio-economic and Health profile of Dadar & Nagar Haveli State as compared to India figures

S. No.	Item	D&N Haveli	India
1	Total population (Census 2001) (in million)	0.22	1028.61
2	Decadal Growth (Census 2001) (%)	59.22	21.54
3	Crude Birth Rate (SRS 2008)	27.0	22.8
4	Crude Death Rate (SRS 2008)	5.4	7.4
5	Total Fertility Rate (SRS 2007)	NA	2.7
6	Infant Mortality Rate (SRS 2008)	34	53
7	Maternal Mortality Ratio (SRS 2004 - 2006)	-	254
8	Sex Ratio (Census 2001)	812	933
9	Population below Poverty line (%)	17.14	26.10
10	Schedule Caste population (in million)	0.004	166.64
11	Schedule Tribe population (in million)	0.14	84.33
12	Female Literacy Rate (Census 2001) (%)	40.2	53.7

Table II: Health Infrastructure of Dadar & Nagar Haveli

Particulars	Required	In position	shortfall
Sub-centre	50	38	12
Primary Health Centre	7	6	1
Community Health Centre	1	1	0
Multipurpose worker (Female)/ANM at Sub Centres & PHCs	44	38	6
Health Worker (Male) MPW(M) at Sub Centres	38	9	29
Health Assistant (Female)/LHV at PHCs	6	3	3
Health Assistant (Male) at PHCs	6	3	3
Doctor at PHCs	6	6	0
Obstetricians & Gynaecologists at CHCs	1	0	1
Physicians at CHCs	1	0	1
Paediatricians at CHCs	1	0	1
Total specialists at CHCs	4	1	3

Radiographers	1	0	1
Pharmacist	7	6	1
Laboratory Technicians	7	6	1
Nurse/Midwife	13	20	-

(Source: RHS Bulletin, March 2008, M/O Health & F.W., GOI)

The other Health Institution in the State are detailed as under:

Health Institution	**Number**
Medical College	Nil
District Hospitals	1
Referral Hospitals	1
City Family Welfare Centre	0
Rural Dispensaries	3
Ayurvedic Hospitals	-
Ayurvedic Dispensaries	3
Unani Hospitals	-
Unani Dispensaries	-
Homeopathic Hospitals	-
Homeopathic Dispensary	1

The team visited the district of Daman and after the briefing at the UT level, visited the district hospital, CHC, PHC, Sub centres, Anganwadi centres and certain villages. The details in CRM format are as follows:

3rdCommon Review Mission November 2009 –Places visited by the team

3rdCommon Review Mission				
3rd November 2009 to 13th November 2009				
Name of State			Daman & Diu (Union Territory)	
Names of Districts visited				
Sno	Name	District HQ	Name of DM	Name of CMO
1	Dadar & Nagar Haveli	Dadar & Nagar Haveli	Sh. A.K. Singh	Dr Laxminarayan Patra

Health Facilities visited				
Sno	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	Government Hospital	District Silwasa	District Hospital	Med. Supdt. V K Das
2	CHC	Khanvel	CHC	Dr. Ganesh
3	PHC	Dudhani	PHC	Dr. Teja Ram Chowdhury
4	PHC	Mandoni	PHC	Dr. Ishwar
5	Sub Centre	Selti	SC	ANM S J Kurkutiya
6	Sub Centre	Kauncha	SC	ANM Smt. Rubina M Mala
7	Sub Centre	Sindoni	SC	Smt. Kurkute & J S Tariya
8.	GNM School	Sylvassa	Training centre	Med. Supdt. V K Das and Principal
9.	Asha Community Member	Shelti village	Shelti village	ANM Smt. Paru
10.	Asha Community Member	Kauncha	Kauncha	ANM
11.	Asha Community Member	Sindoni	Sindoni	ANM
12.	School	Sindoni	Sindoni	ANM
13.	Anganwari Centre	Sindoni	AWC	Anganwari Worker

3 Desk Review

Desk review comprised of information provided by state on the list of health facilities in difficult and inaccessible areas, notes on physical progress of NRHM against the initiatives approved, progress of NRHM in the state format data sheets and additional information on initiatives provided by the Union Territory.

