सत्यमेव जयते

Ministry of Health & Family Welfare
Government of India

NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES & STROKE (NPCDCS)

Training Manual for NCD Programme Managers at State and District Level

September 2017

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Health In Your Hands
National Program for Prevention and Control of Cancer, Diabetes, Cardio-Vascular Disease & Stroke

NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES & STROKE (NPCDCS)

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September 2017

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Foreword

The National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) is being implemented in the country since 2010. States/UTs implementing NPCDCS have already initiated various activities for prevention and control of common non-communicable diseases (NCDs). The Government of India is providing technical, financial and logistics support within the NHM framework for activities at the district level and below.

The NCD cells at state and district levels have been set up to ensure implementation and supervision of programme activities related to health promotion, early diagnosis, treatment and referral, through NCD Clinics and outreach activities. The NCD Cells also serve as focal point for monitoring and reporting of performance of NPCDCS activities.

Periodic programme reviews over the past years have revealed that efficiency of programme implementation varies from one district to another. Although the infrastructure and manpower capacities for implementation are mostly adequate, yet the management capabilities among programme officers in States/Districts need to be strengthened. The limited capacity to absorb/utilize available resources at State/District level results in poor implementation and limits effective expansion of the programme. To address this gap, capacity building of these programme managers is proposed to be undertaken. For this, Training Manual for Programme Managers, dealing with the essentials of programme implementation and management, has been developed with support from WHO-India.

A great deal of management learning comes from experience, however it is necessary that the fundamental tools necessary for management skills are provided through an appropriately designed content. This manual has been designed to increase management skills of the staff at NCD cells about programme implementation, managing resources, communicating with stakeholders, monitoring and supervision, etc. This document uses interactive exercises and practical activities to equip participants with the right tools to deploy in the workplace.

I hope this manual will serve as an important guide to strengthen the capacity of staff at State/District NCD Cells, to learn and adopt programme management skills and eventually improve programme activities essential for implementation and monitoring of NPCDCS in the country.

(Dr Jagdish Prasad)

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Preface

Currently, the Non-communicable Diseases (NCDs) are the leading cause of premature mortality and morbidity in India. This rising trend of NCDs is closely associated with the higher prevalence of NCD risk factors. In view of this, the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) is being implemented in the country to provide promotive, preventive and curative services to people with non-communicable diseases.

The programme is managed through NCD cells at the centre, state and district levels although implementation below the district level is merged with other programs under the National Health Mission. Effective implementation of the program requires program managers to be adequately equipped with skills to efficiently monitor and guide implementation of the program through the primary health care level.

The NCD cells at State and District levels have been set up to ensure implementation and supervision of programme activities related to health promotion, early diagnosis, treatment and referral, through the NCD Clinics at the District Hospitals and Community Health Centres as well as outreach activities and community level NCD screening through the Frontline health workers. These NCD Cells also serve as focal point for monitoring and reporting of performance of NPCDCS activities.

In order to strengthen the management capabilities among programme officers in States/ Districts, this Training Manual for Programme Managers has been developed with support from WHO-India. It deals with the essentials of programme implementation including resource management, coordination with other departments/programmes, planning of IEC and capacity building, advocacy, monitoring and supervision of the programme, etc.

I hope the programme managers at State/District NCD Cells find this manual useful to strengthen their own capacity in terms of programme management skills and programme implementation in the country.

(Navdeep Rinwa)

Contents

About the Manual

Programme managers under the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) at state and district levels require managerial skills to ensure effective implementation of the programme. These skills need to be developed through appropriately planned training programmes which have not yet been undertaken. A training needs assessment of programme managers in select states was carried out to assess the existing capacity in this area. The findings of the assessment guided the development of this manual to address the gaps identified in skills and knowledge. Details of the TNA are given in Annexure1.

This manual is aimed at Nodal Officer/Programme Coordinator for strengthening managerial skills and competencies of NPCDCS programme managers. This will aid health managers and coordinators at the state and district levels to plan, implement, and monitor the NPCDCS programme more effectively.

At the end of the training, the participants will

- Be familiar with common management principles and skills needed to implement the programme efficiently
- Strengthen their analytical skills and ability to use existing data to understand the status of implementation programmes, and use this data for effective programme decision making
- Be able to identify the need for multi sectoral convergence to effectively control NCDs and be familiar with the strategies for involving different stakeholders in the programme

The manual has five sections

Section 1: Preparing Action Plan for NPCDCS

Section 2: Implementation of NPCDCS activities

Section 3: General Management Skills (human resources, purchase and Inventory, finance management)

Section 4: Advocacy, and communication for Multi Sectoral Action

Section 5: Monitoring and Evaluation

Training Techniques

Each session of the training will start with a short introduction of the topic, followed by discussion of case studies, practical sessions and exercises.

The training techniques include the following:

- Lectures: Formal presentations conducted by the facilitator or a resource person to convey information, theories, or principles.
- Exercises: Training will mostly be exercise-driven to apply knowledge and skills. e,g developing an action plan, preparing a budget etc
- Case studies: Participants will use district scenarios, real life experiences to suggest solutions to management issues.
- Group discussions: Participants share experiences and ideas and work together to solve problems.

Skills to be learnt by Program Managers during the training

1. Epidemiology skills
   a. Estimating disease burden
   b. Estimating programme coverage
   c. Monitoring of the programme

2. Management Skills
   a. Assessing resource requirement
   b. Identification of key constraints and barriers in programme implementation
   c. Preparing and budgeting an action plan
   d. Managing finance and logistics; HR
   e. Supportive supervision
   f. Organising h.ealth services

3. Advocacy and Communication Skills
   a. Stakeholders Analysis
   b. Common in other Health programme & Non health sector
   c. Common policy makers

Acknowledgement

This manual was developed by Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi with support from WHO Country Office for India and Directorate General of Health Services, MoHFW, Government of India This manual greatly benefited from the contribution of resource persons from different institutions across the country in the training needs assessment that preceded the development of the manual and in the manual development.

Introduction to NPCDCS

What are Non-communicable Diseases (NCDs)?

Learning objectives

At the end of this module, you should be able to answer the following questions–

- *What is the package of services available through NPCDCS?*
- *What is the National NCD monitoring framework?*

Non-communicable diseases (NCDs) are chronic degenerative diseases. They cause premature death or damage to various organs of the body. They develop slowly over years and often do not have symptoms. Once developed, they are usually not curable. By adopting a healthy lifestyle and regular medications, NCDs can be controlled to prevent premature deaths or damage to organs. Cardiovascular diseases (CVD) which includes coronary artery disease (CAD) and hypertension and stroke, cancers, chronic respiratory diseases (such as COPD and asthma), chronic kidney diseases and diabetes mellitus (DM) are counted among the major NCDs which are to be addressed on priority, even though there are many other NCDs including mental disorders, musculoskeletal disorders and others.

WHY SHOULD WE HAVE A NATIONAL PROGRAMME FOR NCDs

They also cause immense morbidity and economic loss to the country. In addition, cancers and heart diseases are among the most important causes of pushing people into poverty due to the high cost of treatment, especially in private sector.

If these diseases are not diagnosed early and treated adequately, they lead to long term sequelae and complications which affect quality of life. It is costlier to treat complications of NCDs like myocardial infarction or stroke which would need more intensive and high end care. Therefore, it is cost-effective to identify as many persons with NCDs and bring them under regular treatment. aving a national programme will facilitate focusing public health efforts in prevention and control of these NCDs and reduce premature deaths.

WHAT IS THE NATIONAL PROGRAMME FOR CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES AND STROKE (NPCDCS)?

and high blood lipid levels are unhealthy diet, physical inactivity, stress and consumption of tobacco and alcohol, awareness will be generated in the community to promote healthy life style habitsthrough various strategies like inter personal communication (IPC), mass media, involvement of civil society, community based organization, panchayats/local bodies, other government departments and private sector. The focus of health promotion activities will be on:

- Increased intake of healthy foods
- Salt reduction
- Increased physical activity/regular exercise
- Avoidance of tobacco and alcohol
- Reduction of obesity
- Stress management
- Awareness about warning signs of cancer etc.
- Regular health check-up

Screening and early detection of NCDs especially diabetes, high blood pressure and common cancers would be an important component. Common cancers (breast, cervical and oral), diabetes and high blood pressure screening of target population (age 30 years and above,) will be conducted either through opportunistic and/or camp approach at different levels of health facilities or domiciliary screening at community level including in urban slums of large cities using the community level workers. The ANMs and ASHAs will be trained for conducting screening so that the same can be also conducted at sub-centre level. appropriate referral linkages will be defined. . The common infrastructure/manpower envisaged under different programmes such as National Programme for Prevention Control of Cancer, Diabetes, CVDs and Stroke (NPCDCS), National Programme for Health Care of Elderly (NPHCE), National Tobacco Control Programme (NTCP), National Mental Health Programme (NMHP) etc. can be utilized for early detection of cases, diagnosis, treatment, training and monitoring of different programmes.

Community health centers and district hospitals are supported for prevention, early detection and management of common NCDs through NCD clinics and strengthening laboratories at CHCs and DHs. The districts not having Medical College hospitals are provided financial assistance for establishing at least 4 bedded cardiac care unit through renovation and purchase of equipment such as ventilators, monitors, defibrillator, CCU beds, portable ECG machine and pulse oximeter etc. for cardiac care and chemotherapy. In addition, financial support would be provided to district and CHC/FRU/PHC for procurement of screening devices, essential drugs, consumables and, transport of referral cases.

Financial support is provided under the program for contractual staff at DH and CHC level for NCD clinics and cardiac care unit and chemotherapy.

The AYUSH practitioner can supplement the efforts to operationalizing these activities and thus need to be integrated with the National NCD prevention and control programmes. They canbe involved in health promotion activities through behavior change, counseling of patients and their relatives on healthy lifestyle (healthy diet, physical activity, salt reduction, avoidance of alcohol and tobacco) meditation, Yoga, opportunistic screening for early detection of non-communicable diseases and their risk factors, and treatment using Indigenous System of Medicines.

Involve NGOs, civil society and private sector in health promotion, early diagnosis and treatment of common NCDs through appropriate guideline

Support is given to States and Institutes for surveillance & research on NCDs. Emphasis would be given on creating database, applied and operational research related to the programme. Survey for risk factors for NCDs would be conducted at pre-determined intervals to monitor the impact of programme. Monitoring and evaluation of the programme would be carried out at different levels through NCD cells, reports, regular visits to the field and periodic review meetings. National, State and District NCD Cell would be established/strengthened to monitor and supervise the programme by providing the support for contractual manpower, establishment of physical infrastructure and for field visits, contingencies etc. Management Information System (MIS) would be developed for capturing and analysis of data.

WHAT ARE THE PACKAGES OF SERVICES PROVIDED UNDER NPCDCS?

NPCDCS utilizes various levels of healthcare delivery system to deliver a package of services.

Essential Services to be made available at various levels of public health system**

Services	DH*	SDH/CHC*	PHC*	Subcentre*
Health promotion for behaviour change and counselling	Yes	Yes	Yes	Yes
Opportunistic Screening of Diabetes using glucometer kits and HTN using blood pressure measurement	Yes	Yes	Yes	Yes
Screening for common cancers	Yes	Yes	Yes	Yes
Referral services	Yes	Yes	Yes	Yes
Awareness generation of early warning signals of common cancers and other NCDs	Yes	Yes	Yes	Yes
Follow-up of NCD patients for monitoring adherence and control	Yes	Yes	Yes	Yes
Referral of suspected cases of hypertension & diabetes mellitus	-	-	Yes #	Yes
Diagnosis & management and follow-up of Hypertension and Diabetes patients	Yes	Yes	Yes	-
Diagnosis & management and follow up of stable coronary artery disease & stroke patients	Yes	Yes	-	-
Basic lab. investigation & Diagnostics (indicative): Plasma Glucose, Lipid Profile, Serum Creatinine, XR, ECG, Fundus Examination, USG (To be outsourced, if not available)	Yes	Yes	-	-
Advanced lab investigation & diagnostics (indicative): ECHO, TMT, CT Scan, MRI etc. (to be outsourced, if not available)	Yes	-	-	-
Management of cancer (outpatient, inpatient & intensive care) and follow-up of chemotherapy cases	Yes	-	-	-
Emergency services for Myocardial infarction (MI) and stroke	Yes	-	-	-
Rehabilitation and physiotherapy services for survivors of MI, stroke and cancer	Yes	-	-	-

*or urban equivalent centres
** Services could differ depending on the availability of resources, but these are the minimum services recommended under the programme.
#if resources not available

RECENT INITIATIVES UNDER NATIONAL HEALTH MISSION/ NPCDCS

- Strategy for "Population-based Screening (Universal NCD Screening)" for early detection of common NCDs in community, utilising the services of Frontline-workers and Health-workers under the existing Primary Healthcare System
- National Urban Health Mission with its focus on urban health care delivery offers a platform for strengthening NCD services in urban areas through NPCDCS
- Inclusion of guidelines for prevention and management of Chronic Obstructive Pulmonary Disease (COPD) and Chronic Kidney Disease (CKD) under NPCDCS
- National strategy for 'bi-directional screening', early detection and better management of Tuberculosis-Diabetes comorbidities, as a joint collaborative activity between RNTCP and NPCDCS

- Pilot Intervention on Rheumatic Heart Disease
- Joint Collaborative venture through platforms of NPCDCS & RBSK
- Integration of Alternative Systems of Medicine (AYUSH) with NPCDCS: Synergy harnessed for prevention and management of Lifestyle-related disorders between Allopathy under NPCDCS & Alternative Systems of medicine under AYUSH. Initiated in six pilot districts and being expanded to other districts in a phased manner
- National Multisectoral Action Plan: Strategic areas and Key outcomes: This provides guidance for engagement with different ministries. There are four key pillars:

  – Integrated and Multisectoral Coordination, (Nodal Agency - MoHFW)
  – Health Promotion; (Nodal Agency - Central NCD Division)
  – Health Systems Strengthening, (Nodal Agency - State Govt. & MoHFW)
  – Surveillance, Monitoring, Evaluation & Research; (Nodal Agency - ICMR)

Section 1

PREPARING ACTION PLAN FOR NPCDCS

INTRODUCTION

Non Communicable Diseases were estimated to cause approximately 60% of all deaths in India in 2014. One in four Indians carry the risk of dying prematurely due to NCDs (between the ages of 30 and 70 years). While the primary causes of NCDs are outside the health system, NCDs impose a large burden on the health system.

Government of India launched the National Programme for Control of Diabetes, Cardiovascular Diseases and Stroke in 2010-11. After merging the National Cancer Control Programme in 2011-12 to be called the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) (Annexure 2)

NPCDCS aims to integrate its activities under the overall umbrella of National Health Mission (NHM). Other NCDs like chronic respiratory diseases and chronic kidney diseases have recently been included under NPCDCS. The National Monitoring Framework for prevention and control of NCDs provides targets to be achieved by 2025. (Annexure 3)

The **overall objective** of the programme is to **prevent and control common NCDs.**

STRATEGIES

- Health Promotion
- Early diagnosis and treatment
- Establishment/Strengthening of Health infrastructure
- Integration with AYUSH
- Public private partnership
- Surveillance, monitoring & evaluation

ROLE OF PROGRAMME MANAGER IN NPCDCS IMPLEMENTATION

The programme has listed roles and responsibilities for all functionaries under the programme. A summary of your roles and responsibilities as programme managers is given below. Programme managers under NPCDCS are Nodal Officer (NO), Programme Officer , Programme Coordinator. Then working in NCD cell at SH and district levels. They are responsible for all activities under NCD Cell. Activities under state and district NCD Cells are described below

STATE LEVEL

State NCD Cell is responsible for overall planning, implementation, monitoring and evaluation of the different activities, and achievement of physical and financial targets planned under the programme in the State. State Nodal Officer is the overall supervisor of this cell. Following activities are conducted at the level of state NCD Cell –

1. **Planning**
   a. Prepare and incorporate NCD plan in the State action plan for implementation of NPCDCS strategies.
   b. Develop district wise information of NCDs (cancer, diabetes, cardiovascular disease and stroke) for planning and implementation.

2. Implementation

a. Organize State & district level trainings for capacity building
b. Recruit contractual staff sanctioned for various facilities
c. Release funds to districts and submit Statement of Expenditure and Utilization Certificates on time
d. Converge with NHM activities and other related departments in the State / District and participate in different state level coordination committee meetings wherever applicable
e. Supply chain maintenance of drugs and diagnostics
f. Ensure availability of palliative and rehabilitative services
g. Create public awareness regarding health promotion and prevention of NCDs through IEC activities.
h. Maintenance of State and District level data on physical, financial, and epidemiological profile.

3. Monitoring

a. Monitor the programme through HMIS, regular review meetings, field visits.
b. Support any research activities including surveillance and surveys related to NCDs
c. Ensure timely and regular collection, collation, analysis and reporting of data.

DISTRICT LEVEL

The district NCD Cell is responsible for overall planning, implementation, monitoring and evaluation of the different activities and achievement of physical and financial targets planned under the programme in the District. These activities are supervised by the District Nodal Officer designated by state government. Following activities are conducted at the level of district NCD Cell :

1 Planning

a. Prepare the District action plan for implementation of NPCDCS strategies.

2 Implementation

a. Conduct sub-district/ CHC level trainings for capacity building
b. Engage the contractual personnel sanctioned for various facilities in the district
c. Maintain fund flow and submission of financial reports to State NCD Cell.
d. Converge with NHM activities; and convergence with the other related departments in the States/ District
e. Maintain district level data on physical, financial, epidemiological progress

3 Monitoring

a. Maintain and update district database of common NCDs (under the programme)
b. Monitor activities at sub-district levels through supervisory visits

Exercise 1: List some of the problems faced by you in the implementation of the program in your district under Planning, Implementation and Monitoring format.

Note: Please Ensure that

1. These are managerial issues. The issues should cover guidelines etc.
2. These issues are discussed at this training during appropriate sessions

Domain	**Three Key problems**
Planning	1. 2. 3.
Implementation	1. 2. 3.
Monitoring	1. 2. 3.
Any other	1. 2. 3.

SITUATIONAL ANALYSIS OF NPCDCS

"You can't know where you're going until you know where you've been"

Learning objectives

At the end of this module you would be able to

- *Understand the socio-demographic profile of your district and its implications for the program*
- *Identify data sources related to NCDs and estimate the burden of common NCDs in the district*
- *Assess current resource availability – Funds, HR, equipment, medicines and supplies*
- *Estimate current program achievements under NPCDCS*
- *Identify key constraints and barriers for progress*

As a programme manager, one of the responsibilities is to gather district wise information about NCDs being reported under the programme.This information will be needed to help to plan activities and thereby estimate your requirement of funds, manpower and logistics.

All districts are different from each other and planning for implementation needs to consider the differences in the socio-demographic profile (urban/hilly/tribal areas etc.) stage of development and the burden of NCDs and the existing health infrastructure. While the general principles of programme planning, implementation and monitoring are the same, the context and therefore, the strategies could be different. This chapter aims to develop these skills.

Note: Though these examples are given for a District, the State Nodal officer will also have to follow the same process at the state level.

ESTIMATE THE BURDEN OF COMMON NCDs

The training will use three case scenarios – **Districts A, B and C.** Short description of these three districts are given below. The participants will be divided into three teams each looking after a district.

District A has just started the implementation of the program and lacks information. Burden of disease is low(take the lower estimates of burden) and coverage of different services poor (Less than 20%). The program would therefore focus mainly on increasing awareness, building capacity for management of common NCDs.

District B has been implementing the program for some years with moderate level of success. (assume the middle burden estimate and program coverages in the range of 50%-70%). The program would focus on improving awareness, treatment beyond current levels, expand scope of services and coverage as per programme objectives.

District C has high rates of NCD burden. The program implementation is good and therefore program should aim to sustain the current high level coverage (> 80%) and move to the next level of address complications like diabetic retinopathy, stroke care and cancer care including palliative care.