The information gathered under desk review was validated under the detailed on-field visits and discussions with the health secretary, mission director and other medical and administrative officials of the UT. UT is doing reasonably well on various health indicators and goals of NRHM.

The details of documents under desk review attachd in Annexures and finding are presented in the next section.

4 Findings of 3rd CRM in Union Territory of Dadra and Nagar Haveli

The team studied in detail the 22 indicators for 3rd CRM in the UT of Dadra and Nagar Haveli. The findings are as follows:

Infra Structure Up gradation

- UT programme officials are very keen to address infrastructure gaps so that service delivery especially in rural areas can be strengthened. Labor room construction in 22 sub centers is being undertaken. This is likely to increase access for institutional deliveries to rural women in inaccessible areas.
- Similarly one CHC at Khanvel has upgraded to IPHS. This CHC /FRU caters to significant proportion of poor population. Additionally three dispensaries are being upgraded 24x7 facilities.
- Quality of infrastructure works appears to be good at the places visited by the team. The civil hospital at Sylvassa is very well maintained and infrastructure expansion is being done based on the requirements for service provision.

Human Resources in health

- Resources available under NRHM have been used for getting significant number of contractual staff in position and deployed for service delivery to make facilities functional. Specialist positions vacant at FRU in Khanvel , this is a major barrier in making FRU functional. There is need for commensurate increase in remuneration as per prevailing market rates to attract specialists doctors. Given the relative lack of private sector and dependence on public sector, increased load of clients will mean more staff on contractual positions. While UT budgetary resources should be tapped wherever possible , some additional posts in CH should be considered in the PIP. Team suggested that this year's PIP should reflect HR needs based on mapping . exercise and some redeployment may be needed.

Skill Quality

- RCH training such as SBA and IUD and IMNCI are yet to be initiated in UT. Programme managers are planning to initiate these trainings from this year. There has been inordinate delay in start of these trainings. Doctor trained in LSAS ; not optimally used as no Surgeon or Gynecologist available. There is real risk of skill attrition in such a situation as MO has not been given opportunity to practice newly acquired skills in LSAS. GNM training school has come up recently and running very impressive training programme.

Case Load at the facilities

- Over all high case load at all facilities starting from CH (VBCH) to PHCs .Bed occupancy rates are nearly 110 percent at the CH and CHCs, several instances where patients are kept on floor. In the present year till Sept, nearly 1500 deliveries in the institutions. Over all seems to be more than optimal utilization at facilities, Sub centres are also fully functional as many sub centres reporting delivery and regular ANC care

Preparation of facilities for patient care

- Drugs and other supplies are all available in adequate amounts, nowhere team noticed missing supplies or equipments except for new born care. Somehow simple supplies for essential new born care are missing at PHCs. Non availability of blood storage unit at FRU, Khanvel is a problem, although this is now being undertaken on a priority basis. Service environment elements such as privacy, drinking water etc, are well attended. Untied funds are utililized for addressing service delivery gaps at SCs/PHCs

Outreach activities

- UT is following holding two fixed service delivery days in a village each day and this include monthly Immunization day and MAMTA divas in villages.Generally ANMs and ASHAs mobilize women to come to the facilities especially SCs for conduct of ANCs. Given the presence of large number of SCs, this is possible.
- Dates for service delivery in villages being followed in some areas in place of fixed days for VHNDs. Team was told that this will be changed very soon.
- Good liaison with ASHAs for outreach activities. Generally we found that ASHAs have undergone trainings and are working very closely with ANMs. Additionally we were told that UT is also planning to start for a MMU to cover inaccessible areas

Thrust in Difficult areas

- Entire UT is tribal and many villages in hilly terrain and cut off areas. UT is organizing regular service. In one area (Dudhni) cut off villages are being covered through boats for transport and also organizing regular outreach services.
- Common User groups for mobile also useful to cut time in reaching services in difficult areas. This is particularly happening for transport or even initiating radical treatment for Malaria patients, detected positive at PHCs.

Quality of Services provided

- CH at Sylvassa is providing good quality services as this institution have access to to qualified HR, has a system of tele medicine and very well equipped. C-Section facilities are routinely available.
- Medical Officers need MTP trainings to provide services. Team noticed that MTP services are not available at any of sub district facilities.
- Delivery protocols are not being adhered in absence of SBA trainings, and this is a serious concern. 48 hours stay not happening at facilities. It seems that there is high demand from the clients to early discharge so that they can go home early.
- Need to focus on Standard Treatment Guidelines especially in National Programmes such as NVBDCP. In many instances irrational transcription are being adhered. This not only increase cost of care, but also impacts the clinical outcomes.

Diagnostics

- Very well established system for lab investigations and diagnostic technologies was seen at CH, Sylvassa, which includes Cat Scan under RKS. No wet mount testing undertaken at PHCs for RTIs though LTs are available. It seems that MOs do not routinely write for lab tests for RTIs/STIs. Over all labs are very well equipped and routine investigations are taking place. ICTC is functional at CHC Khanvel

Decentralized planning

- SHS formulated and is meeting regularly. ZP participates in SHS meetings. PIP is being formulated at the UT level. VHSCs are registered and resources to these committees

are yet to be transferred. UT needs to address issues related to capacity building of VHSC members.

- Untied funds are made available at facilities and team found several instances of untied funds being used to improve service quality.

Community Processes

- RKS are fully functional at CHC and CH level, funds transferred and being utilized. RKS meetings at CHC Khanvel are infrequent last meeting in Jan 2009. It appears that some capacity building interventions will be of use for effective utilization of resources available.
- No NGOs in the UT and this is hampering Community Monitoring. UT is planning to invite NGOs from Gujarat to provide technical support in community monitoring.

ASHA

- ASHAs are in place and have been selected by PRIs. It is encouraging to note that ASHAs have undergone trainings in all five modules, which were developed. ASHA support system needs to be established. In absence of support system, it will be difficult to sustain interest of ASHAs in the programme. There were many instances of pending payments especially for JSY although very good system of raising monthly bills for ASHAs; exist, ANMs can pay ASHAs. ASHAs engaged in IEC/BCC activities in community and drug kits are available

Disease Control Programmes

- Fund release is still vertical and largely dependent on sanctions. Delays in fund release is common, no clear cut guidelines being followed for use of funds from other programmes so that activities don't suffer. MOs given additional responsibility for these programmes .Staff fully involved in the programme implementation and service delivery

NVBDCP

- API is high, falciparum prevalence in some areas, chloroquin resistance has been reported from pockets. There is reported resistance to Malathion , entomological investigations are going on in the area.RDKs and IBNs are not available.
- Filaria control activities including mass treatment in place. BCC activities were on at the time of visit of team. Very effective system of social mobilization to ensure mass treatment was evident.

RNTCP

- Very good progress registered in RNTCP implementation on sputum conversion rate ie 92.92 percent last year, and cure rates 84 percent. Microscopic centers at PHCs and DOTs at periphery are fully functional. No vacancies for STS and other functionaries in the programme. Required drug kits are available in adequate quantities.

NBCP

- More than three times achievement of targets in the programme, for last year. Involvement of private hospitals is one of the important component of the strategy. Large number cases from adjoining districts in Gujarat and Maharastra

NIDDCP/IDSP

- Salt testing units established at different levels. Similarly IEC activities for consumption of iodised salt were visible in the field.

RCH 2 Programme

- UT has made significant progress in MH. There is improvement in ANC coverage as compared to previous years. PTC kits available and given to ASHAs and ASHAs are using these kits regularly. Nearly 50 percent deliveries are taking place in Institutions. In many villages home deliveries also attended by ANMs. Investing in SBA trainings will be very useful.
- As far as JSY implementation is concerned, JSY payments by ANMs to clients are on time and no delays were noticed. However there are issues such as no disclosures of beneficiary names at facilities.