Next few exercises will take you through the process of understanding the key programmatic issues in your chosen district so that you can plan your work accordingly. This training will use existing information for districts with the states . Table 1.1 provides the basic- socio-demographic information regarding the general population profile of three hypothetical districts.

Table 1.1 Indicative burden for major Non-communicable diseases

Indicators		Rural			Urban			Data Sources
Assumption of Burden		Low	Medium	High	Low	Medium	High	Simplified from Report of the Working Group on Disease Burden for 12th Five Year Plan
Prevalence of Hypertension (%)		10	15	20	20	25	30	
Prevalence of Diabetes mellitus (%)		2	6	10	5	10	15	
Previous Chronic Obstructive Pulmonary Disease (%)		M-4 F–2	7 4	10 6	M-2 F-1	5 2	7 3	
Previous Chronic Kidney Disease (%)		1	2	2.5	0.5	1	1.5	
Prevalence of Coronary Artery Disease (%)		2	4	7	6	9	13	
Annual Incidence of Myocardial Infarction per 1000		2	4	6	4	6	8	Compiled from multiple ad-hoc studies
Annual Incidence of Stroke per 1000		1.0	1.5	2	1.0	1.5	2.0	
Annual Incidence of Cancer per 100000	Oral	5	11	25	1	4	9	Cancer Registry
	Cervical	15	20	25	5	10	20	
	Breast	7	23	31	11	33	40	

Note: Prevalence indicates all cases (both new and old) living at a given time in the population whereas incidence indicates "new" cases occurring in a given time period (annual in this example)

Table 1.2. District socio-demographic profile

Indicators	District-A	District-B	District- C
Total Population (2011 Census)	18,12,520	12,58,405	9,12,920
% Female	45%	48%	51%
% Above 30 years of age	46%	48%	52%
Crude Birth Rate per 1000 population	27.0	22.0	18.0
Crude Death Rate per 1000 population	8.5	7.5	6.5
Proportion tribal	2%	20%	5%
Proportion Rural	92%	56%	26%

Use the data provided in Table 1.2 and the your district data to fill the Exercise 2

Exercise 2. District socio-demographic profile

Indicators	Name of your district -
Total Population (2011 Census)	
Population Above 30 years of age	
% Female in those >30years	
Crude Birth Rate per 1000 population	
Crude Death Rate per 1000 population	
Proportion tribal	
Proportion rural	

Estimates of Burden of NCDs and their risk factors are required for

Planning: It provides information for planning of resources and activities

Advocacy: it provides evidence for advocacy to policy makers and administrators to increase priority and resource allocation to NCDs.

Evaluation: It provides denominator for evaluation of programme performance as it identifies the target population of the programme.

To estimate the burden of diseases in your district we need two sets of data,

1. Population parameters for the denominator
2. Prevalence rates for numerator

Estimating Denominator:

- Remember, all calculations are only on population above 30 years as the eligible population.
- Only female population is eligible for breast and cervical cancer incidence rates.
- Calculate denominator separately for urban and rural areas.
- The district population used will be of 2011 Census.

Box 1. 1. Sources for Data on NCDs and its risk factors

1. National Family Health Surveys (NFHS)- use the recent one which provides district level data on certain risk factors as well.
1. State -wise Global Burden of Disease Assessments
2. Studies commissioned by states like risk factor surveys
3. Published literature searched from medical databases like PubMed, Embase. medIND etc.
4. Data provided by Medical College in your district

Estimating Numerator (Prevalence)

If you do not have district level data for estimation of disease burden then you will have to make an assumption using national average. This may not be entirely suitable for NCDs, but it is a good starting point to know. For our purpose, we will make some assumptions on the prevalence rates. As we know the prevalence varies widely between rural and urban areas, therefore we will assume different rates for these. Indicative estimates of burden of major NCDs is given in Table 1.1. It gives separate estimates for rural and urban areas and for each area it gives low/medium/high estimates.

Calculate the burden of common NCDs in your district

- Remember these are approximations only in order to get a sense of the problem. Unfortunately, we do not have robust Indian data at district level on NCDs.
- Based on your understanding of the situation in your district. Use your judgement to calculate the burden of NCDs e.g

    - If you are unable to make this judgement as you are new to your district or do not have adequate information, take the medium estimates for calculation.

Note: Prevalence indicates all cases (both new and old) living at a given time in the population whereas incidence indicates "new" cases occurring in a given time period (annual in this example)

Wherever available, use data from your district or your state for estimation of disease burden. If not available you can use alternative sources of data on NCDs or its risk factors. Some of these are listed in Box 1.1

Based on your knowledge, decide which estimates will you assume for your district for different parameters listed in table 1.1.

ESTIMATING BURDEN OF COMMON NCDs IN YOUR DISTRICT

Now that we have estimated the numerator and denominator, we can calculate the expected number of cases of these conditions in the district.

We have given an example below how to calculate the burden of hypertension in a district. The same method can be used for Diabetes too. However, the principles learnt can be used for any other disease if the necessary information exists.

Exercise 3: Estimate Burden of Key NCDs in your district

Condition		**Eligible**		**Prevalence**		**Expected number of cases**		**Expected cases in District (rounded to nearest thousand)**
		Rural	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	
Hypertension (**worked out example for district A)**		**18,12,250*.92*.45 = 750272**	**18,12,250*.08*.45 = 65241**	**10%**	**20%**	**75027**	**13048**	**88,000**
Hypertension								
Diabetes mellitus								
Coronary Artery Disease								
Chronic Kidney Disease								
Chronic Obstructive M Pulmonary Disease F								
Incident Myocardial Infarction								
Incident Stroke								
Annual Incidence of Cancer	Oral							
	Cervical							
	Breast							

RESOURCE AVAILABILITY ASSESSMENT

The next step is to assess resource availability in the following domains-
Infrastructure: By this we mean health facilities at various levels providing NCD related services. These can be

- From general health system or NCD specific infrastructure
- As needed under the programme.

Table W1. Health infrastructure in the district

Item	Number
Presence of Medical college	
ICU/CCU in district hospital	
District NCD clinic	
Sub-district/Sub-divisional hospitals	
CHC NCD clinic	
CHC	
PHCs	
Subcentres	
Anganwadi centres	
Total Beds available in public facilities	
Total Beds available in private facilities	
Number of public laboratories providing key lab services for NCDs	
Number of private laboratories providing key lab services for NCDs	
Hemodialysis facilities	
Day care cancer facilities	
Tertiary cancer care facilities	

*The blank rows are for adding any other infrastructure item that is relevant to NPCDCS

Table W2 : Infrastructure for Health Promotion in the district

Item	Number
Number of middle schools in the district	
Number of Resident Welfare Associations in the district	
Number of Industrial sites in the district	
NGOs working in the NCD sector	
Agencies developing NCD IEC materials	

TableW3. Availability of Human Resources in the districts

Human Resources	Numbers
DPO	
DPC	
FCLC	
DEO	
Cardiologist	
Oncologist	
Pathologist	
Ophthalmologist	
Gynaecologist	
Surgeon	
Dental surgeons	
Physicians	
Medical Officers - M	
Medical Officers - F	
Staff Nurses	
Lab Tech	
Counsellor	
Physiotherapist	
ANM/Health Workers	
ASHAs	
Anganwadi workers	

*The blank rows are for adding any other infrastructure item that is relevant to NCDPC.

Table W4. Availability of Key NCD related Equipment in the district (Public sector Only)

Equipment	Numbers
CT Scan	
Ultrasound	
ECG Machine	
Biochemical analyser	
Dental Chair	
Colposcope	
Cryotherapy machine	
Cardiac monitor	

Look at the list of drugs and reagents to be available in the district as given in Annexure. Classify them into two categories – adequate and inadequate. This has to be based on the current load of the patients in the health system and not based on what you estimated as this is the baseline analysis.

Table W5: Assessment of adequacy of supplies under NPCDCS

Domain	Adequate	Inadequate
Lab Supplies		
Drugs		

Table W6 : Expected number of cases

Condition	Expected Number of cases in your district	Cases being seen under HFs in your district	Coverage with Program
Hypertension			
Diabetes			
CAD			
MI			
Stroke			
COPD			
CKD			
Cervical Cancer			
Breast Cancer			
Oral Cancer			

Table W7: Coverage with Capacity Building /Training

Workforce to be trained under the program	Total Numbers in the district	Number trained this year	Cumulative Number already trained

Table W 8: Assessment of Health Promotion activities

Type of Activities	Number done	People covered	
Community Meetings			
Healthy Schools			
Healthy Workplace			

PREPARING ACTION PLANS

Learning Objectives
At the end of this module, you would be able to prepare an Action Plan for submission to higher authorities. As a part of that you will be able to

- *Define objectives*
- *Identify strategies and activities*
- *Prepare a budget for the activities*

"People don't plan to fail. Instead they fail to plan."

In the previous section, the following information has already been generated.

1. District socio-demographic profile
2. Estimated burden of Key NCDs in the district
3. Current Resource availability –human resources, equipment and medicines and supplies
4. Current estimated programme achievements under NPCDCS
5. Key constraints and barriers for progress

These provide a situation analysis of the NPCDCS and help in drawing a profile of the district. This is also the first step in preparing an action plan. A summary of this should form the first section of an action plan.

This chapter focuses on preparing a District Action Plan. State Action Plan will be a compilation of all District action plans and some extra components which are relevant to the state level, following a similar process. are to be prepared by the DNO for each district and by the SNO for the state.

Steps in Preparing an Action Plan

An action plan consists of a number of actions, steps or changes to be brought about in a given setting. Before preparing the action plan one should be clear of what needs to be achieved as a result of the plan. (objectives) Each action step or change to be sought should include the following information:

- What actions or changes will be taken?
- Who will carry out these changes?
- By when they will take place, and for how long?
- What resources (i.e., money, staff, time) are needed to carry out these changes?
- Communication (who should know what?)

A good Action Plan is:

- Complete-It lists all the action needed to achieve the objectives.
- Clear – It is apparent who will do what by when.
- Realistic - The action plan based on the current situation and resource availability.

Planning is an iterative process and a collaborative activity.You, as the district programme manager, should consult other stake holders while preparing PIP.

Defining Aims /Objectives/Targets

The objectives of the Action Plan keeping with that of NPCDCS as listed below

NPCDCS has an overall goal of preventing and controlling NCDs with three broad objectives–

1. adoption of healthy behaviours by population through health promotion,
2. improve outcomes in people with disease through strengthening health system (includes both facilities and HR) for early diagnosis and treatment and
3. monitor progress by establishing appropriate systems. Based on these more specific objectives will need to be framed.

These should be further converted into specific objectives. For example,

1. Health promotion – improve the awareness of population about NCDs, create an enabling environment in schools, communities and workplaces to promote healthy choices (healthy settings approach).
2. Health system strengthening--to improve the awareness, treatment and control of hypertension and diabetes.

One other aspect for you to consider is to strengthen linkage with other national programmes and initiatives. There are many complementary components which would benefit all the programmes and optimize resources. (Annexure 4).

Tips

- It may not be possible to do everything in a year and therefore it is best to keep a five-year timeframe for all the activities
- Then prioritize in terms of logical sequence and resource availability.
- Based on situation it could be for three years or even seven years.

The next step in the planning process is to clearly define your targets/outcomes to be achieved in a given timeframe. The objectives and targets should be in keeping with the broad NPCDCS guidelines as adapted to the local context. Not all states or districts are similar, therefore, it is not appropriate to just copy the national targets into state or district one. It could be too easy or too difficult. In either case the staff would not be enthused to achieve it. A good target should be ambitious and at the same time realistic.

Considering the districts we discussed in the previous section, we can set the following targets:

- Improve the population coverage with screening for hypertension from 20% to 50% in district A over three years
- Ensuring 100% availability of blood pressure apparatuses in all health facilities over one year
- Include some schools (e.g 10% schools in the district) for health promotion activities.
- All concerned units to implement the bi-directional screening for DM and TB in the district.

These are indicative examples. Note that just ensuring presence of blood pressure apparatuses does not result in achieving the outputs. One has to ensure that sufficient trained human resources are there and a plan is made to cover whole of district in a time bound manner.

Once you have a five-year target, convert it into annual targets. This could be done by dividing it by five, assuming equal progress in the time-period (appropriate in a fully functional programme) or have lower targets in the initial years to allow for strengthening of the programme and the initial delays/inertia in the system. These require judgements of the programme manager on the current situation and how the programme and its resources are progressing. and Setting targets.

Exercise 5. Framing Objectives and Setting targets

Clearly define the objectives for the next few years in terms of what is given above.

Exercise 5a. Framing Objectives

(Do not have more than two in any one domain. Some examples are given to get you started. You can change them or keep them as felt appropriate)

Domain	Objectives
Health System Strengthening	1. Improve Coverage with Screening and early detection of HT,DM and Cancers 2. Improve access to acute cardiac and stroke care services
Capacity Building	3. Increase the proportion of staff trained under NPCDCS 4. (Please add one more objective)
Health Promotion	5. Increase awareness of the population regarding NCD risk factors 6. (Please add one more objective)
Integration with other Programs/NHM	7. Integrating implementation of RNTCP for bi-directional screening for diabetes and TB. 8. (Please add one more objective)
Multi-sectoral Action	9. Involving non-health sector in NCD control activities 10. (Please add one more objective)

Exercise 5b. Set targets for different indicators identified in previous tables. Add more indicators as appropriate.

Indicators	Current Levels (From Table W5)	Desired level in five years	Desired level next year

Exercise 6: Summarize your Action Plan in the form of a Gantt Chart

Serial Number	Activities		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter

Prioritizing Strategies

Once the objectives are finalized, the next step is to decide how to achieve them. Strategies are the methods used to achieve specific objectives. Where alternative strategies are possible, a choice has to be made among the different options.

Strategies are chosen based on the situational analysis and after considering the feasibility of various options weighing the advantages and disadvantages of possible alternative ways of addressing specific problems and accomplishing objectives. This is best done in a participatory manner as it ensures better co-operation of the stakeholders and ensures continuity of thinking even if individuals leave the organization.

Strategies must be:

- appropriate – address the priority problems and risks effectively, coherently and efficiently in a manner suited to the local context; and
- feasible – able to be implemented in the local context and with the resources expected to be available.

First level of prioritization has already occurred at the time of target setting. For each of the target/objective you will have to decide one or multiple strategies.

For example, if you wish to **improve hypertension control** among patients being treated in your district health facilities, the **strategies could be**

- Improve drug availability to the patients and ensure continuity in treatment
- Improve counselling services to the patients
- IEC in health facilities

For each of the objectives/targets set in the previous section, you should list the strategies.

Identifying Activities

These strategies would need further detailing as activities. While strategies are broad based, actions are specific and quantifiable. For each action proposed, one should be able to answer it in as done or not done or should be able to quantify amount of work done. For example – 20 trainings held, 100 workers trained etc.

For each of the strategies, detail the actions to be taken, who will take them and timeline for it to be done as shown in example below (Table 1.4).

Table 1.4: Example for planning strategies & activities

Objective	Strategy	Activities
Improve control of hypertension among patients on treatment	Improve drug availability to the patients	• Review the drugs used for treatment – look at cheaper but equally effective options • Rationalize the amount of drugs purchased/ indented • Giving patients one month's quota of drugs rather than 1-week quota
	Improve counselling services to the patients	• Facilitate training of counsellors • Make space and time available to the counsellors • Prepare job responsibilities, plan of work including reporting for counsellor

While finalizing strategies, please keep in mind that the activities are planned under certain assumptions e.g availability of guidelines and norms, adequate funds are available, optimum staff are in place, communication channels, administrative processes are established, etc.

Exercise 7: Finalizing Strategies and activities, timelines and responsibilities

Objective	Strategy	Activities	Responsible Person		Timeline

Objective	Strategy	Activities	Responsible Person	Timeline

Quantifying Resources

The final and most important step is to estimate resources required to execute the plan. While some activities can be carried out without additional resources, many activities cannot be done unless resources are provided for it.

In the above example, making space in the CHC or District hospital may only need rearrangement and not new resources. However, if there is no space, then it would need additional resource which need to be identified.

Budget preparation: The next step is to prepare a cost of all the activities proposed to be undertaken. These are general principles for preparing a budget, it is good practice for states- to take inputs from the districts while preparing the budget.

- Budget planning must be done as per the different heads of programme implementation plans (PIP) under NCDPCS in NCD flexi pool under NHM. It includes expenditure for different activities at state NCD Cell, district NCD cell, district NCD clinic, district CCU/ Day care centres, CHC NCD clinic, PHC and Sub-centre

- A detailed justification would be useful for decision makers especially if it deviates from norms and guidelines.
- Budget should be in a tabular manner with a column for justification. These could be done in an excel sheet.

The **financial guidelines under NPCDCS** are given in Annexure 4. Example of PIP for NPCDCS is given in Annexure 5.

You would also be familiar with the usual amount of funds made available under the programme for a district. Keep your budget in a similar range so that there is not too much difference between what is asked and what is given. This will make your action plan still usable if you get your "average" amount.

One of the important reasons that budget is cut is that it is not well justified. Always provide good justification for the budget that you ask for.

Exercise 8: Budgeting the Action Plan

Activity	Cost item	Justification	Amount (Rs)
Total			

Section 2

IMPLEMENTATION OF NPCDCS SERVICES

ORGANIZATION OF HEALTH SERVICES

"Every successful work needs proper organization"

Learning objectives
At the end of this module, you should be able to understand–

- *Health services provided under NPCDCS*
- *How to organize hospital based health services*

WHAT ARE THE HEALTH SERVICES PROVIDED THROUGH NPCDCS?

The package of services envisaged under the programme includes health promotion, early detection and treatment and follow up of patients.

Health promotion

Lifestyle related factors such as unhealthy diet, physical inactivity, consumption of alcohol and tobacco increase the risk for NCDs. Hence, health promotion through information, education and communication is an important and perhaps essential activity to be carried out under the program. Health promotion in the community should be done through

- Increasing awareness through Interpersonal communication, mass media (television, newspaper, social media) and community level discussions, Civil society, Panchayat Raj Institutions, Resident Welfare Associations (RWAs), Health workers, ASHAs, anganwadi workers and school-teachers
- Healthy lifestyle approach
- Counselling services

Box 2. 1 describes the focus areas of community based health promotions

Box 2.1: Focus of community based health promotion activities

- Healthy and balanced diet – low saturated fat intake, high fibre intake, adequate fruits & vegetables intake, low salt and sugar intake
- Increase physical activity – Reduce sedentary activity time, increase exercise time (150 minutes per week)
- Avoid tobacco and alcohol use
- Reduction of weight
- Stress management through Yoga, meditation
- Awareness about danger signs of common cancers
- Regular health check up

Early detection and appropriate management

Screening of hypertension, diabetes and common cancers (Oral, Breast, Cervix)

Early diagnosis is hallmark of management of hypertension, diabetes and common cancers. Screening refers to be detection of cases in asymptomatic individuals by actively looking for them. It can be done at health set up i.e. sub centres, PHCs, CHCs (opportunistic screening/ hospital based screening) or at the community (population based screening). Among cancers, oral, breast and

cervical cancers are commonest type of cancers in India and relatively easy to detect at an early stage. Screening for early detection and adequate treatment of these cancers is critical for patient survival.

Population-based Screening of common Noncommunicable Disease (NCDs) like Diabetes, Hypertension and common cancers (Oral, Breast, Cervix) has been initiated by MoHFW under the umbrella of National Health Mission. The prime objective of this intervention is early detection of common NCDs and awareness generation on healthy lifestyles to prevent NCDs through activities at the community and primary health care level. The services will be implemented through frontline health workers - ASHAs, Staff Nurse/ANM, and Medical Officers at the PHC level.

Treatment and follow up of diagnosed patients

Patients screened for hypertension, diabetes and common cancers at sub centres or the household levels need to be investigated further and appropriately managed at higher centres. Primary Health Centre will be the First Referral Unit for all cases referred from the sub-centre/ community. Cases requiring tertiary care management should be referred to District hospital where facility of Cardiac Care Unit (CCU) is established under the program.