- Maternal deaths are being reported .Only 3 maternal deaths reported last year to the programme authority.
- UT need to focus on provision of MTP services especially MVA and Medical abortion facilities. This will entail developing a training plan and also to ensure availability of equipments and supplies.
- Though NICU at CHC and VBCH are fully functional new born care corners needed at PHCs and SCs. Ambu bag for resuscitation are not available in field.
- Good progress in immunization coverage has been registered this year.
- Unmet demand for contraceptive remains high as per DLHS 3. Team did not notice any IUD insertions at SCs, though ANMs appear to be trained. No emphasis on NSV in the programme. ECP not available at periphery and many providers are even not aware about these govt. supplied pills although they remember several commercial brands.

RCH (ARSH)

- UT is running impressive School health programme which is reaching to 300 schools and more than 60,000 children in the UT.It is suggested that a team from GoI can more closely examine this model in light of NSMP and make appropriate recommendation for states to scale up. Team felt that it is possible to delegate and decentralize some of the tasks/activities.

Inter Sectoral convergence

There is effective convergence with HIV as ICTCs are providing services for PPTCT also. Similarly ICDS infrastructure is being used for services delivery. School system fully on board on the SHP.

Nutrition

As this is a tribal district, nutrition needs attention. Though there is some improvements in BF and CF, more needs to be done. Malnutrition grades are being monitored through ICDS. School health programme also need to address prevailing nutritional deficiencies in the UT.

NGO Partnerships

UT is handicapped as there are no NGOs . Considering effective presence of NGOs in neighbouring Gujarat, programme managers are thinking to invite NGOs from the state.

Programme Mangement

PMU is fully functional and well integrated within the system. Overall they are providing necessary support to the programme managers by analyzing data and also ensuring work plan implementation.

Financial management

84 percent of allocated funds utilized last year. Regular Audit reports are available and FMR are submitted in time. Audit report did not point out any major non compliance.

Data Management

Web based reporting started in January 2009 and UT is posting progress regularly. There is good system of data reporting in monthly meeting of SCs using form 6. However there is need to focus on analysis and feedback. UT may like to consider investing in capacity building in use of data may be required.

Status of progress

- **IMR 34, MMR less than 50**
- **TFR 2.4**
- **Mothers with 3 or more ANC: 67 %**
- **Institutional Deliveries: over 50 percent**
- **Fully Covered Immunisation: 87% (ORG Marg Survey)**
- **BF initiated in half hour of birth : 50 percent**

Recommendations

- **In the PIP for year 2010, UT should reflect on need for additional HR to provide quality services. Considering the prevailing market rates UT should submit proposals for higher remuneration for specialists.**

- **Much time has been lost in starting Clinical trainings in RCH. While existing GNM training centre can be used for some the skill based trainings, training of MOs and others also need attention. Training infrastructure available in neighboring states can be used for meeting training load on a priority basis.**
- **Community processes in place; needs more nurturing and investments in capacity building. State should consider NGOs support to roll out community monitoring processes as envisaged in the NRHM.**
- **There is need to focus on STGs adherence so that rational drug therapeutics are adhered. This is true for malaria , malnutrition , scabies management and also for other diseases.**
- **School Health programme being implemented in the states need to be reviewed.**
- **The CH at Sylvassa should be reviewed from hospitals systems perspectives. This hospital, appears to be the state of art, fully computerized, linked with tele medicine can be a good model for replication. However the budgetary implications should be looked more closely before making any recommendations.**

Annexures: Information received from States as part of Desk Review

PROFORMA - I

STATUS OF PRIMARY HEALTH INFRASTRUCTURE

SUB CENTERS, PHCs AND CHCs REQUIRED AND IN POSITION

STATE / UT . : Dadra and Nagar Haveli Report for the year 2009

Health **Institution**	**Required (As per population based on 2001 census)**	**No. Functioning As on 31st March 2008**	**No. Established during the year**	**Total Functioning 2009**
(1)	(2)	(3)	(4)	(5)=(3)+(4)
Sub Centres	44	38	--	38
PHCs	7	6	--	6
CHCs	2	1	--	1

Note: Requirement for Sub Centers should be worked out on the basis of population norm of 5000 population in plane and 3000 population in tribal, hilly, desert and backward areas respectively. For PHCs the population norms are 30000 & 20000 in plain and tribal /hilly/ desert areas respectively. One Community Health Center is for every four PHCs.

PROFORMA –II

SUB CENTERS, PHCs & CHCs REQUIRED IN POSITION IN DIFFICULT AREAS INCLUDING TRIBAL /HILLY/ DESERT AND OTHER BACKWARD AREAS

State/Ut. : Dadra and Nagar Haveli **Report** for the year 2009

Category of area	Rural Population (2001) in lakh	SUB CENTRES		PHCs		CHCs		Remarks if any
		Total required	In position	Total required	In position	Total required	In position	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
i.) Plain Area (A)	154034	31	28	5	4	2	1	
ii.) Difficult area including tribal, hilly, desert and other backward area (B)	66417	13	10	2	2	--	--	
Total (A+B)	**220451**	**44**	**38**	**7**	**6**	**2**	**1**	

iii.) Tribal Area	33492	11	6	1	1	--	--	

Note: Norms for establishment of infrastructure in difficult areas including tribal, hilly, desert and other backward areas.

i) One sub center for every 3000 population,
ii) One PHC for every 20,000 population,
iii) One Community Health Center for every four PHCs .
iv) No column should be left blank. If there is no tribal/hilly/desert/backward area in the State, It should be clearly stated in the footnote.
v) In column (2), the rural population in the plain areas (A) of the State / UT is to be given along with the rural poulation in the areas classified as either tribal/ hilly,/ desert/ backward area (B). For instance, if an area is classified as, both tribal as well as hilly area, then corresponding rural population of this area is to be included once in working out the total rural population in difficult areas. The total(A+B) must tally with the figures given in Proforma I.
vi) The item (iii) requires the separate information about the tribal areas.

PROFORMA-III

FUNCTIONAL STATUS OF PRIMARY HEALTH INFRASTRUCTURE

STATE/UT **Dadra and Nagar Haveli** Report for the year 2009

Number of Districts : 01 Number of development Blocks : 01

A : FOR SUB CENTERS	**Number**
1.Total No. of Sub Centers functioning (As mentioned in Proforma I)	38
2. No. of Sub Centers functioning without ANMs	--
3. No. of Sub Centers functioning without Health Worker (M)	29
4. No. of Sub Centers functioning without Health Worker (M) and ANM (both)	--
5. No. of Sub Centers with ANM quarters	38
6. No. of Sub Centers with ANM living in SC quarters	21
7. No. of Sub Centers with ANM living in SC village	12
8. No. of Sub Centers without all weather motor able approach road.	02
9. No. of Sub Centers without regular water supply	12
10. No. of Sub Centers without electric supply.	--
12. No. of Sub Centres having a regular supply of generic drugs (Both AYUSH and Allopathic) for common ailments	38

B. For Primary Health Centers	**Number**
1. Total No of PHCs functioning (As mentioned in Proforma I)	06
a. No.of PHCs functioning with 4 or more Doctors only	01

b. No.of PHCs functioning with 3 Doctors only	--
c. No. of PHCs functioning with 2 Doctors only	02
d. No. of PHCs functioning with 1 Doctors only	03
e. No. of PHCs functioning without a Doctor	--
Total (a+b+c+d+e)	
(Total of figures against S.No. 'a' to 'e' should be equal to figure at S.No.1)	
2. No. of PHCs functioning with lady Doctor (s)	05
3. No of PHCs functioning without lab.technician	--
4. No of PHCs functioning without Pharmacist	--
5. No of PHCs functioning without lab.technician and Pharmacist (both)	--
6. No.of PHCs functioning without Nurse Midwife/Staff Nurse	--
7. No.of PHCs functioning without ANMs	--
8.No.of PHCs with labor room	06
9. No. of PHCs with O. T.	03
10. No. of PHCs with 4 – 6 beds	06
11(a) **No. of PHCs functioning for 24X7 days**	06
(b) **No. of PHCs with round the clock facility for delivery**	06
12. No. of PHCs without electricity	--
13. No. of PHCs without regular water supply	--
14. No. of PHCs with telephone facility	06

15. No. of PHC without all weather motorable approach road.	--
16. No. of PHCs with computer facility	06
17. No. of PHCs having the post of Computor / Statistical Assistant for MIS	--
18. No. of PHCs having Doctor's quarter	06
19. No. of Doctors living in PHC quarter	06
20. No. of PHCs having a vehicle	06
21. No. of PHCs having a regular supply of generic drugs (both AYUSH and Allopathic) for common ailments	06