Once a patient is diagnosed and started on treatment, follow up of the patient should be carried out at the community level to ensure compliance, adherence to treatment, detection of complication and assessment of control.

HOW TO ORGANIZE HOSPITAL BASED HEALTH SERVICES UNDER NPCDCS?

As you are aware, execution is the backbone of success of the program. Along with thorough planning, co-ordination and monitoring are the key to success in this task. *Let us look at screening as an example for how services need to be organized.* Successful execution of screening of NCDs and common cancer will rest on following three pillars –

STEPS AND ACTIVITIES TO BE CARRIED OUT FOR SETTING UP SCREENING AT PRIMARY HEALTH CENTRE

Planning for resources

Human resources: The Primary Health Centre, Medical Officer In-charge, Health Supervisors and ANMs will need to be trained in screening. As a District Program Manager/ Co-ordinator you will be responsible for conducting district level training for all people in the district involved in the community based screening.

As discussed earlier, district level training will be carried out in batches. Training should be organised separately for Medical officers, ANMs/ supervisors and Laboratory technicians. By this time, you must have prepared a training calendar as discussed in the earlier chapter.

At this point, if all of your staff positions are not filled and there are still some vacant posts, you may need to rework your training schedule.

You can carry out the training with the availabale staff. ***However, make sure that the health functionaries of one PHC are all trained in one round of training so that you will have one PHC with fully trained staff and ready to roll out the program activities in a coordinated manner.***

Focus areas for training of PHC manpower for enhancing knowledge and skills required for screening of hypertension and diabetes at PHCs are described in Box 2.2

Roles and responsibilities of various people involved in the screening activity are already defined in the program. (Refer to operational guidelines of NPCDCS)

Box 2.2: Focus areas for training for screening of hypertension and diabetes

- Need of screening, early diagnosis and treatment of hypertension, diabetes, cervical cancer, oral cancer
- Risk factors for these illnesses
- Risk assessment techniques
- Anthropometric measurements – Height, weight, waist circumference, BMI calculation
- Blood pressure measurement
- Blood sugar measurement using glucometer
- Referral mechanism
- Follow up of the diagnosed patient ensuring compliance to the treatment
- Record keeping

Material Resources: Medical officer I/C should estimate the requirement of materials required on the basis of estimated OPD attendance. Adequate inventory (material supply) at the PHC needs to be ensured. List of materials required for screening are described in Table 2.1. These supplies should be available in adequate quantities.

- Most of the drugs are integral part of routine supply to PHC under NHM. If not, then Medical officer I/C should indent the required drugs with required amount from district headquarter.
- Procurement can be done at district or state level as per state policy
- Procurement process has to be initiated well in advance before commencement of the activity to eliminate any latent period in supply. (Refer to chapter on inventory management for details)
- Guidelines/ algorithms required for management of hypertension and diabetes should be available with the medical officer.

Table 2.1: Materials essential for implementation of NCD Screening at PHC

Non-consumables	Consumables
Weighing scale	Lancet, spirit swabs
Stadiometer	Glucostrips
Measuring tape	Anti-diabetic, antihypertensive medicines (Refer to operational guidelines of NPCDCS)
Glucometer	Registers for follow up record
Blood pressure measuring instrument (Digital/ analogue)	Reporting forms
	Posters/pamphlets for health promotion

Financial resources: Screening of NCDs at the PHCs should be included in the annual PIPs in order to get funding under the program. Budget under capacity building can be utilized for training human resource for screening. Similarly, various other heads such as IEC activities can be utilized for spreading awareness in the community to maximize the impact of screening at the PHC.

More details are provided in the Operational Guidelines for Prevention, Screening and Control of common NCDs: *Hypertension, Diabetes, common cancers (oral, breast and cervix), National Health Mission.*

(http://www.nicpr.res.in/images/PDF/guidelines_for_population_level_screening_of_common_NCDs.pdf)

IMPLEMENTATION OF SCREENING

Implementation of activities can be divided into

- Preparedness for the screening at PHC
- Process of screening at PHC
- Follow up activities

Preparedness for the screening at PHC

Preparedness for the screening shall include following activities –

- **Creating awareness in the community-** Awareness about screening can be done with the help of ANM, Health worker (male) (if available) and ASHA about the screening activity at PHC. Each ANM and ASHA can cover the catchment area of their respective sub-centres for awareness generation in the community. Planning and organizing community awareness campaign through mass media and local media.
- **Engagement with various community leaders and other stakeholders** such as Sarpanch/ village-head, religious leaders, Resident Welfare Associations (RWAs), ICDS staff, Village Health, Sanitation and Nutrition Committees (VHSNC) and Mahila Arogya Samiti (MAS) (in urban area) for ensuring community response. *(Refer to Chapter on engaging with other partner)*
- Initially, screening may be caried out at selected days in a week during morning OPD at PHC. This can be increased to daily screening gradually once the process picks up and the staff is conversant with the entire process.

Process of screening at PHC

As you are aware, under opportunistic screening all adults aged more than 30 years attending the PHC/ subcentre need to be screened for hypertension, diabetes and common cancers under the program, irrespective of the reason for their OPD visit. Detailed screening guidelines are given in the operational guidelines for population based screening.

Follow up activities

Patient follow up for control

- Patients must be informed to come for follow up in the PHC regularly.
- Before coming for a follow up visit, patients with diabetes Mellitus should be advised to get his/her fasting blood sugar done at the Subcentres if feasible. If possible, HbA1C should also to be done at the CHC or District Hospital.
- During follow up visit, the patient should bring the fasting blood sugar report. Weight & BP should be checked for all patients on every visit. Look for complications and referal to higher facility to be done if needed.
- Medical officer will review the status of the patient and advise accordingly.

Record keeping and reporting

- Staff nurse/ ANM/ Health Assistant should be assigned the job of record keeping of hypertension and diabetes screening at the PHC.
- Treatment card should be filled up and given to the patient
- Records should be maintained in a screening register (Annexure)
- Monthly report should be compiled and sent once a month according to the reporting formats provided under the NPCDCS program (Annexure).
- Each follow up visit should be recorded in the patient tracking register. To ensure continuity in care, each confirmed patient on treatment should be recorded on a separate page or half a page so that details are recorded in the same page during follow up.

Patient tracking and monitoring

- PHC Medical officer should ensure that there is continuous tracking of patients who are on treatment.
- ASHA/ Health workers, during their domiciliary visits, will also follow up those patients who are on treatment from their respective SC/ PHC
- Motivate patients to comply with regular monitoring of blood sugar and BP
- Emphasize on the importance of compliance to medication.

HOW TO INTEGRATE NPCDCS ACTIVITIES WITH OTHER PROGRAMMES UNDER NHM?

Various programmes to control diseases like malaria, tuberculosis, HIV/AIDS, and maternal/child health activities are implemented at district level under NHM. Funds obtained from central government and state government under NHM are channelled through the State Health Societies to the District Health Societies. The programmes under NHM are detailed in Annexure 6.

District-wise programme implementation plan (PIP) or action plans are developed annually. Human resources and other logistics such as drugs, equipment and consumables are procured either centrally at the state level or purchased locally through Rogi Kalyan Samiti or similar funds. ***You should make yourself aware of the various activities under NHM going on in your state.***

A programme manager under NPCDCS should be aware and utilize the existing channels of NHM for implementation of relevant activities. For example - The Village, Health, Sanitation and Nutrition Committee (VHSNC) is a good platform for you to plan NCD related activities. Leverage reporting and monitoring mechanism under NHM or Utilizing human resources available under NHM for NCD related activities are some other options.

Case Study -1

You have successfully organized health facility based screening program at all PHCs in your district in last financial year. In this financial year, you want to roll out population based screening of hypertension and diabetes using in your district. In phase one, you want to focus on rural population. Your district has rural population of 1,80,000 with five PHCs and one CHC. Describe the activities to be carried out in a capacity of district program manager to achieve coverage of > 80% in rural area of your district.

HEALTH PROMOTION/ IEC ACTIVITIES

Learning objectives

At the end of this module, you will learn about

- *Concept of health promotion and Settings- based approach*
- *Health promotion strategies in schools, industries and community*

Health promotion enables people to increase control over their health. It covers a wide range of social and environmental interventions. These are designed to benefit and protect individual people's health by addressing the root causes of ill health.

SETTINGS-BASED APPROACH FOR HEALTH PROMOTION

Settings- based approach promotes establishment of healthy settings such as healthy cities, workplaces, schools, hospitals, villages, islands, districts and markets etc. Following are three key elements this approach:

- A healthy working and living environment
- Integrating health promotion into the daily activities of the setting
- Reaching out into the community

The following are three examples of healthy settings that can be introduced as part of health promotion activities

1. Health promoting schools
2. Health promotion at the workplace
3. Health promotion in community

Health Promoting Schools (HPS)

A health promoting school constantly strengthens its capacity to launch a comprehensive school health programme and serve as a healthy setting for living, learning, sharing and working. Collaboration with the education department is required for implementation of NPCDCS. The CBSE has developed guidelines for health promoting schools.

Under the School Health Program, there is a School Health Promotion Committee and a School Health coordinator at the district level. Active collaboration with the school health promotion committee can lead to involvement of school authorities and teachers in health promotion activities and screening of children. Screening of children for general ailments is recommended under the School health program by ANMs/MPWs in one school every week on an average for detailed screening and treatment of minor ailments. Those requiring referrals will be identified and referred to the PHC. In addition, a Medical Officer will also visit one school per month for additional screening, treatment and referral. However, both government and private schools and all zilla saksharata samitis (District Education Committees) need to be involved.

Health promotion at workplace

Workplace directly influences the physical, mental, economic and social well-being of workers and in-turn the health of their families, communities and society. Health promoting workplace is a combined effort of employers, employees, society. This offers an ideal setting and infrastructure for promoting health of a large audience. The health of workers is also affected even by non-work related factors. Many workplaces are offering opportunities such as healthy food, a built-in gym, regular and medical check-ups and so on.

Health Promotion in community

Effective health promotion practice keeps people at the heart of all activities. Health promotion needs to be carried out by people and with people, rather than on people or to people. This requires us to engage with communities in ways that allow people to have ownership of and involvement in all stages of health promotion activities.
The most basic level is to provide information to individuals or the community about decisions and activities underway while the most advanced engagement is to have a partnership with the community in health promoting ways like tobacco-free villages, physical activity promoting towns and other such initiatives.

PLANNING FOR IEC ACTIVITIES

IEC activities are crucial especially in the early stages of implementation of the programme. There are certain guidelines that will help to plan IEC activities.

- Decide on the target group e.g adults (males/females) and area (urban, rural), school children, adults in work place etc
- Decide at which level would you carry out the activities – entire district or selected CHC/PHC
- A situational analysis would be a good starting point to help in planning meaningful IEC activities. Situational analysis could include

    - Current behavioural pattern – use of tobacco, alcohol, physical activity, dietary habits. This will help you to plan useful intervention according to the need
    - Availability and use of media – popular and preferred media for that community
    - Local support groups, PRI, NGOs, women & youth groups etc

- Decide the method – group/individual counselling/ community level/ family level. Some messages are preferably communicated through mass media, while others through group activities in the community.
- IEC materials to be used like films, posters, pamphlets should be available in adequate quantities in all blocks in the districts.
- Make a calendar of activities. Take into account festivals, important health days.
- IEC activities should be sustained to reinforce health messages in the community
- Make sure you include the budget for your IEC activities while developing the PIP

Exercise 9: prepare a plan for IEC activities and budget it

Section 3

GENERAL MANAGEMENT SKILLS

MANAGING HUMAN RESOURCES

"The most important asset of an organization is human resources, not buildings or equipment"

Learning objectives
In this session you will learn about

- *Recruitment of contractual staff*
- *Organising training programmes*
- *Performance appraisal*
- *Dealing with conflicts among your staff*

WHAT IS HUMAN RESOURCES MANAGEMENT AND WHY IS IT IMPORTANT?

A programme manager will have to deal with management responsibilities like dealing with manpower, managing other resources like material, time, finances. All are important, but since 80% of health budget is spent on salaries and staff benefits, it is important for you to understand how to effectively manage your staff. Now that activities have been planned, adequate staff should be in place. There may be existing staff in the programme, or there may be vacant posts which need to be filled up.

Table 3.1: Staffing in NCD Cell

Staff at District NCD Cell	Number
District Programme Officer	1
Programme Assistant	1
Finance cum Logistics Officer	1
Data Entry Operator	1

Table 4.2: Staffing in NCD clinic

Staff at District NCD Clinic	Number
General physician	1
GNM	2
Physiotherapist	1
Counselor	1
Data entry operator	1
CCU	
Specialist – Cardiology / General Physician	1
GNM	4

RECRUITMENT OF CONTRACTUAL STAFF

Recruitment of contractual staff is to be done according to the guidelines of NHM. Details of eligibility criteria & pay scale of NPCDCS staff for State and District are given in the programme guidelines. In the NPCDCS programme, the staff will be recruited on contract basis to manage NCD clinic /CCU, to provide emergency, OPD services, counselling, and rehabilitative services.

A vacant post should trigger the need for new recruitment. State Programme Officer and District Programme Officer should take the initiative to start the process within the NCD cell. Recruitment can be done through direct recruitment or outsourcing as per state NHM directives.

Solutions to overcome HR shortage

- New recruitment which could be- regular or contractual
- Transfer from outside or from some other department
- Re-deploy from within the existing staff – this is a quicker method to address shortage for a short term, as compared to new recruitment process which could take time and would generally be out of your control

TRAINING

Newly recruited staff will need to be trained. It is also important to train those who are already on the job if there is a new activity under the programme. State NCD Cell is responsible for organizing State & district level trainings for capacity building. District NCD Cell will conduct sub-district/ CHC level trainings.

Generally, there are two types of training

1. **Induction Training-** At the time of entry into service
2. **In-service Training-** It must be provided to all categories of staff to upgrade their knowledge and skills in technical and management fields while in job. There is need to hold these trainings at periodic intervals.

Prepare a training calendar

While preparing the PIP, you have already prepared a training plan and estimated the budget for it. Now an annual training calendar giving details of the work plan with dates needs to be prepared. Barring any emergencies, the training plan should be adhered to.

District training calendar

Prepare the training calendar at least two months ahead and send it to the state NCD cell. The training calendar should take into consideration:

- The training load
- Availability of training days
- Availability of training venues
- Availability of facilitators
- Other training courses for your target group (Medical Officers/ health workers/ ASHA) State training plan

State training calendar

- Compile and collate the various district training plans after ensuring their appropriateness.
- Plan for training of trainers to enable the districts to undertake all the training planned by them.
- Prepare database of available trained manpower in the state for various skills.

An example of a training calendar is given below.

Example of a training calendar

Category of staff to be trained	Duration of training	Venue	Batch size	Total training load			Target no. of batches for year 2017-18	April 17	May 17	June 17
				Sanctioned strength	In position	Total untrained load				
Medical officers	3 days	Distict	20	200	150	150	7	15 -18th	-	1st- 3rd
ANM	5 days	CHC	20	1000	850	850	12	20-24th	10-14th	3rd – 8th
ASHA	5 days	CHC	30							
Counsellor	3 days	CHC	20							
(Others)										

Exercise 10: Prepare a training calendar for your District

PERFORMANCE APPRAISAL

Performance appraisal is important as it allows you to evaluate your staff performance and accomplishments for a given period of time. It is usually done annually. Performance appraisal will be used as a basis for extending or terminating a contract in case of contractual staff. It can be done by several ways. You can also develop your own appraisal proforma. Keep in mind that

- It should be an objective assessment.
- It should evaluate the performance of your staff according to the Terms of Reference given in their contract.

Health care delivery is a team work. Assess the staff concerned regarding his/her ability to work as a member of a team.

Example of attributes for performance appraisal

- Punctuality and work ethics
- Ability to lead and work as a team
- Technical competence
- Performance and discharge of responsibilities

SUPERVISING THE STAFF

Supervision is a way of supporting the staff and ensuring the quality of the health services they provide. All levels of staff need ongoing support for solving problems and to overcome difficulties.

They also need constructive feedback on their performance and continuous encouragement in their work. Such a supportive supervision ensures smooth implementation and continuous programme improvement. However, supervisory visits need certain logistics, including time and transport, and therefore have resource implications. In order to carry out regular supervision, it is necessary to prepare a supervisory schedule that lists who will visit which worker on which days, what are the transport needs, etc.

Supervision consists of three sets of activities

1. **Concurrent supervision (supportive supervision) -** In this type of supervision, you (or any supervisor) will accompany the worker while he or she carries out the programme activities. You can use a short checklist to observe the work and evaluate the quality of work. The checklist is only a guide to capture critical indicators. Hence capture other relevant issues and best practices beyond the items mentioned in checklist.
2. **Random verification -** you can also randomly verify the work already done and reported by the worker. For example, if the worker has reported the presence of a cancer patient in a particular household, you (or supervisor) verify it and confirm the other details provided. By doing an independent supervision, you can also take a feedback about the worker's performance in day-to day activities.
3. **Record review -** Review reports and documents for correctness and timeliness. You can check the monthly reports, OPD records, registers, forms etc that are maintained in the centre.

Feedback of supervision

An essential and perhaps the most important aspect of the supervision is giving feedback to the worker. This is what ensures a constant improvement in the system. It has to be done in such a way that the staff/worker does not feel threatened. For example, the checklist can be jointly reviewed by you (or supervisor) and the staff. Both can feel assured that if all features of a checklist are in place, the function or programme is performing up to expected standards. Alternatively, highlight any deficiency that you detect and suggest ways of improvement.

Practical Tips for Supervisory visits

Supervision is often neglected, as you get busy with other activities. Some of you may be having additional charges and are responsible for other programmes besides NPCDCS. So how will you find the time for supervision?

Firstly, as we have discussed in the beginning, plan for supervisory visits while preparing your action plan for the year. Once an activity is budgeted, you will be forced to complete it.

Secondly, plan for your visits in such a way that you can cover as many CHCs/ PHCs as possible in one year. Make special efforts to visit centres which are located in difficult to reach areas, far from the district headquarter, as these will be the ones which are often neglected and will need more support.

Thirdly, utilise all opportunities that you get to supervise the programme. You may have to visit your CHC/ DH for some other purpose like a camp, special programme, meeting etc. Make use of those visits to check on some programme activities like records, monthly reports, stock register etc.

Attributes of effective supervision

Effective supervision

- Plan ahead. Make a supervisory plan
- Inform about your visit
- Acquaint yourself with baseline data of area/facility to be visited
- Use a checklist.
- Set example –demonstrate correct practices
- Record important observations of the visit
- Communicate the observations to staff and appropriate authorities
- Keep track of actions taken on the recommendation

An example of a reporting format for supervision is given below:

Supervisory Report format:

Name of Health facility: _____Date & time of visit:_____

Name of the supervisor: _____Designation:_____

Persons interviewed: _____

Activities observed	***Problem identified***
Administrative (HRD and Financial) Diagnostic, drugs and Lab consumables Treatment and follow up, Records and Reports, IEC etc	
Recommendations with persons responsible and Time frame	
Follow up action taken based on the previous recommendations	
Comments	
Name & signature Date:	

Exercise 11: Prepare a supervision plan for your district

DEALING WITH PROBLEMS AND CONFLICTS

Conflicts are common at workplace and as a manager, it is often your role to discern when a conflict is a normal part of the work day and work relationships or whether you need to take extra efforts to deal with it

Types of Conflicts

Conflict type	Description
Values conflict	Involves incompatibility of preferences, principles and practices that people believe in such as religion, ethics or politics.
Organizational conflict	Involves inequalities in the organizational hierarchy and how employees report to one another.
Power conflict	Occurs when each party wishes to maintain or maximize the amount of influence that it exerts in the relationship and the social setting such as in a decision making process.
Economic conflict	Involves competing to attain scarce resources such as monetary or human resources.
Interpersonal conflict	Occurs when two people or more have incompatible needs, goals, or approaches in their relationship such as different communication or work styles.