C. For CHCs

1. Total No. of CHCs functioning (As mentioned in Proforma I)

2.No.of CHCs having specialist Doctors	Physician	Obstetrician & Gynaecologist	Surgeon	Paediatricians
	--	--	--	01

3. No. of CHCs with functional Laboratory	01
4. Number of CHCs with functional O.T.	01
5. Number of CHCs with functional Labor Room	01
6. Number of CHCs with 30 beds	01
7. Number of CHCs with functional X-Ray machine	01
8. Number of CHCs having quarters for specialist Doctors	01
9. Number of CHCs with specialist Doctors living in quarters	--
10. Number of CHCs having regular supply of generic drug (both AYUSH and Allopathic) for common ailments	01
11.Number of CHCs presently operating in PHC building	

D. FIRST REFERRAL UNITS	
1. No. of First Referral Units (please provide a list of FRUs) available in the State/ UT	
a) at PHC level	--
b) at CHC level	--
c) at Sub District level	--
d) at District level	01
Total of (a,b,c.d)	**01**
2. No. of FRUs with more than 30 beds	01
3. No. of FRUs with round the clock delivery services including normal & assisted deliveries	01

4. No. of FRU's wth Emergency obstetric services
Including surgical interventions

5. No. of FRU's with	**Gynaecologist**	**Pediatritician**	**Anesthetist**
	3	2	1

6. No. of FRU's with functional O.T	1
7. No. of FRU's with functional labor Room	1
8. No. of FRU's with functional X- Ray Machine	1
9. No. of FRU;s with functional Lab.	1
10. No. of FRU's with Blood storage/linkage facility	--
11. No. of FRU's having referral transport service	1
12. No. of FRU's with back up generator/electric supply	1
13. No. of FRU's without residential quarters for essential staff	1

E. Additional Information on Health Facilities				
1. No. of Districts where scheme of ASHA has been implemented (Uni District) 1				
1. No. of villages in each district where ASHA is functioning (District wise no. of villages to be attached)				
3. No. of centres having Rogi Kalyan Samiti / Hospital Management Society at	Sub Centres	PHCs	CHCs	FRU's

	--	--	1	1
4. No. of CHCs with two rooms for AYUSH Practitioners and Pharmacist under the IPHS model				
5. No. of PHCs having two doctors including AYUSH practitioner				06
6. Referral transport available at	No. of Sub Centres	No. of PHCs	No. of CHCs	
	--	06	01	
7.No. of villages in each district having trained birth attendants (District-wise no. of villages to be attached)				
8.No. of Mobile Medical Units operating in the State/Uts				No

PROFORMA IV

BUILDING POSITION OF SUB CENTERS, PHCs AND CHCs REQUIRED AND IN POSITION

STATE /UT : Dadra and Nagar Haveli Report for the year 2009

Name of Health Institution	Total No. Functioning	No. Functioning in Govt. Buildings	No. functioning in rented Buildings	No. functioning in other Buildings of Panchayatas/ Vol./social Organisations etc.without paying any rent	No. of Buildings Under Construction	No. of buildings required to be constructed yet
(1)	(2)	(3)	(4)	(5)	[6]	(7)
Sub Centers	38	38	--	--	--	7
PHCs	6	6	--	--	--	--
CHCs	1	1	--	--	--	--

Note:

1. Total of column (3), (4) & (5) should be equal to figure in column (2)
2. Column (7) = [column (4) + column (5)] – column (6)

PROFORMA V

BUILDING STATUS IN TRIBAL AREAS

STATE /UT: Dadra and Nagar Haveli Report for the year 2009

Health Institution	Total No. Functioning	No. Functioning in Govt. Buildings	No. Functioning in rented Buildings	No. functioning in other Buildings of Panchayatas/ Vol./social Organisations etc.without paying any rent.	No. of Buildings Under Construction	No. of buildings required to be constructed yet
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Sub Centers	38	38	--	--	--	--
PHCs	6	6	--	--	--	--
CHCs	1	1	--	--	--	--