Preventing conflicts

The commonest cause of conflicts in a work team is confusion, caused by people having different ideas about what is to be done and how it is to be done. Such disputes can be minimized or prevented by:

- Frequent meetings with your staff members
- Having clear and detailed job descriptions
- Having clear instructions and procedures to follow
- Distributing tasks fairly
- Creating work schedules that distribute work fairly.
- Allowing people to express views openly and letting the whole group decide what should be done

A common cause of argument is jealousy and favouritism. A supervisor must behave towards each member of the team with complete fairness and justice, and must never criticize staff in public.

How to resolve conflicts

- Tackle the issue after both parties have calmed down.
- Maintain a positive outlook
- Practice "active listening
- Ask the other person to suggest a solution
- Consider your role in the conflict
- Never criticize in public

MANAGE YOUR TIME WELL

We often complain that we do not have time for doing the things that we want. While this may be to some extent true, it is also true that we can always improve our time management to do things which are more urgent or important. One of the simple way of prioritization is to make this two by two table.

Importance and Urgency

	Urgent	Not Urgent
Important	I. ACTIVITIES • Crises • Pressing problems • Deadline-driven projects	II. ACTIVITIES • Relationship building • Recognising new opportunities • Planning, recreation
Not Important	III.ACTIVITIES • Interruptions, some calls • Some mail, some reports • Some meetings • Proximate, pressing matters	IV. ACTIVITIES • Trivia, busy work • Some mail • Some phone calls • Time wasters • Pleasant activities

STRATEGIES FOR TIME MANAGEMENT

We have listed here some strategies for becoming a better time manager.

1. Discipline: If you are an effective manager of yourself, your discipline comes from within; it is a function of your independent will. Until and unless you feel motivated to implement changes in your style of working, you cannot effect a transformation. Consistency is the key word for getting returns and this is possible only through discipline.

2. Importance of learning when and how to say 'No': To say 'yes' to important Quadrant II priorities (Important but not urgent), you have to learn to say 'no' to other activities, sometimes apparently urgent things. You have to decide what your highest priorities are and have the courage—pleasantly, smilingly, non-apologetically—to say 'no ' to other things.

Exercise 12: Think of your typical day and classify all things that you did into these four categories and also the time spent on them. Do you see any problem?

CONDUCTING MEETINGS

How can you ensure that meetings are effective?

Meetings are an essential part of management. In fact, we seem to go from one meeting to another the whole day. If most meetings seem a waste of time with no outcomes, it is only because they are not well planned. Meetings are also tools for team building, platforms for problem solving, platforms for decision making and forums for brainstorming.

The following rules will help making the meetings effective:

1. Keep an agenda: Always circulate a well-defined agenda, well in advance, to all the participants so that there is enough time to modify the same if the feedback warrants it. This also helps in better preparation. Add in the agenda a couple of lines on each person's copy stating clearly what information he or she is expected to bring to the meeting.
2. Information regarding the meeting well in advance to allow sufficient time for all participants to obtain approvals as required and make preparations for travel
3. Prepare well: Lack of preparation only holds up meetings. More time is spent on pulling people up for not bringing the relevant data, and having them leave the meeting to get it, than for anything else. You must go fully prepared.
4. Meeting arrangements: The logistics should be well organized for meetings including delegation of responsibilities, meeting venue preparations, resource material in sufficient quantities, Audio-visual media, required formats for settling bills for travel or stay of participants if relevant and attendance sheet. List of participants, resource persons, follow up with participants and agenda for the meeting should be kept ready
5. Manage Time Well: This means start and end meetings on time. It is almost a given in India, that the meeting does not start on time. This is a reflection of our disregard for not only our time but also other people's time. While preparing an agenda the convener has already thought about the time required for each item. The chairperson or time keeper should let the participant know that they are exceeding the time and delaying or shortening the rest of the discussion. If there is a contentious issue which is being unendingly discussed, this issue could be postponed and the rest of the meeting agenda covered.
6. Have a conducive environment: This includes both physical as well as psychological. A reasonably comfortable room with basic amenities with appropriate size for the size of the meeting should be fixed. To facilitate discussion, circular position of chairs works the best. The chairperson should be non-judgmental and give everyone a chance to speak.
7. Conclude with a summary: Meeting should not end with a resolve to meet again. Always insist on a conclusion. Summarize the progress made in terms of what was decided/agreed and what were unresolved issues
8. Report of the proceedings: Minutes of the meeting should be prepared within a reasonable time frame and shared with the participants. The minutes should clearly outline the summary of discussions, action points and recommendations to enable follow up activities.

HANDING OVER AND TAKING OVER

It is commonly seen that program managers or nodal officer change, either due to transfer or a change of job ore retirement. A good program manager ensures that this change does not affect work by ensuring a smooth handover. Some tips one ensuring smooth transfer is provided below. The aim is that the work does not suffer and the discontinuity in the system is least. It also ensures that institutional memory is present.

The handover should be structured, take at least half a day and include all the employee's day-to-day tasks. There should also be a written note, with specific instructions about systems or projects, and useful contact numbers. Some of the issues to be covered during the handing over/taking over are listed below.

Domain	Issues	Tips
Managerial	• The key priorities of the program should be clearly communicated. • Key pending issues should be arranged as immediate/ priority, medium and long term • Key barriers to implementation of the program should be told. • It might be good to clear some critical files before you go as the newcomer may take time to understand the issue delaying the process.	• Tips on managing the bosses are always welcome. • Successor needs to take time to understand the problem but also approach them with a fresh set of eyes. • It might be good to prepare a typical day/month scenario.
Human Resource	• A list of all workers, their position and roles with their contact number should be given. • Make the successor meet the key people. If need be call people from peripheral sites like PHCs to the district office.	• Let him know the good workers and trouble makers. However, successors should make their own judgements as these often have personal biases.
Finance & Inventory	• Both should sign the key finance and stores registers and other documents. • List of pending bills or payments should be given in writing. • Handing over major cost items in the stock should be done in person. • Any important pending purchase issue or equipment repair should be communicated.	• There are no shortcuts for this critical aspect of handing over
Time	• Take at least half a day for explaining • Do not hurry to finish the handing over.	• Have a transition period. Working side by side allows better understanding.
Documentation	• Share key files/ letters/ manuals / documents	• Some Offices have prescribed handing over and taking over documentation process.

If you get repeated calls from your successor or boss of your earlier office, then you can be sure that the handing over has been inadequate!

MATERIALS MANAGEMENT

Purchase and Inventory

"The line between order and disorder lies in logistics"

Learning Objectives:

- *To understand inventory management procedures*
- *To understand proper documentation related to inventory management*

INTRODUCTION

Logistics management is practised by all managers and material management is an important component thereof so it is important that managers understand this component properly. Health care programmes are heavily dependent on materials in the form of equipment and drugs & consumables like laboratory reagents, diagnostic kits, outpatient stationery like forms, registers, etc.

Material management aims to "coordinate, supervise and execute the task of flow of materials to, through and out of an organization". Good material management practice ensures continuous supply of good quality material at the lowest possible price, at the same time mainitaining the inventory level to the minimum so the working capital is not blocked. **In brief, material management means availability of the right item, at the right time, right place with the right person who can contribute to the health care provision.**

Under the programme, an indicative list of drugs for common NCDs is provided (Annexure). The NPCDCS Operational Guidelines also provide an indicative list of essential equipment under the programme.

Activities under Material Management

The important activities which is undertaken under the material management are as follows

a) Planning and forecasting
b) Procurement
c) Storage
d) Supply and distribution

For management to be effective, it is important that the persons involved in these processes should work in tandem as a team.

Inventory means a stock of items held to meet future demand. An effective inventory management should ensure a continuous supply of drugs and other consumables to facilitate uninterrupted care and maintain sufficient stock in periods of short supply.

a. Planning and Forecasting

As a programme manager you should be well informed about the funds available for procurement of materials under the programme. As emphasised earlier, you should place the estimated cost for procurement in the National Health Mission PIP or Programme budget well in advance. Forecasting of procurement costs is an important activity which has to be done in consultation with finance personnel.

Total drug requirement for a month = (consumption by new patients in a month) plus (continuing consumption by old patients in a month) minus (stock on hand)

b. Procurement

This refers to actually obtaining the materials needed. All procurements of goods/ articles under the programme should be made as per the NHM guidelines and State Government Procurement Rules which includes the limit for invitation of tenders, limit for quotations, formation of procurement committee, etc.

Before procurement is made, as managers you should make sure the following things are done

Requisition & placing orders

- Proper written policies and procedures to control and monitor inventories should be in place.
- The purchases to be made or services to be received should be according to the approved plan.
- Before planning any purchase, existing stock position must be assessed.
- Specifications of the items to be purchased should be very clear
- All purchase orders should be prepared on the basis of approved purchase requisitions.
- All purchase requisitions should be reviewed by a senior official to ensure reasonableness and appropriate delivery address.
- Purchase orders should have all the relevant information pertaining to purchase and the information should be classified in an orderly manner.
- While procuring items with a fixed shelf life like drugs or reagents for lab use due emphasis should be placed on *the expiry date*

Issues related to Maintenance

- While drawing specifications other terms and conditions must be drafted too, especially those related to maintenance of equipment. The usual dictum is to minimise the break down time.
- The items should be procured with the longest possible maintenance contract with the manufacturer. It is good to have a good length of warranty and equal length of CMC (Comprehensive maintenance contract)
  - o e.g. A number of state governments have made 5 or 10 year maintenance of equipment compulsory for the firms supplying the same.
  - o If you are procuring auto-analysers it is good idea to fix the cost of consumables for the next five years with the supplier.

Deciding specification of item (s) to be purchased

Specification of item is the key to the procurement process.

- The specification is drawn by a group of technical experts who are well versed with item in question (specification committee).
- Usually specification should be broad based and inclusive. The specifications should not be too restrictive or tailor made to meet any particular brand or manufacturer. The practical way to draw specifications is to draw common points of commonly available brands in the market.
- While procuring materials such as diagnostic tools (auto-analysers or X-ray machines) preference should be given open system over closed systems. Open systems allow consumables of all manufacturers to be used with the machine. Closed systems allow the consumables of the same manufacturer for the machines.

Method of procurement:

Procurement of items should follow the laid down financial rules of National Health Mission or State governments. The General Financial Rules (GFR) 2005, Ministry of Finance, Govt. of India should be the guiding principle for procurement of items.

The usual techniques followed in procurement of items are tenders, rate contracts or local purchases.

Tender

Tender based purchases are resorted to by all government and public sector organizations. The manager invites responses from all prospective suppliers based on technical specifications of item in question. Tenders can be classified as open, limited or global tenders. In open tender enquiries are floated through advertisement in the media (website, newspapers).

Rate contract

Rate contract is the purchase system wherein the rate of an item is determined through a tender system, without specifying the quantity to be purchased. Rate contracts are available through DG S&D (Director General Supplies and Disposals) which can be resorted to if the item in question is listed there.

Local Purchases

Local purchase refers to purchases made from open market strictly on the basis of need and is usually confined to emergency procurement of low priced items required in small quantities. These are usually for an amount below a specified limit

Web-based methods

A number of states are now implementing a web based application, 'e-Aushadhi module', which deals with the management of stock of various drugs, diagnostic aids and surgical items required by different district drug warehouses of the state. The main aim of 'e-Aushadhi' is to ascertain the needs of various district drug warehouses such that all the required materials/drugs are constantly available to be supplied to the user district drug warehouses without delay.

Inventory

- All purchases have to be taken into the inventory. Purchased consumable items are entered in the stock register (Fig 3.1) whereas the non- consumables (life of over one year) are entered in the fixed assets register. (Fig 3.2) Stock record should be maintained as per the prescribed format to reflect stock-wise quantities and locations by individual items.
- All stock movements should be supported by formal pre-numbered documentation and be appropriately authorized-

Maintaining records

- Maintaining records is an essential step in efficient inventory management
- Stock records should be updated immediately on issue/ receipt of any item.
- The store officer is accountable for matching the physical availability and data records as per stock register

Storage

The next important step in material management is storage of equipment and consumable. Some good practices involving stores are:

- Store should be managed by an authorized store keeper and store records should be kept under his custody only.
- Fire safety and pest control should be in place to keep the stored items safe from damage
- Appropriate stock records should be maintained for receipt and issue of material
- Items / material should be arranged/ stacked properly in the store to facilitate FIFO (First In, First Out) method of issue of store items.
- Periodical stock verification should be conducted by the store keeper along with an independent officer appointed by head of office; any discrepancies should be appropriately recorded and reported to the higher authorities.
- Obsolete, expired, damaged, and slow-moving items should be identified on periodical basis (monthly/ quarterly basis) and reported to higher authorities.

Date	V. S.No.	Particulars	Location	Asset Quantity (Nos)				Asset Cost (Rs)			
				Begining of the Year	Addition	Deletion/ Transfer	End of the Year	Beginning of the Year	Addition	Deletion/ Transfer	End of the Year

Figure 3.1 An example of a page from stock register

Date & month	Particulars	Bill No	Opening stock in qty.	Receipt		Issued in qty.	Balance stock	Remarks
				Qty.	Rate			

Figure 3.2 An example of a page from fixed assets register

Case study 3: Human resources management

In a CHC Y, there was staff nurse posted for NPCDCS (NCD Clinic staff nurse). NCD clinic staff nurse is trained in NCD clinic related services. In the CHC, all the staff nurses are working in coordinated manner. In each three months, she gets night duty for seven days for RCH services as per roster. This results in unavailability of trained staff nurse for NCD for entire two weeks. How would you solve this issue in the capacity.

Case study 4: Managing Inventory

In the district D, there are 20 Primary health Centres. As the District programme officer (NPCDCS) when you reviewed the position of drugs availability in these PHCs, there were two PHCs had excess amount of metformin tablets in the stock and two PHCs having nil stock of metformin tablets. In a position of manager, what would be your approach to solve this problem to prevent in future?

Case study 5: Managing inventory

You are a state programme manager for state X. You received request for 5 new autonalyser from five districts and two request for repair of autonalysers from two districts. You have budget available for tow autonalysers only. How will you prioritise the districts to purchase the autoanalyser and how would you handle the maintenance issue?

Tips on good storage practices

- Access to the store should be limited to authorized personnel only
- Stock records should be updated immediately on issue/ receipt of any item
- Fire safety and pest control should be in place
- Random checking should be done by concerned authorities to ensure compliance

Supply and distribution

- Supply and distribution of equipment and consumables at the right time to the right place in the right hands is an important task in material management.
- Once the material is delivered by the supplier, the first step would be entering in the appropriate stock register. Conventionally two registers are maintained for consumable and non-consumable items.
- Items should be issued based on the indent received from the place of use. Usually in the health system fixed day issue per month is practised for consumable items.

How will you ensure that there is no stock out period?

Indenting of consumables should follow scientific principles based on buffer stock and lead time.

Buffer stock is also known as safety stock or reserve stock. Buffer stock is the minimum quantity of supplies set apart as reserve against variation in supply and demand. Buffer time is greatly influenced by lead time. Lead time is length of time in days between the decision to replenish an item and the actual addition to the stock. Buffer stock is usually calculated by multiplying average demand and maximum delay or probable delay.

Buffer Stock = (Average Demand per day) X (Average Lead time in days)

Example: In case daily demand of Metformin tablet is 600 tablets (30 tablets each to 20 persons) and the time from demand to indent is 15 days a buffer stock of 9000 tablets should be kept. Demand for tablets should be sent once the stock reaches 9000 tablets.

During the time buffer stock is being used the number of tablets issued per person might have to be reduced in case there are reasons to believe that time to replenish would be more than the assumed lead time.

In nutshell, the aim of supply and distribution is to ensure there is no stock out period and at the same time there is no excess stock. Excess stock takes up space and is liable to expire before it is fully used thus contributing to wastage of funds.

Record keeping:

This is an important requirement for efficient inventory management. Maintaining records will help provide accurate information about the available stock, determine ordering or purchasing needs, control theft and pilferage and be ready for computerization.

FINANCE MANAGEMENT

"Money is a tool – used properly it makes something beautiful – used wrong it makes a mess"

Learning Objectives

- *Understand steps in financial management at state and district level*
- *Enable the managers to prepare budget for the planned activities*
- *Understand key accounting procedures and reporting formats*

WHAT IS FINANCIAL MANAGEMENT?

The programme has a separate cadre of financial management personnel however it is pertinent that programme managers are aware of financial management procedures. Detailed operational manual for financial management under NHM is available online for ready reference.

Financial management means efficient and effective management of money (funds) in such a manner as to accomplish the objectives of the organization. It is made up of a number of distinct processes that happen in a cyclical way In our context the main aim is to operationalise an effective and accountable financial management system for budgeting, release, monitoring and utilization of funds under NHM at the central, state, district, block and facility levels.

Financial planning

- The first step in financial management is financial planning. This is intertwined with the service planning for the programme activities . For this achievable goals and targets that have been set by the facility/ district/ state need to be considered. Detailed budgeting is the outcome of this financial planning. Hence budget reflects service priorities and is the framework for spending monety and assessing financial performance.
- Detailed justification of all items in budget needs to be prepared too. It must be mentioned here that NHM follows a botom up approach for planning and budgeting .
- The process begins at district health plan and these are then used to prepare state project Implementation plans.

Allocation and release of funds

Once the budget proposal reaches the central government – the same is reviewed by the financial management group, programme division and sub groups (comprising MOHFW and state government officials) – and if need be, the states are asked to revise their project implementation plans. These are then discussed in the National Programme Coordination Committee (NPCC) meetings and finalised .

Accountability for expenditure is important, hence proper accounting needs to be maintained. It involves proper documentation of all expenses as well as inward remittances
The accounting records are used to prepare financial reports. Such reporting is done in fixed formats within stipulated timelines to report ulitilzation of fuds that were disbursed.

Under the National Health Mission to ensure efficient financial management a separate financial management group (FMG) has been established at the central level (Govt. of India), which is supported by respective finance units at state, district and block levels. Funds are pooled together under NHM and provided for implementation of various programmes under it. - The funds for NCDCPS is provided under the NCD flexi pool.

Budget preparation and allocation

All state and district programme managers are involved in preparing the budget for themselves and those under them

- The planning must be done as per the different activity heads of programme implementation plans (PIP) under the NCDPCS. It includes expenditure for different activities at state NCD Cell, district NCD cell, district NCD clinic, district CCU/ Day care, CHC NCD clinic, PHC and Sub-centre
- The plan is prepared by bottoms up approach starting from the district health action plan.
- At state level budget proposal is approved bythe state Mission Director of NHM, priorities are revisited, targets are scaled down and at times the budget itself would need to be scaled up or down, States have the flexibility for inter-usability of funds from one component to another under NCD Flexi- pool as per NHM guidelines, under intimation to the GOI.

Accounting

Accounting includes proper recording of all transactions through vouchers in different books of accounts including cash books, journals, ledger etc. All financial transactions must be recorded, classified and summarised. Various types of books (records) need to be maintained to capture the financial transactions in a proper way. This is important as it helps organizing and preparing the financial statements, budget and financial plans and facilitates auditing.

Financial reporting and monitoring

A programme manager must be aware of the key financial reports that need to be submitted at regular intervals. The reporting requirement at different levels is depicted in Table 4.2.The commonly used reports under NHM include

Financial Monitoring Report (FMR):

FMR is one of the primary financial reports which provide component wise utilization against the allocated budget.

- Only actual expenses should be reported (unsettled advances should not be reported as expenditure)
- It also must include physical progress against the target determined.
- Information for the specific period (Monthly/ Quarterly) and cumulative ‘year to date”
- Must be signed by the head of the unit with counter signature by finance head of the unit

Utilization Certificate (UC)

Utilization Certificate (UC) (Provisional & Final Audited): UC is a form to be submitted by spending unit certifying the amount actually spent against the grant disbursed to it.

- It has to be provided by all units from State health society down to sub centres provided sanction-wise details of grant received, purpose of the grant, amount spent and unspent balance in a timely manner.
- UCs pertaining to various programmes should not be clubbed in any case and should be furnished separately
- All grant- in- aids sanctioned and released by the government of India to State Health Society in a particular financial year shall be indicated by the society in its UC of that financial year irrespective of the fact that the amount is received by the society in subsequent financial year

- Expenses shown in UC should include expenditure as per the Income and Expenditure account plus amount of Capitalized assets.
- SHS should submit the UC in Form No GFR 19A and it should be signed by mission director/project director/ state programme officer and statutory auditor to MoHFW along with audited annual financial statements
- In case of units below the level of State the UC should be signed by the head of the unit and counter signed by the Charted accountant and should be submitted along with audited report for that programme for the same financial year.

Statement of Expenditure (SoE):

SoE provides expenditure against the funds received under various components of the programme

Table 4.2 Different reports under NHM and their time lines

Unit/ Frequency	Financial Reports and their Timelines		
	Monthly	Quarterly	Annually
State to GoI	• SFP	• FMR • Statement confirming State's contribution	• UC (Audited) • Provisional UCs on demand • Statement of Interest Earned
District to State	• FMR • SFP	-	• UC • Statement of Interest Earned
Block to District	• SoE	-	• UC • Statement of Interest Earned
CHC/PHC to Block/ District	• SoE	-	• UC
Sub Center to Supervisory unit	• SoE	-	• UC

Monitoring financial activities

In addition to financial reporting, certain ancillary monitoring activities too need to be carried out under NHM at each level. These include:

- **Monitoring timely submission of financial reports:** timelines need to be set up and rigorously followed up any reasons for delay must be intimated to higher units
- **Periodic financial analysis:** Different types of analysis at state and national levels e.g. Budget vs. Expenditure analysis, Physical vs. Financial performance, etc
- **Monitoring concurrent audit activities:** Concurrent audit is a systematic examination of financial transactions on a regular basis to ensure accuracy, authenticity, compliance with procedures and guidelines. This is done by independent chartered accountants identified by state and district level authorities.
- **Periodical meetings at supervisory level:** These happen at block/ district/ state levels to review performance, provide feedback to improve performance, address queries or to intimate new guidelines related to financial management
- **Common/ Joint review missions / Mid-term review:** conducted by external agencies
- **External Reviews:** conducted by external agencies

AUDIT

The key objectives of audit are:

- To assess and provide an opinion on whether the Financial Statements present a “True and Fair” view of

1. The financial position (Balance Sheet) at the end of the period; and
2. The financial performance (Income and Expenditure account) during the period

To test whether requisite internal controls are in place, commensurate to the size and volume of operations of the entity

Two types of audits are done under NHM namely statutory audit and concurrent audit, besides these audits, CAG Audit is also conducted at various levels in respect of Health department.The primary objective of 'Statutory Audit' is “to ensure that the financial statements i.e. the Balance Sheet, Income & Expenditure Account and Receipt & Payment Account, give a true & fair view and are free from any material misstatements”. In context of NHM, Statutory Audit also aims at ensuring that the respective programme expenditures are eligible for financing under the relevant grant/ credit agreements (under programmes supported by development partners) and that the funds have been utilized for the purpose for which they were provided. Statutory audit of State and District Health Societies is supposed to be carried out by Chartered Accountant firms appointed by the SHS.

Exercise 13: Examine and understand a Financial Management Report (FMR)

Section 4

ADVOCACY AND COMMUNICATION FOR MULTISECTORAL ACTIONS

Learning objectives
At the end of this module, you should be able to Advocate action for NCDs to different stakeholders in the district including the District Commissioner

WHAT IS ADVOCACY?

Advocacy is a combination of individual and social actions designed to gain political and community support for a particular health goal or programme. Advocacy is an action-oriented process that involves providing sound solutions to someone with the power to make change (such as an elected politician or government bureaucrat). To be successful, advocates must have a sound, evidence-based argument; understand the specific windows of opportunity for their cause; and build communication that fosters social awareness and a shared understanding of how to achieve measurable change.

NCD prevention depends on action beyond the health sector, and requires appropriate policies and investments from government, industry, and community organisations. Yet decision-makers are confronted daily with the many competing interests of individuals, groups and organisations, and often there is a trade-off between one issue and another. Advocacy for health is not a 'one-off' event. It requires sustained action with multiple players.

PRINCIPLES OF ADVOCACY

Advocacy needs to be well planned. General principles are:

Identify target audience

It is important to identify decision-makers -- the people with decision-making power (primary target audience), as well as the influencers -- people who influence decision-makers such as staff, advisors, media and the public (secondary target audience).

Select and frame issues

Identify the issues that need to be addressed and prioritize the issues. Advocacy messages should be tailored as appropriate to different audiences.

Evidence-based

Advocacy messages and campaigns should always be based on robust data and evidence. When combined with compelling real life stories and case studies, data will come to life.

Campaign

Campaigns designed to influence a specific group - are a powerful tool. Link your NCD campaigns to political events (e.g., relevant national and international days) to create a larger impact.

Engage the media

Building strong relationships with journalists are important avenues to raising awareness, educating the public, demanding attention from decision-makers, and influencing your target audiences to take action on NCDs.

Monitoring and evaluation of advocacy

Incorporate monitoring and evaluation into advocacy planning from the beginning.

MULTI-SECTORAL ACTION

NCD prevention includes a wide spectrum of activities, most of which are in the non-health sector e.g. tobacco, alcohol, healthy diet, physical activity. If we are to address these problems, we have to involve different sectors, work with non- health departments and move beyond hospitals and health centres. e.g food vendors, traders, media, youth groups, women's groups etc. Some of them are shown in the figure below (Figure 4.1). Hence you are encouraged to plan activities and involve multiple stakeholders for NCD prevention activities.

IDENTIFY PARTNERS FOR NCD CONTROL ACTIVITIES

Although inter-sectoral collaboration is required between many sectors as stated above, at district level, you need to work closely in collaboration with the following sectors:

- Panchayati Raj Institutions (PRIs)
- Local NGOs
- Women's self- help groups
- Youth groups (yuva mandals)
- Private sector– private health sector
- NGOs, Civil society,
- Mass media
- Corporate industries through the Corporate Social Responsibility (CSR)

Table 4.1: Examples of cross-sectoral government engagement to reduce risk factors, and potential health effects of multisectoral action.

Sector	Tobacco	Physical inactivity	Harmful use of alcohol	Unhealthy diet
Health	√	√	√	√
Agriculture	√		√	√
Food processing			√	√
Finance, tax and revenue	√	√	√	√
Law and justice	√		√	√
Information and broadcasting	√	√	√	√
Consumer affairs	√		√	√
Women and child development	√	√	√	√
Commerce and industry	√		√	√
Human resource development	√	√	√	√
Youth affairs and sports	√	√	√	√
Road transport and highways			√	
Labour	√	√	√	√
Urban and Rural development	√	√	√	√
Social justice and empowerment	√	√	√	√
Environment	√	√	√	√

Coordination Mechanism:

It is necessary as a program manager to establish a platform at district and state level that can bring together all stakeholders. Formation of district level coordination committees is one such mechanism. There are many examples of how such committees should be formed. The National Tobacco Control Programme has a coordination committee with similar terms of reference that would be relevant for NCD control.

The coordination will bring together the stakeholders identified in the table above for joint planning, convergence of activities and providing support to different activities of sectors outside health. The head of such a committee should be the District Collector or some officer at a high level who has the convening power.

Let us now understand the concept of stakeholder analysis. It is a process of identifying the individuals or groups that are likely to affect or be affected by your activities and sorting them according to their impact on the action and the impact the action will have on them. One method is by using the Influence -interest grid.

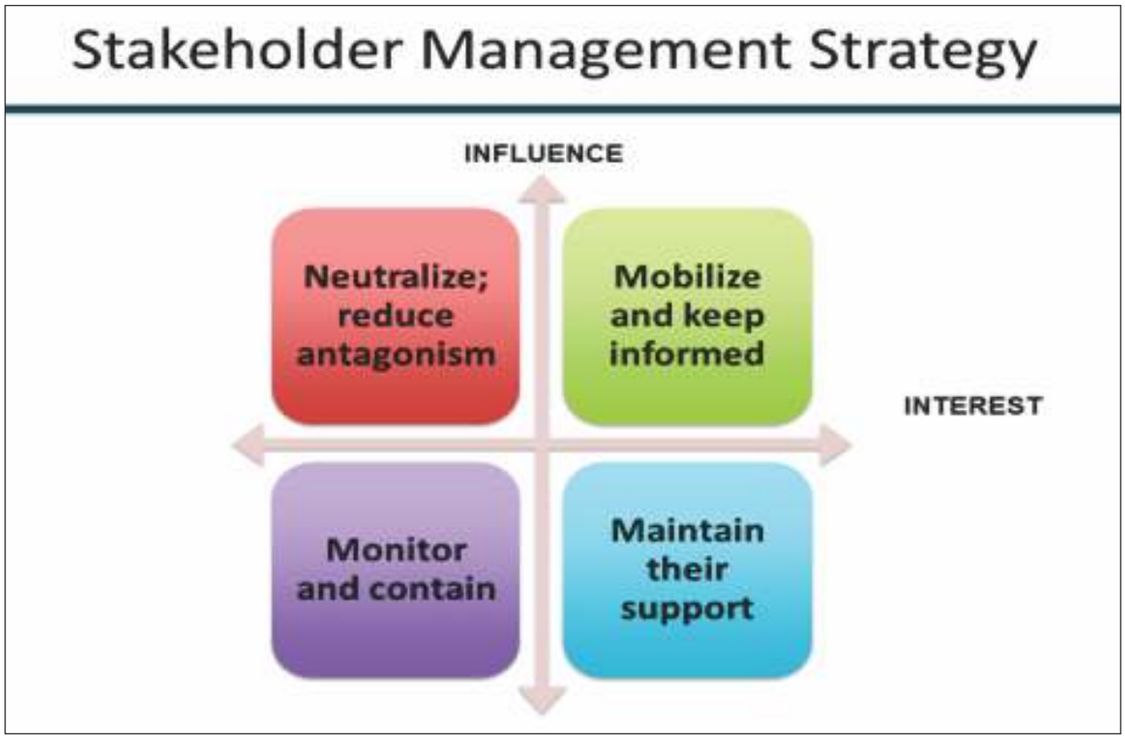


Fig 4.1 Influence-Interest Grid

Plot stakeholder's position on the grid above using the following guidelines:

- High influence, interested people: these are the people you must fully engage and make the greatest efforts with e.g. local leader, sarpanch, political leader, school principal, head of NGO etc
- High influence, less interested people: provide sufficient information to these people to ensure that they are up to date but not overwhelmed with data
- Low influence, interested people: keep these people adequately informed, talk to them to ensure that no major issues arise.
- Low influence, less interested people: provide these people with minimal communication to prevent boredom e.g. other departmental members, teams unaffected by the change.

Exercise 14: Using the "Influence-interest grid" for stakeholders in NCD activities, develop a plan for NCD prevention & control with non- health sector (e.g communities, schools, administration, PRI etc)

Stakeholders Identified   Activities planned/ Timeline etc (elaborate)

COMMUNICATION SKILLS

Communication is one of the most crucial skills for a manager to have. Communication enables others to appreciate your point of view and being more likely to do what you want them to do. It involves at least two people: the sender and the receiver of information. Communication implies understanding. By communicating effectively, a manager minimizes workplace confusion and makes expectations clear.

A wise manager takes more time to listen more seriously and effectively. An important skill that all the communicators possess is the skill to actively listen. Developing the skill of active listening enables you to avoid misunderstandings, confusions, and misinterpretations.

SEVEN "Cs" OF COMMUNICATION

1. Credibility: Reliable or sustainable communication is not possible unless and until the sender is viewed as a credible source of information. In general, in our society doctors are considered as credible source of information and are more likely to be accepted.
2. Context: In which context has the message been delivered. We rarely start a communication from scratch but build on an existing relationship – good or bad. Also, the situational analysis of the district w.r.t to NCDs provides the context. While the context has to be more thoroughly researched and rehearsed before presenting it to the superior, it can be more relaxed when being presented to the subordinate.
3. Content: This is critical. What we say must be technically correct and be supported by evidence. It should not be anecdotal and the science ; evidence and logic behind our message; should be communicated.
4. Clarity: Clarity, both in diction and in pronouncement of ideas, is desired for greater impact of the communicated message. For the message to be correctly and accurately conveyed it is imperative that the message be as clear as possible to the listener.
5. Channels: Credibility and clarity of the message depends on the channels, which are selected to convey the message. We can use multiple channels – television and other mass media, newspapers, one to one meeting, etc. If the same message is repeated across channels it reinforces the message.
6. Consistency: The same message consistently presented in different meetings and fora – by different people carries more weight.
7. Capability of the audience: Gauging the capability of the audience prior to speaking enables the sender to modify his message according to the capacity of the receiver. The choice of language, level of technicality and the kind of outcome expected from the audience dictate the message and content of communication.

VERBAL AND NONVERBAL COMMUNICATION

Most of the points have already been covered in communication skills section. Nevertheless verbal communication is one of the most important forms of communication. While verbal channel is used primarily for conveying information, the non-verbal channel is used for negotiating, interpersonal attitudes. It also includes body language. Each gesture is like a single word and a word may have several different meanings. It is important to observe the gestures of the other person during meetings/conversation to understand his/her feelings and attitudes.

Effective communication:

- Speak with confidence.
- Remain calm and courteous.
- Speak with a logical sequence.
- Learn to be comfortable speaking in front of others.
- Rephrase to ensure clarity.
- Be generous with praise.
- Be friendly and cordial.
- Call people by name.
- Paraphrase questions you are asked to make meanings clear.
- Vary your tone, pace, and volume to keep others interested.
- **Don't' Take things personally**
- **Don't Lose your poise,**
- **Don't Swear.**

HOW TO MAKE AN EFFECTIVE PRESENTATION

As a communicator, it is important that you should speak effectively. It would mean speaking with confidence, having a good posture, direct eye contact, clear knowledge of the subject, thinking before speaking, speaking with a logical sequence and being clear in making your points.

Enhance your presentation Skills

To make a presentation means to communicate something specific for a specific audience and putting across one's thoughts limiting oneself to the area of the specific subject. Managers may have to address their colleagues or different stakeholders already identified.

Steps to make presentation

Planning- Thorough planning is required to make an effective presentation

- What is the purpose /objective of the presentation?
- Who are the audience? Why do they need to listen to this presentation?
- What is the structure of the presentation?
- What will be the duration of the presentation?
- What visual aids are required?

Purpose

- To inform
- To persuade
- To report

Audience

- The number of people in the event
- Their age/ their level of knowledge
- Their possible attitude towards your presentation
- Need of the audience should be assessed and one tries to provide relevant information

Structuring your Presentation
A typical presentation will have

- Introduction- greet, introduce, announce the topic, explain the purpose, outline of the presentation.
- Main body- should devote 60 % of the total presentation time
- Conclusion- summing up the main points, reiterating the central point offering comments, suggestions, recommendations
- Questions and responses- listen carefully, patiently, address the entire audience

Rules for making a good power-point presentation

- Make all the visual aids consistent but not boring. The titles should be of the same size, style and colour. Make sure you never use more than three colours.
- Keep the visual aid out of sight until you are ready to use it.
- Always talk to the audience, not the visual aid.
- Stand to the side of what you are showing, not in front of it.
- Practise using your visual aids as you practice your whole talk.

Exercise 15 : Prepare a 10-minute presentation to convince the District Collector of your district why and how he should promote NCD control activities.

Section 5

MONITORING AND EVALUATION

UNDERSTANDING DATA MANAGEMENT SYSTEM

"Records remember, people forget"

SUPERVISORY CHECKLIST

Learning objectives

At the end of this module, you will learn about

- *Need and purpose of Data Management System*
- *Data flow in NPCDCS*
- *Ensuring quality of Data*
- *Analysing data for action*

NEED AND PURPOSE OF HEALTH MANAGEMENT INFORMATION SYSTEM

A continuous flow of good quality information on inputs, process, outputs and outcome indicators facilitates monitoring of the programme. An efficient data management system is essential to assist, at all levels, in managing and planning the programme. The concepts of data, information, and knowledge are often used interchangeably though they are not synonymous. Often collecting more data is regarded as creating more knowledge, which is a wrong assumption.

Data: It is the raw material in the form of numbers or characters and it is without context.

Information: It is a meaningful collection of facts/data with reference to a context arrived after analysing the data.

Knowledge: When information is analysed, communicated, and acted-upon it becomes knowledge.

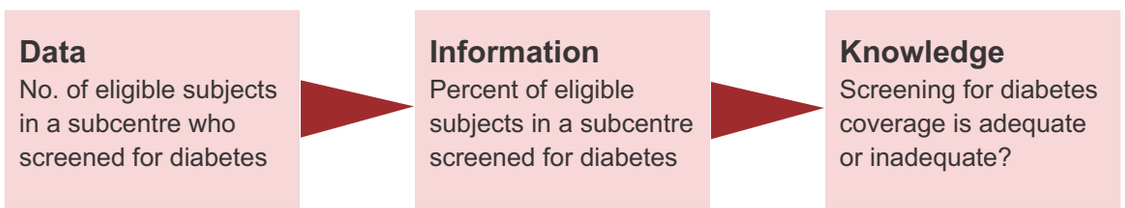


Figure 5.1: Translation from data to knowledge

Thus data have to be used to generate knowledge. Data is useless if it does not lead to any action.

DATA FLOW IN NPCDCS

Data recording and reporting is one of the most important activities for a programme manager. Your work is reflected by the reports that you submit. Therefore, it is important for everyone who is responsible for filling up the reports to do it timely, correctly and completely.

Figure 5.2. Data flow under NPCDCS Programme

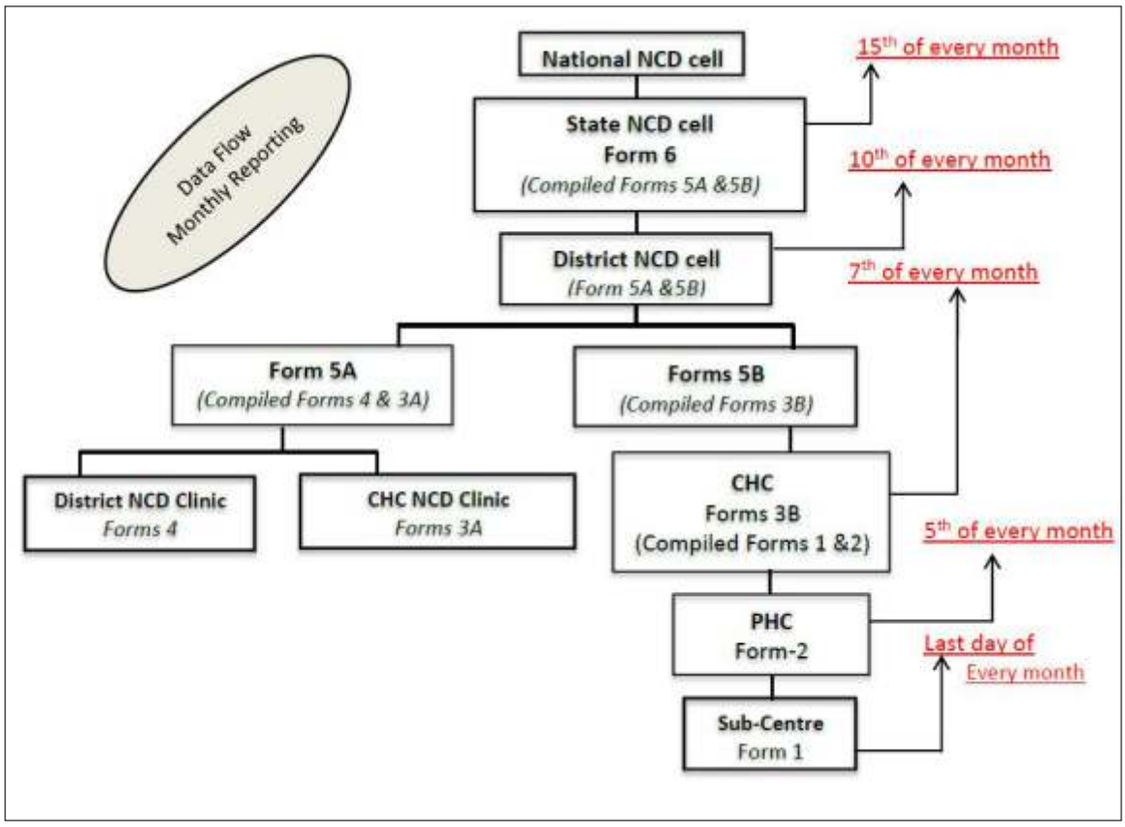


Table 5.1: Responsibility of reporting, flow of information and frequency of reporting.