Note:

1. Total of column (3), (4) & (5) should be equal to figure in column (2)
2. Column (7) = [column (4) + column (5)] – column (6)

PROFORMA VI

TOTAL HEALTH MANPOWER IN RURAL AREAS

Category **(1)**	**Required (as per existing centres) (2)**	**Sanctioned** **(3)**	**In position** **(4)**		
Manpower at CHC			**Regular**	**Contractual**	**Total**
1 a. Surgeons	01	--	--	--	--
b. Obstetricians/Gynecologist	01	--	--	--	--
c. Physicians	01	--	--	--	--
d. Pediatricians	01	--	--	--	--
Total (a+b+c+d)	04	--			
2. Other Manpower					
a. Anaesthatist	01	--	--	--	--
b. Eye Surgeon	01	--	--	--	--
c. Public Health Programme Manager	--	--	--	--	--
d. General Duty Medical Officer	04	--	03	01	04
3 Nursing Staff (7+2 per CHC**)** Including Public Health Nurse /ANM/Staff Nurse/Nurse Midwife	**09**	**--**	**04**	**05**	**09**
4.Pharmacist/Compounder	01	--	01	--	01
5**.** Lab Technician	01	--	01	--	01
6. Radiographer	01	--	--	--	--
Manpower at PHC					
1. Total Allopathic Doctors	06	06	04	02	06
2.Lady Doctor (if any) at PHC					
3**.** Block Extension Educator	**06**	**04**	**01**	**--**	**01**
.4Pharmacists	06	06	06	--	06

5. Lab Technician	**06**	**06**	**06**	**--**	**06**
6. Health Educator	--	--	--	--	--
7. Health Assistant (M)	--	--	--	--	--
8**.** Health Assistant (F)/LHV	**07**	**07**	**02**	**--**	**02**
9. Health Worker (F)/ANM	--	--	--	--	--
10**.**Nurse Midwife/Staff Nurse	12	08	07	05	12
Man Power at Sub Centres					
1. Health Worker (F)/ANM	**72**	**38**	**38**	**22**	**60**
2. Health Worker (M)	38	09	09	--	09

Note: Information given in column (2) & (3) should not change from quarter to quarter, unless there are some specific reasons.

PROFORMA VII

TOTAL HEALTH MANPOWER IN TRIBAL AREAS

Entire Area of this U.T. is Rural & Tribal

Category **(1)**	**Required (as per existing centres) (2)**	**Sanctioned** **(3)**	**In position** **(4)**		
Manpower at CHC			**Regular**	**Contractual**	**Total**
1 a. Surgeons					
b.Obstetricians /Gynecologist					
c. Physicians					
d. Pediatricians					
Total (a+b+c+d)					
2. Other Manpower					
a. Anaesthatist					
b. Eye Surgeon					
c. Public Health Programme Manager					
d. General Duty Medical Officer					
3 Nursing Staff (7+2 per CHC**)** Including Public Health Nurse /ANM/Staff Nurse/Nurse Midwife					
4.Pharmacist/Compounder					
5**.** Lab Technician					
6. Radiographer					
Manpower at PHC					
1. Total Allopathic Doctors					
2.Lady Doctor (if any) at PHC					
3**.** Block Extension Educator					
.4Pharmacists					
5. Lab Technician					

6. Health Educator					
7. Health Assistant (M)					
8**.** Health Assistant (F)/LHV					
9. Health Worker (F)/ANM					
10**.**Nurse Midwife/Staff Nurse					
Man Power at Sub Centres					
1. Health Worker (F)/ANM					
2. Health Worker (M)					

Note: Information given in column (2) & (3) should not change from quarter to quarter, unless there are some specific reasons.

Proforma VIII.

District wise Availability of Health Centre : Uni District

Name of State : Dadra and Nagar Haveli

Sr. No	Name of District	No. of Sub Centres	No. of PHCs	No. of CHCs	No of Hospitals	
					Government	Private
01	Dadra and Nagar Haveli	**38**	**06**	**01**	**01**	**13**

Note: District-wise total should tally with the figure for entire State as given in Performa I.