Level	Reporting Form	Data generated from	Person responsible	Reporting to	Submission by
Sub-centre	Form 1	ANM screening Register	ANM/MHW of SC	MO I/C PHC	Last day of the month
PHC	Form 2	PHC OPD Register	MO -I/C PHC	CHC/BPHC	5th of following month
CHC /BPHC/SDH	Form 3A	CHC NCD OPD Register	MO -I/C CHC NCD Clinic/ BPHC/SDH	District NCD Cell	7th of following month
	Form 3B	Compiled all Forms 1 & 2			
District NCD Clinic (Hospital)	Form 4	Dist. NCD Clinic/ Dist. Hospital Register	MO -I/C District NCD Clinic	District NCD Cell	7th of following month
District NCD Cell	Form 5A	Compiled all Forms 3A & 4	Dist. Nodal Officer (NCD)	State NCD Cell	10th of following month
	Form 5B	Compiled all Form 3B			

Reporting formats are given in the Annexure 4.

DATA QUALITY

In this manual we will discuss the issues that are related to reporting from the District level onwards. It is not enough to collect and report data, data should be checked for quality to minimize errors so that they can be used for decision making. Reports should be **correct, complete, consistent and timely.**

Common problems encountered in reporting

Late reporting:

- Late reporting is a common problem encountered at many centres. e.g Forms 3A, 3B from the CHC should reach the district by 7th of every month. Ensure that the CHCs do not delay the reports by sending them reminders on the 1st or 2nd of every month. The timeline for receipt of reports from all levels is given in Table 5.1.

Incomplete reports, misreporting

- After you receive the reports, check that all column and rows have been filled. If the forms are incomplete, contact the responsible persons immediately and inform them to complete the report.
- Check for errors in data entry e.g randomly check the number of males and females should be equal to the total column.
- Number of reporting PHCs should be equal to the total PHCs in the district. If not, you should find out the reasons for non-reporting.
- If there is any missing information it should be reported as ZERO instead of leaving the columns blank. No cell should be left blank

What are common data entry errors?

Data entry errors could be due to…

- *Typing errors: wrong numbers typed in computer*
- *Wrong box entry: data entered in wrong box e.g Males for cervical cancer screening*
- *Calculation errors: during data entry basic computation happens if formulae are incorrect then errors can happen.*
- *Duplicate entries*

How can you identify data entry errors?

- *Performing validation checks: Validation is performed by comparing values of 2 (or more) that are related e.g number of male & female patients seen in OPD should be equal to the total number of cases.*
- *Identification of statistical outliers e.g. if the number of patients seen is abnormally higher or lower than the average number that you usually report every month*
- *Visual scanning – this would need more experience to detect errors by simply looking at a report.*

How can you ensure proper reporting?

- Discuss about the problems of incomplete reports in the monthly meetings; take corrective action as needed.
- Poor understanding of data definitions and data collection methods, data entry errors- proper training of date entry operator should be done to prevent these mistakes
- Find out the reasons for late reporting and take action to prevent the delay. Some reasons may be absence of staff, staff on leave, computer related problems. Try to find local solutions like deputation of other staff for data entry, making alternative arrangements for computer repair etc.

- Send reminders to the CHC/ Districts which are habitually sending reports late.Some examples of some incompletely filled forms are shown here.

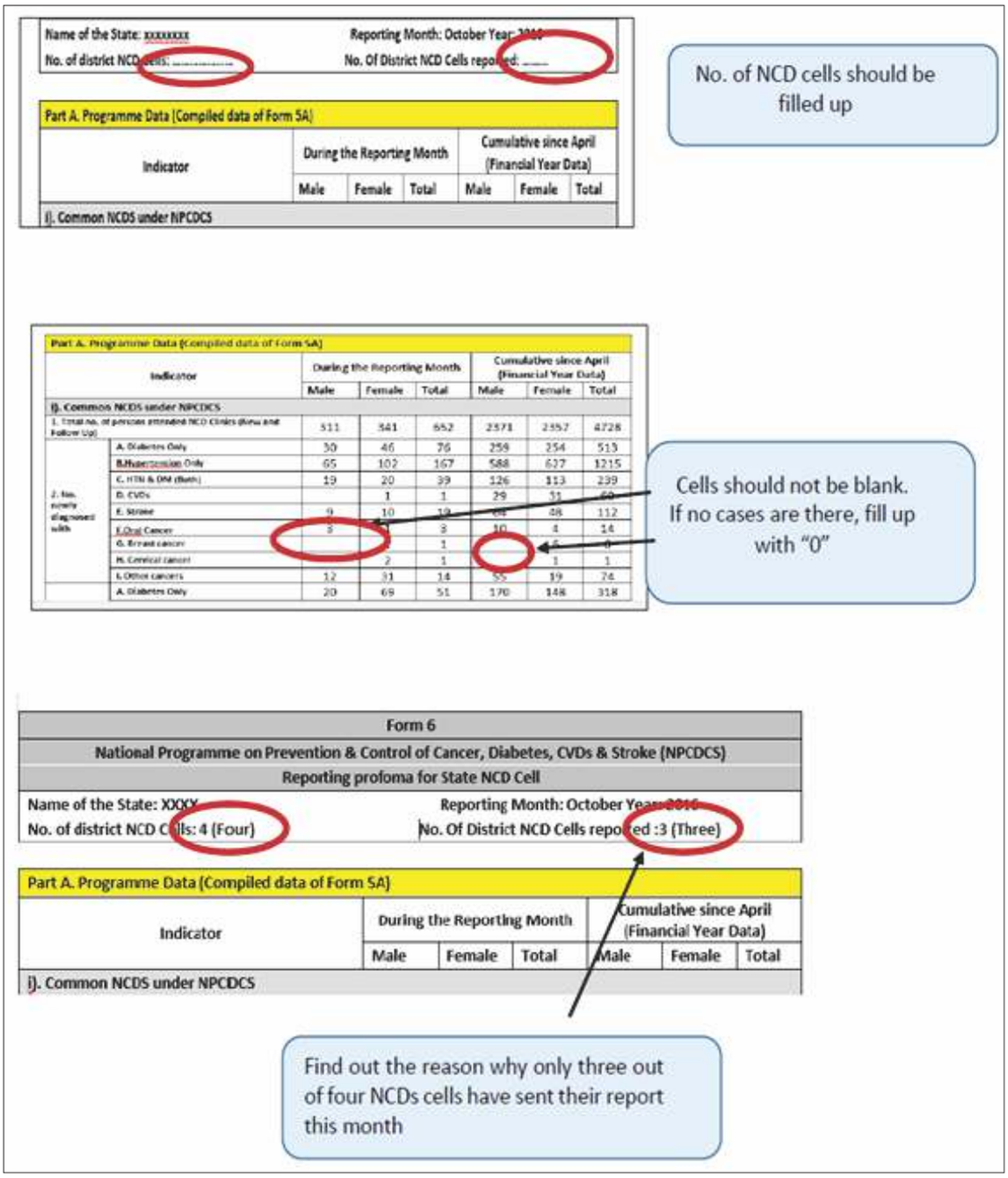


Figure 5.3

DATA VERIFICATION AND TRANSMISSION

All forms should be checked and verified before transmission to PHC/ CHC/District. Two copies should be prepared, and after being signed (with stamp and date) by the medical officer in-charge, send one to the CHC/ district and file one copy for official record.

At the District, reports should be generated based on the verified data received from the Blocks/ CHCs, monthly stocks, and District facilities (District Hospital/SDH, etc.). A paper copy of the generated report must be verified (signed and stamped) and maintained at the District Office and other copy may be sent to the State Office. After verification, the report can electronically be forwarded to the State through Email.

At the State level, confirm the reports and forward to the National level through Email after due verification. A manual copy of the verified and forwarded reports must be filed in the State records.

ANALYSIS OF DATA

Persons responsible for filling up the form or preparing the report should understand the importance of the reports that they are generating and not simply a job of just filling up some numbers. In order to make sense of the numbers generated monthly, data can be analysed a the CHC/District/ State and performance of assessment performance can be made at local level.

Some of the things that can be done with data are:

1. Prepare a bar chart or pie diagram of the reporting month.
2. Compare the report with the previous month.
3. Compare the report of the corresponding month in the previous year.
4. Look at the month-wise indicators e.g number of cases reported in previous months, and see if there is any abnormal pattern e.g unusually high or unusually low number of cases screened in any month. Find out the reasons for this abnormality.

By doing so, timely and appropriate action at local level can be taken.

FEEDBACK

Feedback is an important by often neglected part of HMIS. Feedback ensures that the staff realise that their work is being reviewed by someone and is meaningful.

Verbal

During monthly meetings you can give verbal feedback through discussions where the concerned staff and health workers share their successes and failures, find solutions to the problems, trouble shooting, identifying management issues and actions for future. You should also visit PHCs and listen to the whole team together.

Written

Feedback should be provided on indicators for facilities/ CHCs (blocks)/ Districts monthly, quarterly and half yearly basis.

Exercise 16: Compare between reports of two different months of the same state

State- XXXX

Form 6							
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)							
Reporting profoma for State NCD Cell							
Name of the State: XXXX				Reporting Month: October Year: 2016			
No. of district NCD Cells: 4 (Four)				No. Of District NCD Cells reported :3 (Three)			
Part A. Programme Data (Compiled data of Form 5A)							
Indicator		**During the Reporting Month**			**Cumulative since April (Financial Year Data)**		
		Male	**Female**	**Total**	**Male**	**Female**	**Total**
i). Common NCDS under NPCDCS							
1. Total no. of persons attended NCD Clinics (New and Follow Up)		2276	2401	4677	20037	20731	40768
2. No. newly diagnosed with	**A. Diabetes Only**	83	61	144	761	581	1342
	B.Hypertension Only	206	199	405	1696	1322	3018
	C. HTN & DM (Both)	19	12	31	142	113	255
	D. CVDs	26	17	43	131	111	242
	E. Stroke	13	7	20	118	72	190
	F.Oral Cancer	0	0	0	0	0	0
	G. Breast cancer	0	0	0	0	0	0
	H. Cervical cancer	0	0	0	0	0	0
	I. Other cancers	2	3	5	14	7	21
3. No of new patients initiated on treatment	**A. Diabetes Only**	52	42	94	520	384	904
	B.Hypertension Only	130	115	245	823	793	1616
	C. HTN & DM (Both)	13	9	22	106	88	194
	D. CVDs	17	8	25	81	55	136
	E. Stroke	12	6	18	103	77	180
	F.Oral Cancer	0	0	0	0	0	0
	G. Breast cancer	0	0	0	0	2	2
	H. Cervical cancer	0	0	0	4	1	5
	I. Other cancers	2	3	5	7	4	11
4. No of Patients on Follow up	**A. Diabetes Only**	26	30	56	262	186	448
	B.Hypertension Only	35	32	67	367	303	670
	C. HTN & DM (Both)	5	5	10	55	45	100
	D. CVDs	0	0	0	30	25	55
	E. Stroke	2	0	2	39	30	69
	F.Oral Cancer	0	0	0	1	0	1
	G. Breast cancer	0	0	0	0	1	1
	H. Cervical cancer	0	0	0	0	0	0
	I. Other cancers	4	0	4	24	8	32
5. No. of Patients	**A. Diabetes**	2	1	3	14	8	22
	B. Hypertension	1	1	2	28	14	42
Referred to Tertiary Care/TCCC	**C. CVDs**	5	3	8	39	20	59
	D. Stroke	0	0	0	33	16	49
	E. Cancers	0	0	0	9	2	11
6. No of patients treated at CCU	**A. CVDs**	0	0	0	28	13	41
	B. Stroke	0	0	0	4	4	8

7. No. of persons attended day care centre		0	0	0	4	3	7
8. No. of Persons counselled for health promotion and prevention of NCDs		242	232	474	1224	1058	2282
9. No. of patients attended physiotherapy		29	29	58	197	168	365
ii). Comorbid Conditions							
10. Among all confirmed Diabetic patients **[New (2A+2C) & Follow up (4A+4C)]**	A. No. of known TB cases on ATT	1	1	2	20	6	26
	B. No. screened for TB Symptoms	1	1	2	69	30	99
	C. No. suspected for TB & referred to DMC/ PI	13	7	20	96	43	139
B. Other Programme Markers (Compiled data of Form 5B)							
Total No. of NCD check-ups done		1368	1248	2616	5661	7050	12711
Total No. Of Persons Suspected and referred for	**Diabetes only**	114	91	205	392	276	668
	Hypertension Only	246	227	473	1100	1062	2162
	Oral Cancers	13	6	19	148	60	208
	Breast Cancers	0	19	19	0	96	96
	Cervical Cancers	0	14	14	13	72	85
	Other Cancers	69	42	111	686	380	1066
No. of diagnosed patients on follow up in PHC and Sub centres	**HTN /Diabetes/ Both HTN and DM**	193	204	397	989	783	1772
	Cancer patients	2	2	4	13	38	51

C. Physical targets and achievements

Name of Facility	Annual Target for the year 2016-17	Achievement during the reporting month	Cumulative achievement since 1st Apr 2016	Cumulative achievement since beginning	Remarks
District NCD Cells					
District NCD Clinics					
District CCU facilities					
District Day Care Centres					
CHC NCD Clinics					
Others					

State XXXX

Form 6	
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS) Reporting profoma for State NCD Cell	
Name of the State:XXXX	Reporting Month: July Year: 2016
No. of district NCD Cells: ……	No. Of District NCD Cells reported: ……

Part A. Programme Data (Compiled data of Form 5A)							
Indicator		During the Reporting Month			Cumulative since April (Financial Year Data)		
		Male	Female	Total	Male	Female	Total
i). Common NCDS under NPCDCS							
1. Total no. of persons attended NCD Clinics (New and Follow Up)		311	341	652	2371	2357	4728
2. No. newly diagnosed with	A. Diabetes Only	30	46	76	259	254	513
	B.Hypertension Only	65	102	167	588	627	1215
	C. HTN & DM (Both)	19	20	39	126	113	239
	D. CVDs		1	1	29	31	60
	E. Stroke	9	10	19	64	48	112
	F.Oral Cancer	3	1	3	10	4	14
	G. Breast cancer		1	1		6	6
	H. Cervical cancer		2	1		1	1
	I. Other cancers	12	31	14	55	19	74
3. No of new patients initiated on treatment	A. Diabetes Only	20	69	51	170	148	318
	B.Hypertension Only	51	14	120	316	377	693
	C. HTN & DM (Both)	11	1	25	83	79	162
	D. CVDs	0	8	1	28	31	59
	E. Stroke	8	0	16	63	46	109
	F. Oral Cancer	4	1	4	4	1	5
	G. Breast cancer	0	0	1	0	3	3
	H. Cervical cancer	0	2	0	0	0	0
	I. Other cancers	7	32	9	39	17	56
4. No of Patients on	A. Diabetes Only	19	45	51	128	143	271
	B. Hypertension Only	34	9	79	168	231	399
	C. HTN & DM (Both)	41	0	50	60	25	85
Follow up	D. CVDs	0	0	0	12	7	19
	E. Stroke	0	0	0	0	0	0
	F.Oral Cancer	0	1	0	7	4	11
	G. Breast cancer	0	1	1	0	0	0
	H. Cervical cancer	0	6	1	0	0	0
	I. Other cancers	2	0	8	6	12	18
5. No. of Patients Referred to Tertiary Care/TCCC	A. Diabetes	0	0	0	3	0	3
	B. Hypertension	0	0	0	1	1	2
	C. CVDs	0	0	0	0	1	1
	D. Stroke	0	0	0	0	0	0
	E. Cancers	2	4	6	21	12	33
6. No of patients treated at CCU	A. CVDs	0	0	0	0	0	0
	B. Stroke	0	0	0	0	0	0
7. No. of persons attended day care centre		5	7	12	52	40	92
8. No. of Persons counselled for health promotion and prevention of NCDs		67	50	117	529	400	929
9. No. of patients attended physiotherapy		28	28	56	292	239	531

ii). Comorbid Conditions							
10. Among all confirmed Diabetic patients **[New (2A+2C) & Follow up (4A+4C)]**	A. No. of known TB cases on ATT	1	0	1	1	0	1
	B. No. screened for TB Symptoms	2	1	3	5	2	7
	C. No. suspected for TB & refered to DMC/ PI	1	0	1	2	0	2

B. Other Programme Markers (Compiled data of Form 5B)							
Total No. of NCD check-ups done							
Total No. Of Persons Suspected and refered for	**Diabetes only**						
	Hypertension Only						
	Oral Cancers						
	Breast Cancers						
	Cervical Cancers						
	Other Cancers						
No. of diagnosed patients on follow up in PHC and Sub centres	**HTN /Diabetes/ Both HTN and DM**						
	Cancer patients						

C. Physical targets and achievements

Name of Facility	Annual Target for the year 2016-17	Achievement during the reporting month	Cumulative achievement since 1st Apr 2016	Cumulative achievement since beginning	Remarks
District NCD Cells	11	0	0	11	
District NCD Clinics	11	0	0	11	
District CCU facilities	1	0	0	1	
District Day Care Centres	2	0	0	2	
CHC NCD Clinics	5	0	0	0	
Others	0	0	0	0	

Exercise 17 : Interpret the district reports and make diagrammatic presentation in MS Excel

The following reports are from four different districts. Look at the reports given.

1. What is your interpretation?
2. What are the ways by which you present the data graphically in MS Excel

District-1

Form 5A				
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)				
Reporting Profoma for District NCD Cell				
District_____1(one) _____ **State_____**				
Month_____ Year_____				
Indicator		**During the Reporting Month**		
		Male	**Female**	**Total**
I. Common NCDS under NPCDCS				
1. No. of persons attended NCD Clinics (New and follow up)		1404	1780	
2. No. newly diagnosed with	**A. Diabetes Only**	163	1813	
	B. Hypertension Only	293	2655	
	C. HTN & DM	141	1296	
	D. CVDs	7	53	
	E. Stroke	0	4	
	F. Oral Cancer	2	11	
	G. Breast cancer	0	16	
	H. Cervical cancer	0	5	
	I. Other cancers	2	12	
3. No. of newly diagnosed patients put on Treatment	**A. Diabetes Only**	142	1498	
	B. Hypertension Only	237	2343	
	C. HTN & DM	77	759	
	D. CVDs	6	51	
	E. Stroke	0	4	
	F. Oral Cancer	0	0	
	G. Breast cancer	0	4	
	H. Cervical cancer	0	3	
	I. Other cancers	0	2	
4. No. of persons on treatment follow up	**A. Diabetes Only**	181	1809	
	B. Hypertension Only	271	2600	
	C. HTN & DM	117	685	
	D. CVDs	8	34	
	E. Stroke	1	7	
	F. Oral Cancer	0	0	
	G. Breast cancer	0	3	
	H. Cervical cancer	0	0	
	I. Other cancers	0	1	

5. No of person referred to Tertiary hospital/TCCC	**A. Diabetes**	18	99	
	B. Hypertension	21	111	
	C. CVDs	10	56	
	D. Stroke	0	0	
	E. Oral Cancers	1	17	
6. No. of Patients treated at CCU	**A. CVDs**	1	9	
	B. Stroke	0	1	
7. No of cancer patients treated in Day Care facility		0	2	
8. No. of persons counselled for health promotion & prevention of NCDs		703	8148	
9. No. of patients underwent Physiotherapy		167	1690	
II. Co-morbidities				
1. Among all confirmed Diabetic patients **[New (2A+2C) & Follow up (5A+5C)]**	A. No. of known TB cases on ATT	11	8	
	B. No. screened for TB Symptoms	25	22	
	C. No. suspected for TB & referred to DMC/ PI	9	7	
B. Other Programme Markers (Compiled data of Form 5B)				
Total No. of NCD check-ups done		**661**	**821**	
Total No. Of Persons Suspected and referred for	**Diabetes only**	**106**	**109**	
	Hypertension Only	**135**	**151**	
		0	**0**	
	Oral Cancers	**3**	**2**	
	Breast Cancers	**0**	**0**	
	Cervical Cancers	**0**	**0**	
	Other Cancers	**0**	**0**	
No. of diagnosed patients on follow up in PHC and Sub centres	**HTN /Diabetes/ Both HTN and DM**	**225**	**234**	
	Cancer patients	**0**	**0**	

District-2

Form 5A				
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)				
Reporting Performa for District NCD Cell				
District_____2 (two) _____ **State_____**				
Month_____ Year_____				
Indicator		**During the Reporting Month**		
		Male	**Female**	**Total**
I. Common NCDS under NPCDCS				
1. No. of persons attended NCD Clinics (New and follow up)		1580	2002	
2. No. newly diagnosed with	**A. Diabetes Only**	184	227	
	B. Hypertension Only	330	332	
	C. HTN & DM	158	162	
	D. CVDs	8	7	
	E. Stroke	1	0	
	F. Oral Cancer	3	1	
	G. Breast cancer	0	2	
	H. Cervical cancer	0	1	
	I. Other cancers	2	2	
3. No. of newly diagnosed patients put on Treatment	**A. Diabetes Only**	159	187	
	B. Hypertension Only	267	293	
	C. HTN & DM	87	95	
	D. CVDs	7	6	
	E. Stroke	1	0	
	F. Oral Cancer	0	0	
	G. Breast cancer	0	1	
	H. Cervical cancer	0	0	
	I. Other cancers	1	0	
4. No. of persons on treatment follow up	**A. Diabetes Only**	203	226	
	B. Hypertension Only	304	325	
	C. HTN & DM	132	86	
	D. CVDs	8	4	
	E. Stroke	2	1	
	F. Oral Cancer	0	0	
	G. Breast cancer	0	0	
	H. Cervical cancer	0	0	
	I. Other cancers	0	0	
5. No of person referred to Tertiary hospital/TCCC	**A. Diabetes**	20	12	
	B. Hypertension	23	14	
	C. CVDs	11	7	
	D. Stroke	0	0	
	E. Oral Cancers	1	2	

6. No. of Patients treated at CCU	**A. CVDs**	2	1	
	B. Stroke	0	0	
7. No of cancer patients treated in Day Care facility		0	0	
8. No. of persons counselled for health promotion & prevention of NCDs		791	1018	
9. No. of patients underwent Physiotherapy		187	211	
II. Co-morbidities				
1. Among all confirmed Diabetic patients **[New (2A+2C) & Follow up (5A+5C)]**	A. No. of known TB cases on ATT	13	9	
	B. No. screened for TB Symptoms	28	25	
	C. No. suspected for TB & referred to DMC/ PI	10	7	
B. Other Programme Markers (Compiled data of Form 5B)				
Total No. of NCD check-ups done		**744**	**923**	
Total No. Of Persons Suspected and referred for	**Diabetes only**	**119**	**122**	
	Hypertension Only	**152**	**169**	
		0	**0**	
	Oral Cancers	**4**	**2**	
	Breast Cancers	**0**	**0**	
	Cervical Cancers	**0**	**0**	
	Other Cancers	**0**	**0**	
No. of diagnosed patients on follow up in PHC and Sub centres	**HTN /Diabetes/ Both HTN and DM**	**254**	**263**	
	Cancer patients	**0**	**0**	

District-3

Form 5A				
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)				
Reporting performa for District NCD Cell				
District_____3 (three) _____ **State_____**				
Month_____ Year_____				
Indicator		**During the Reporting Month**		
		Male	**Female**	**Total**
I. Common NCDS under NPCDCS				
1. No. of persons attended NCD Clinics (New and follow up)		1826	2314	
2. No. newly diagnosed with	**A. Diabetes Only**	212	2357	
	B.Hypertension Only	381	3452	
	C. HTN & DM	183	1685	
	D. CVDs	10	69	
	E. Stroke	1	5	
	F.Oral Cancer	3	14	
	G. Breast cancer	0	21	
	H. Cervical cancer	0	7	
	I. Other cancers	2	16	
3. No. of newly diagnosed patients put on Treatment	**A. Diabetes Only**	184	1947	
	B.Hypertension Only	308	3046	
	C. HTN & DM	100	987	
	D. CVDs	8	66	
	E. Stroke	1	5	
	F.Oral Cancer	1	0	
	G. Breast cancer	0	6	
	H. Cervical cancer	0	3	
	I. Other cancers	1	2	
4. No. of persons on treatment follow up	**A. Diabetes Only**	235	2352	
	B.Hypertension Only	352	3380	
	C. HTN & DM	152	891	
	D. CVDs	10	44	
	E. Stroke	2	9	
	F.Oral Cancer	0	0	
	G. Breast cancer	0	3	
	H. Cervical cancer	0	0	
	I. Other cancers	0	1	
5. No.of person referred to Tertiary hospital/TCCC	**A. Diabetes**	23	128	
	B. Hypertension	27	144	
	C. CVDs	13	73	
	D. Stroke	0	0	
	E. Oral Cancers	2	22	

6. No. of Patients treated at CCU	**A. CVDs**	2	12	
	B. Stroke	0	1	
7. No of cancer patients treated in Day Care facility		1	2	
8. No. of persons counselled for health promotion & prevention of NCDs		914	10592	
9. No. of patients underwent Physiotherapy		217	2197	
II. Co-morbidities				
1. Among all confirmed Diabetic patients **[New (2A+2C) & Follow up (5A+5C)]**	A. No. of known TB cases on ATT	15	11	
	B. No. screened for TB Symptoms	32	29	
	C. No. suspected for TB & refered to DMC/ PI	12	9	
B. Other Programme Markers (Compiled data of Form 5B)				
Total No. of NCD check-ups done		**860**	**1067**	
Total No. Of Persons Suspected and referred for	**Diabetes only**	**137**	**141**	
	Hypertension Only	**175**	**196**	
		0	**0**	
	Oral Cancers	**4**	**3**	
	Breast Cancers	**0**	**1**	
	Cervical Cancers	**0**	**0**	
	Other Cancers	**0**	**1**	
No. of diagnosed patients on follow up in PHC and Sub centres	**HTN /Diabetes/ Both HTN and DM**	**293**	**304**	
	Cancer patients	**0**	**0**	

District-4

Form 5A				
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)				
Reporting Performa for District NCD Cell				
District_____4 (four) _____ **State_____**				
Month_____ Year_____				
Indicator		**During the Reporting Month**		
		Male	**Female**	**Total**
I. Common NCDS under NPCDCS				
1. No. of persons attended NCD Clinics (New and follow up)		277	351	
2. No. newly diagnosed with	**A. Diabetes Only**	32	357	
	B. Hypertension Only	58	523	
	C. HTN & DM	28	255	
	D. CVDs	1	11	
	E. Stroke	0	1	
	F. Oral Cancer	0	2	
	G. Breast cancer	0	3	
	H. Cervical cancer	0	1	
	I. Other cancers	0	2	
3. No. of newly diagnosed patients put on Treatment	**A. Diabetes Only**	28	295	
	B. Hypertension Only	47	462	
	C. HTN & DM	15	150	
	D. CVDs	1	10	
	E. Stroke	0	1	
	F. Oral Cancer	0	0	
	G. Breast cancer	0	1	
	H. Cervical cancer	0	1	
	I. Other cancers	0	0	
4. No. of persons on treatment follow up	**A. Diabetes Only**	36	356	
	B. Hypertension Only	53	512	
	C. HTN & DM	23	135	
	D. CVDs	1	7	
	E. Stroke	0	1	
	F. Oral Cancer	0	0	
	G. Breast cancer	0	1	
	H. Cervical cancer	0	0	
	I. Other cancers	0	0	
5. No. of person referred to Tertiary hospital/TCCC	**A. Diabetes**	3	19	
	B. Hypertension	4	22	
	C. CVDs	2	11	
	D. Stroke	0	0	
	E. Oral Cancers	0	3	

6. No. of Patients treated at CCU	**A. CVDs**	0	2	
	B. Stroke	0	0	
7. No of cancer patients treated in Day Care facility		0	0	
8. No. of persons counselled for health promotion & prevention of NCDs		138	1605	
9. No. of patients underwent Physiotherapy		33	333	
II. Co-morbidities				
1. Among all confirmed Diabetic patients **[New (2A+2C) & Follow up (5A+5C)]**	A. No. of known TB cases on ATT	2	2	
	B. No. screened for TB Symptoms	5	4	
	C. No. suspected for TB & referred to DMC/ PI	2	1	
B. Other Programme Markers (Compiled data of Form 5B)				
Total No. of NCD check-ups done		**130**	**162**	
Total No. Of Persons Suspected and referred for	**Diabetes only**	**21**	**21**	
	Hypertension Only	**27**	**30**	
		0	**0**	
	Oral Cancers	**1**	**0**	
	Breast Cancers	**0**	**0**	
	Cervical Cancers	**0**	**0**	
	Other Cancers	**0**	**0**	
No. of diagnosed patients on follow up in PHC and Sub centres	**HTN /Diabetes/ Both HTN and DM**	**44**	**46**	
	Cancer patients	**0**	**0**	

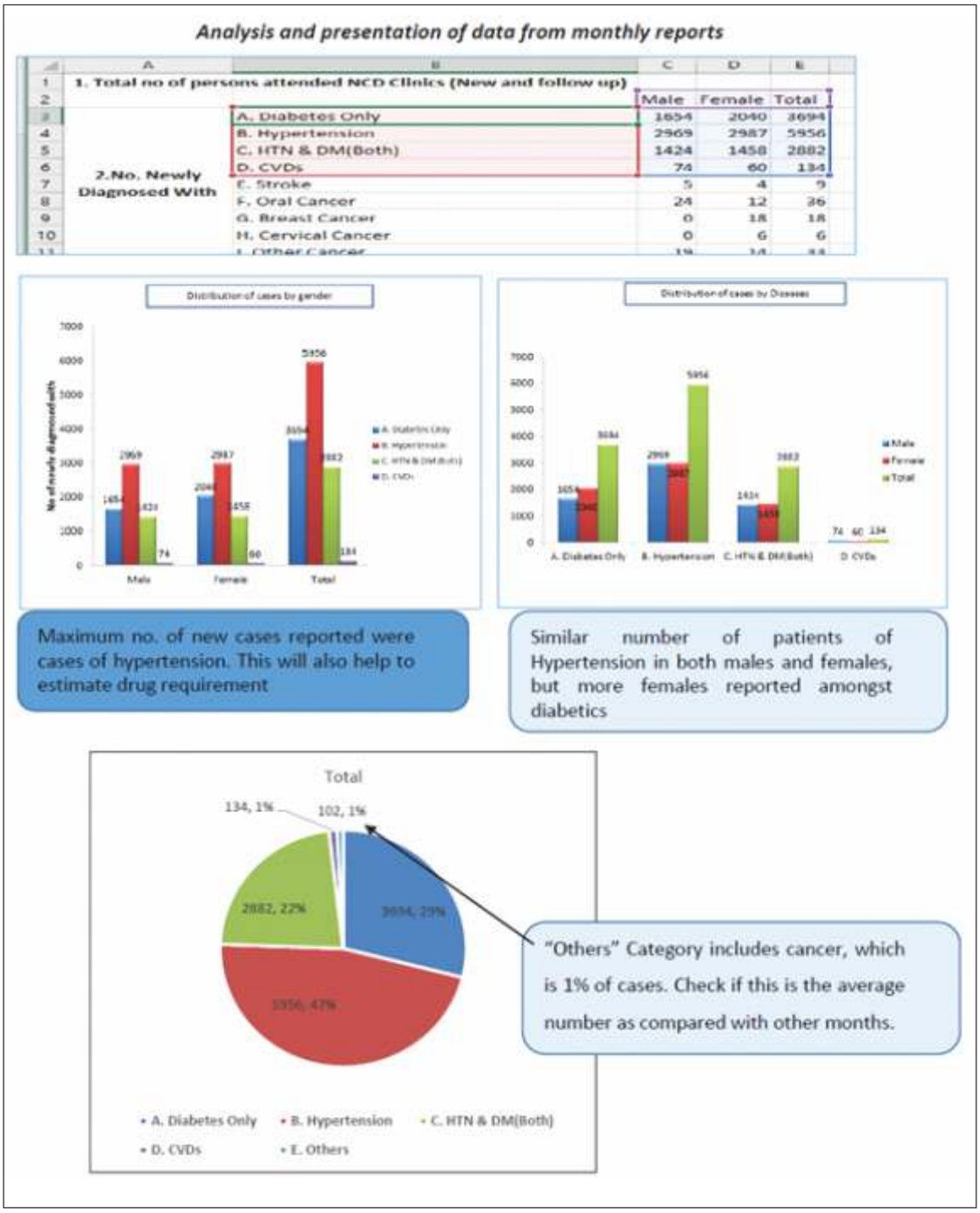

Analysis and presentation of data from monthly reports
1. Total no of persons attended NCD Clinics (New and follow up)
Male Female Total
A. Diabetes Only 1654 2040 3694
B. Hypertension 2969 2987 5956
C. HTN & DM(Both) 1424 1458 2882
D. CVDs 74 60 134
2.No. Newly Diagnosed With
E. Stroke 5 4 9
F. Oral Cancer 24 12 36
G. Breast Cancer 0 18 18
H. Cervical Cancer 0 6 6
Distribution of cases by gender
Male
Female
Total
Distribution of cases by Diseases
Male
Female
Total
Maximum no. of new cases reported were cases of hypertension. This will also help to estimate drug requirement
Similar number of patients of Hypertension in both males and females, but more females reported amongst diabetics
Total
134, 1%
102, 1%
2882, 22%
3694, 29%
5956, 47%
A. Diabetes Only
B. Hypertension
C. HTN & DM(Both)
D. CVDs
E. Others
"Others" Category includes cancer, which is 1% of cases. Check if this is the average number as compared with other months.

Figure 5.4

MONITORING THE PROGRAMME

"What gets measured, gets done".

Learning objectives
In the end of this chapter you will understand
- *What is monitoring and why is it important*
- *What is program evaluation*
- *Indicators for program monitoring and evaluation*

WHAT IS MONITORING AND WHY IS IT IMPORTANT

Monitoring is an ongoing function where data is collected on specified indicators to provide managers of an ongoing programme with indications of the extent of progress, achievement of objectives and use of resources.

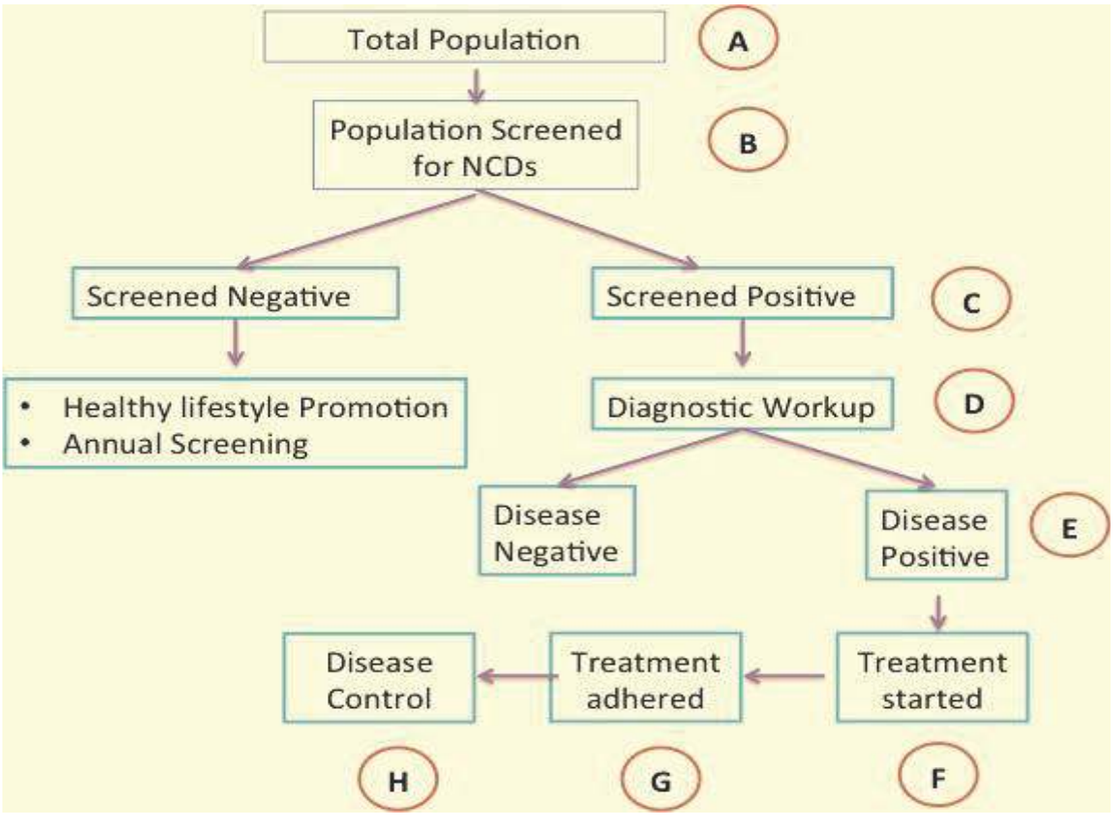
What is monitoring?
- Monitoring is the simple description, counting and tracking of processes or events.
- Monitoring answers the following questions: What? Where? When? and How much or how many?

What is NOT monitoring
- Policing
- Fault finding

How is monitoring done?
- Staff meetings –Monthly, quarterly, annually
- Supervisory visits
- Progress reports/Statistics
- Periodic reviews (e.g Common review mission)

Using the same example given the earlier Fig.5.5 we can calculate the indicators using information from the data available in the programme.

Figure 5.5. Flowchart for Evaluation of Screening and treatment programme HT, DM and Common Cancers for persons above 30 years of age



Most of this information is currently not being collected in the routine reporting. However, this is the ultimate indicator for the success of the programme. Therefore, till this information is captured by the programme, you should collect this system in a sample of health facilities under you annually. This could be clubbed with an operational research component (for client satisfaction etc.) in the budget head. Plan for at least 200 samples spread over 20 health facilities (of primary and secondary together).

Examples of other indicators

- The indicators for health promotion would include number of schools and workplaces targeted for intervention, number IEC materials distributed.
- The indicators for capacity building indicators would be number of trainings held, number of people of different cadres trained and finally proportion of different cadres trained.
- Indicators for outcome of health promotion activities is measured as prevalence of risk behaviours (tobacco, alcohol consumption, diet and physical activity) that comes from population based surveys. The reach of communication coverage comes from population based surveys e.g DLHS provides some of these data.

Table 5.2. Indicators for Evaluation of screening and treatment programmes for HT, DM and common cancers (refer to Fig.5.2)

Term	Definition	Calculation	Comment
A. Coverage with Screening	Out of the total eligible for screening (people above 30 years), proportion that has been screened last year	Total screened as per programme reporting **(B)** divided by the total population in the age group. **(A)**	It is not expected to screen whole population every year. If it is to be done every three years then the total population gets divided by three in the denominator (eligible). This indicator measures coverage with screening services. Will be calculated separately for each disease. For Opportunistic Screening, eligible will be only those above 30 years who attend OPDs. The numbers from the two screening cannot be combined as there could be double counting.
B. Follow-up of screened	Out of those who were screened positive, how many completed the diagnostic workup	Number who complete diagnostic workup **(C)** divided by total who were screened positive **(D)**	Measures the ability of the health system to follow up screened positives which is ethically important. This aspect is often ignored.
C. Treatment rate	Out of those diagnosed with disease by the public health facilities, how many are currently on treatment within the system	Number currently on treatment in govt. health facilities **(E)** divided by total diagnosed positives time **(F)**	It indirectly assesses access to and satisfaction with the government health system. As NCDs require lifelong treatment this is an important aspect.
D. Control rate	Those currently being treated with medication who have achieved control values as defined for HT or DM	Number of those currently being treated **(E),** who are controlled **(G)**	People who are on treatment are not adequately controlled either because they are no fully adherent to treatment (both medicines and lifestyle advices) or because of inadequate treatment. Definition of Control will be as per operational guidelines of the programme.

MANAGEMENT AUDIT

Another way in which you can keep track of your activities in your own state or district is to maintain a management audit checklist which you can review quarterly or six- monthly. This will help you to assess whether you are on track or is your work lagging behind as compared to the objectives that you set out to achieve in the beginning of the year. An example of a management audit plan is given below (Table 5.3):

Table 5.3: Example of a management audit plan (could be for six-monthly or quarterly review)

Planned activity	Achievement	Status of implementati	Reasons for observed implementation performance
District level meetings	Meetings held in 8 out of 8	Completed	Invitations sent out well in advance; Sufficient IEC of materials available
Training of ASHA (for 20 villages	15 out of 20	Incomplete	5 trainings were postponed because of unavailability of funds in time, rainy season, disease outbreak etc
Procure and distribute blood pressure machines to CHWs in 20 villages	10 out of 20	Only partially implemented	Inadequate (only 10% ofrequestedwerereceived)
Screening of 25 % of population by ASHA	All houses visited as scheduled	Completed	Prior planning and training of ASHA was done
Develop supervisory checklist for PHC Medical Office	Done	Completed, but not yet printed	

(in this way you can add the activities that you have proposed and asses the progress for timely action)

PROGRAMME EVALUATION

Programme monitoring and evaluation are important components of a programme and are critical to sound strategic planning and its continued improvement.

Monitoring is important for assessing whether something is being done and, if so, whether it is being done as intended. Monitoring largely utilizes data from routine reporting of the programme.

In contrast, Evaluation involves collecting special data on a periodic or 'as-and-when-needed' basis to address issues that cannot be examined using routinely collected data, such as a project's cost-effectiveness or overall impact. Evaluation answers the following questions: Is it effective? or Why is it effective?

A monitoring and evaluation framework is composed of different indicators that measure inputs, process, outputs, outcomes and impact.

What is evaluation

While monitoring is to be done on a continuous basis, evaluation is mainly for assessment of output or impact, hence evaluation may be done at longer intervals say, annually or once in 3-5 years. Briefly, evaluation can be done in several ways e.g

Concurrent: Analyse your monthly/ quarterly report and see how has your performance been. Is it satisfactory? If not find out the reasons or barriers e.g staff shortage, lack of drugs, shortage of equipment etc

Annually: Look at the targets set in the beginning of the year. At the end of the year, you can analyse your performance through the data available from HMIS and services provided. e.g have you achieved the targets set in the beginning of the year? If not, what were the problems?

External evaluation: An external evaluation of the programme in your area can also be carried out through an external agency like through studies conducted by government agencies, WHO, NGOs or even research studies by medical colleges and institutions. External programme reviews e.g. Joint Monitoring Mission(JMM), Common Review Mission (CRM). Some information related to NCDs is also available through national surveys like National Family Health Survey (NFHS), District Level Household and Facility Survey (DLHS) etc.

It is important to realize that monitoring and evaluation is not meant to be for finding faults but to help you understand whether the programme implementation is as desired and take corrective actions if needed.

Annexure 1

TRAINING NEEDS ASSESSMENT

Executive summary

A training needs assessment is required to determine the gaps between what is currently in place and what is actually needed. Toward this end, it is important to include all stakeholders as partners from the initial stages of developing training package which is appropriate and need based.

Objectives of TNA

To identify the performance gaps and training-needs of NPCDCS program officers and coordinators at the state and district level for efficient discharge of their managerial responsibilities

Methods

TNA was carried out among State Program Officers/ Managers/ coordinators posted at the State and district NCD cells vis-a-vis implementation of NPCDCS program activities. Twelve states and twenty-four districts in the selected states across India were included in the TNA to ensure geographical representation. In-depth interviews of state program officer/coordinator & district program officer/coordinator using a detailed questionnaire were carried out from September to October 2016.

Results

Training needs assessment was carried out in 12 states spread in all six zones of the country namely, Bihar, Haryana, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Odhisa, Punjab ,Rajasthan, Tripura, Uttar Pradesh and Uttarakhand. A total of 41 persons were interviewed which included 13 State Program Officers/ Co-ordinators and 28 District Program Officers/ Coordinators. The majority of the State Program Officers (73%) were regular employees, while 48% of district program officers were contractual. Approximately 35% had received training under NPCDCS. The areas identified through training needs assessment can be summarized as follows:

Domain	Training needs	Non training needs
Human resources management	1. Communication skills- with both superiors and subordinates. 2. Conflict management, 3. Group dynamics and leadership skills	1. Appointment related problems 2. Disproportionate salary
Materials management	1. Inventory management methods, 2. Procurement process – rate contract, tendering, local purchase. Estimating demand. 3. Material management in case of shortage and emergency management 4. Annual Maintenance Contract.	1. Mechanisms to prevent delay in delay in drug and 2. Equipment procurement process
Financial management	Preparation of - 1. annual budgets 2. Statement of Expenditure 3. Utilization certificate 4. Program Implementation Plan	1. Increase in fund allocation 2. Timely release of salaries

Screening & patient care	1. Guidelines/algorithm for management of patient at NCD Clinic. 2. Methods of Screening of oral and cervical cancer	1. Lack of space, reduction of budget for supplies 2. Insurance based linkage for chronic diseases
Reporting system, monitoring and supervision	1. Reporting formats, 2. Systematic reporting mechanism 3. Mechanism for ensuring follow up of patients.	1. Provision of computers, adequate work space 2. Internet connectivity
PIP	1. Preparation of annual PIP	

Conclusion

The training needs assessment was carried out to identify gaps in the current capacities of program staff at the centre, state and district level in relation to the implementation of NPCDCS program activities. This included assessment of knowledge and skills on program management and monitoring and identifying gaps. Capacity gaps were identified both at Individual and institutional level. There was a great felt need for financial management and training for preparation of PIP, expressed by a majority of the program officers. The outcome of TNA helped in the development of this training manual which will be used in training program managers in enhancing managerial skills.

Annexure 2

National Monitoring Framework for Prevention and Control of Noncommunicable Diseases
NCD TARGETS and INDICATORS

S.NO.	Framework element	Targets			Indicators
		Outcomes	2020	2025	
Mortality and morbidity					
1.	**Premature mortality from NCDs**	Relative reduction in overall mortality from cardiovascular disease, cancer, diabetes, or chronic respiratory disease	10%	25%	1. Unconditional probability* of dying between ages 30-70 from cardiovascular disease, cancer, diabetes, or chronic respiratory disease 2. Cancer incidence, by type of cancer, per 10,00,00 population
NCD Risk factors					
2.	**Alcohol use**	Relative reduction in alcohol use	5%	10%	3. Age standardised prevalence of current alcohol consumption in adults aged 18+ years
3.	**Diabetes and obesity**	Halt the rise in obesity and diabetes prevalence	No mid-term target set	Halt the rise in obesity and diabetes prevalence	4. Age standardised prevalence of obesity among adults aged 18+ years (defined as body mass index greater than 30 kg/m^2) 5. Prevalence of obesity in adolescents(defined as two standard deviations BMI for age and sex overweight according to the WHO Growth Reference) 6. Age standardised prevalence of raised blood glucose/diabetes among adults aged 18+ years (defined as fasting plasma glucose value 126 mg/dl or on medication for raised blood glucose
4.	**Physical inactivity**	Relative reduction in prevalence of insufficient physical activity	5%	10%	7. Age standardised prevalence of insufficient physical activity in adults aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent) 8. Prevalence of insufficiently physically active adolescents (defined as less than 60 minutes per day of physical activity)
5.	**Raised blood pressure**	Relative reduction in prevalence of raised blood pressure	10%	25%	9. Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ⩾ 140 mmHg and/or diastolic blood pressure ⩾ 90 mmHg) and mean systolic blood pressure
6.	**Salt/sodium intake**	Relative reduction in mean population intake of salt, with aim of achieving recommended level of less than 5 gms per day	20%	30%	10. Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years.
7.	**Tobacco use**	Relative reduction in prevalence of current tobacco use	15%	30%	11. Age standardised prevalence of current tobacco use (smoking and smokeless) among adults aged 18+ years 12. Prevalence of current tobacco use (smoking and smokeless) among adolescents
8.	**Household air pollution**	Relative reduction in household use of solid fuels as a primary source of energy for cooking	25%	50%	13. Proportion of households using solid fuels as a primary source of energy for cooking
		Additional indicator			14. Age standardised prevalence of adults (aged 18+ years) consuming less than five total servings (400 gms) of fruit and vegetables per day
National systems response					
9.	**Drug therapy to prevent heart attacks and strokes**	Eligible people receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	30%	50%	15. Proportion of eligible adults (defined as aged 40 years and older with a 10-year cardiovascular risk greater than or equal to 30% including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes
10.	**Essential NCD medicines and basic technologies to treat major NCDs**	Availability and affordability of quality, safe and efficacious essential NCD medicines including generics, and basic technologies in both public and private facilities	60%	80%	16. Availability and affordability of quality, safe and efficacious essential NCD medicines including generics, and basic technologies in both public and private facilities
11.	**Additional indicators**				17. Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer 18. Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (Hep B3) administered to infants 19. Proportion of women aged between 30-49 screened for cervical cancer at least once 20. Proportion of women aged 30 and above screened for breast cancer by clinical examination by trained health professional at least once in lifetime 21. Proportion of high risk persons (using tobacco, smoking and smokeless and betel nut) screened for oral cancer by examination of oral cavity

* Not dependent on probability of other causes of death

Annexure 3

PATTERN OF FINANCIAL ASSISTANCE UNDER NPCDCS

I. State NCD Cell

Funding pattern	Heads	Unit Cost (Rs. In lakhs)
Non-Recurring: (One time)	Renovation and furnishing, furniture, computers, office equipments (fax, phone, photocopier etc.)	05.00
Recurring grant: (Annual)	Human Resource (on contract): 1 Epidemiologist/ Public Health Specialist, 1 State Programme Coordinator, 1 Finance cum Logistics Consultant, & 1 Data Entry Operator	24.24
	Miscellaneous (communication, monitoring, TA, DA, POL, Contingency etc.)	10.00
	Awareness generation (IEC) *	50.00 – 70.00
	Sub -total Recurring grant per annum	104.24
Total		109.24

II. District NCD Cell

Funding pattern	Heads	Unit Cost (Rs. In lakhs)
Non-Recurring: (One time)	Renovation and furnishing, furniture, computers, office equipments (fax, phone, photocopier etc.)	05.00
Recurring grant: (Annual)	Human Resource (on contract): 1 Epidemiologist/ Public Health Specialist, 1 District Programme Coordinator, 1 Finance cum Logistics Consultant, & 1 Data Entry Operator	21.84
	Miscellaneous (communication, monitoring, TA, DA, POL, contingency etc.)	06.00
	Awareness generation (IEC) *	3.00 – 5.00
	Sub -total Recurring grant per annum	32.84
Total		37.84

III. District NCD Clinic:

Funding pattern	Heads	Unit Cost (Rs. In lakhs)
Non-Recurring: (One time)	Strengthening of laboratory	10.00
	Furniture, Equipment, Computer etc.	01.00
	Sub-total Non-Recurring	11.00
Recurring grant: (Annual)	Human Resource (on contract)*: 1 Doctor, 2 GNMs, 1 Lab Technician, 1 Physiotherapist, 1 Counselor & 1 Data Entry Operator	21.48
	Drugs and consumables* (@ Rs. 01 lakh/month)	12.00
	Transport of Referred / Serious patients	02.50
	Contingency	01.00
	Sub -total Recurring grant per annum	36.98
Total		47.98

IV. District CCU / Day Care Facility:

Funding pattern	Heads	Unit Cost (Rs. In lakhs)
Non-Recurring: (One time)	Developing / strengthening and equipping Cardiac Care Unit (CCU) / ICU	150.00
	Equipments for Cancer Care	05.00
	Sub-total Non-Recurring	155.00
Recurring grant: (Annual)	Human Resource (on contract)*: 1 Specialist (Cardiologist/trained Physician), 4 GNMs	20.40
	Consumables and other investigations outsourced*	31.00
	Sub -total Recurring grant per annum	51.40
Total		206.40

V. CHC NCD Clinic:

Funding pattern	Heads	Unit Cost (Rs. In lakhs)
Non-Recurring: (One time)	NCD Clinic Furniture, Equipment, Computer, etc.	01.00
	Lab equipments	08.00
	Sub-total Non-Recurring	09.00
Recurring grant: (Annual)	Human Resource (on contract)*: 1 Doctor, 1 GNM, 1 Lab Technician, 1 Counselor & 1 Data Entry Operator	13.68
	Laboratory tests, equipments & consumables*	02.00
	Transport of referred cases including home based care	00.32
	Miscellaneous (communication, TA, DA, contingency, etc.)	01.00
	Sub -total Recurring grant per year	17.00
Total		26.00

VI. Budget for NCD activities at PHC:

Funding pattern	Heads	Unit Cost (Rs.)
Recurring grant: (Annual)	Glucostrips, Lancets, Swabs, Consumables (@ Rs. 10/ person, for 2500 persons)*	25,000
	Referral Card (@ Rs. 5/ person, for 500 persons)	2,500
	Contingency, travel etc. (@ Rs. 2500/month)	30,000
Total		57,500

VII. Budget for NCD activities at Sub Centre:

Funding pattern	Heads	Unit Cost (Rs.)
Recurring grant: (Annual)	Glucostrips, Lancets, Swabs, Consumables (@ Rs. 10/ person, for 2500 persons)*	25,000
	Referral Card (@ Rs. 5/ person, for 500 persons)	2,500
Total		27,500

VIII. Budget for CKD intervention (per facility):

Funding pattern	Heads	Unit Cost (Rs. In lakhs)
Non-Recurring: (One time)	For 4 Hemodialysis Machines per facility: 4 nos. each [Dialysis machine (@ Rs. 7 lakh/unit), Ancillaries equipment (R.O. system etc. @ Rs. 3 lakh/unit), Consumables (@ Rs. 3.5 lakh/unit, for 5 yrs.)]	110.00
Recurring grant: (Annual)	Drugs & Consumables	To be borne by state
	Manpower	To be borne by state

IX. Budget for COPD intervention (per facility):

Funding pattern	Heads	Unit Cost (Rs. In lakhs)
Non-Recurring: (One time)	Equipment	15.00
Recurring grant: (Annual)	Drugs & Consumables	25.00
	Manpower	To be borne by state

(*Budget reflected under NHM Flexi-pool)

X. Budget for Population Based Screening (in Rs.)

	Year 1	Year 2	Year 3
Cost for one Subcentre (SC)	161,300	50,390	50,390
NPCDCS Provision	25,000	25,000	25,000
Additional Budget per SC	1,36,300	25,390	25,390
Cost per 400SC/ PHC	5,45,20,000	99,90,400	99,90,400

Annexure 4

INDICATIVE LIST OF DRUGS FOR COMMON NCDs*

Name of Disease	Class of Drug	Name of Drug
Hypertension	**ACE Inhibitor**	Enalapril, Ramipril, Lisinopril
	Diuretics	Indepamide, Chlorthalidone, Frusemide, Hydrochlorthiazide Aldosterone antagonist
	Calcium channel blocker	Amlodipine
	Beta blocker	Atenolol, Metoprolol
	Nitrates	Isosorbide dinitrate, Glyceryl trinitrate
Diabetes	**Oral Hypoglycemic drugs**	Biguanides **-** Metformin Sulfonylureas – Glibenclamide, Glimepiride, Gliclazide
	Injectable Hypoglycemic drugs	Insulin – regular, intermediate, long acting
Hyperlipidemia	**Lipid lowering Agents**	Statins (HMG CoA reductase inhibitors): Atorvastatin, etc. Lipoprotein Lipase Activators: Clofibrate, Fenofibrate, etc.
Stroke	**Anti-platelet drugs**	Aspirin (Acetyl salicylic acid), Clopidogrel
	Thrombolytics/ Fibrinolytics	Streptokinase, rTPA(Alteplase)
	Anticoagulants	Warfarn, Heparin
COPD	**Bronchodilators**	**Inhaled:** Salbutamol, Levosalbutamol, Ipratropium, Formoterol, Salmeterol
		Oral: Theophylline, Salbutamol
	Corticosteroids	**Parenteral:** Hydrocortisone, Methyl prednisolone, Dexamethasone
		Oral: Prednisolone, Methyl prednisolone
		Inhaled: MDI, DPI, Combination of LABA+ICS (Formoterol/ Budesonide, Salmeterol/ Fluticasone)
	Nebulization solution	Budesonide, Ipravent/ Levoline, Salbutamol
Rheumatic Heart Disease	**Antibiotics for treating bacterial sore throat & RF for RHD prevention**	**Injectable:** Benzathine Penicillin G **Oral:** Penicillin V
Others	**Other Important Drugs**	• Adrenaline (1:1000), Atropine, Mannitol, Mephentine, Lignocaine, Dopamine, Protamine • Digoxin, Promethazine, Methyldopa • Diazepam, Carbamazepine, Phenytoin, Levetiracetam, Valproic acid, Midazolam • Vitamin B-complex, Niacin, Omega 3 Fatty Acids • Ondansetron, Domperidone • Amoxicillin, Erythromycin ethyl succinate, Co-amoxyclav, Cephalosporin like Cephalexin, Cephadroxyl, etc. • Pantoprazole, Sodium bicarbonate, Clonidine, Potassium Chloride, Ferrous sulphate, Erythropoetin, Iron sucrose

* *Except anti-cancer drugs*

Annexure 4

REPORTING FORMATS

Form 1
National Programme for Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)
Reporting performa for Sub Centre

Name of the Sub-centre_____ PHC _____ Block/ Mandal _____ District_____ State_____

Month_____ Year _____

Part A: Hypertension and Diabetes Screening

Name of the village	Total No. of NCD Checkups Done			No. of new persons Suspected for DM refered for Confirmation			No. of new persons Suspected for HTN refered for Confirmation			No. of known cases of DM on Follow-			No. of known cases of HTN on Follow		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Total															

Part B: Screening for Common Cancers

Name of the Village	No. of persons screened for cancers			No. of persons suspected with cancer and refered to PHC/ CHC/ GH						No. of persons referred by the Subcer last month who underwent investigati at higher facility			Total No. of known Cancer patients ir Village		
				Oral											
	Male	Female	Total	Male	Female	Total	Breast	Cervical	Total	Male	Female	Total	Male	Female	Total
Total															

_____
Signature
Name and Designation
Date of reporting_____
***The Report should be filled by ANM of Sub centre and sent to MO I/C PHC on last day of the same month.**

Form 2

National Programme for Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)

Reporting performa for Primary Health Centre (PHC)

Name of the PHC_____ **Name of the linked Block PHC/CHC** _____ **District**_____ **State**_____

Month _____ **Year**_____

No. of Sub-centres under the PHCs _____ **No. of Sub-centres reported during the month:**_____

Part A (Screening for HTN and Diabetes)

Name Of the Sub Centre / P	Total NCD Checkups Done			No. of new persons Suspected for D and refered for Confirmation			No. of new persons Suspected for H and refered for Confirmation			No. of known cases of DM on Follow			No. of known cases of HTN on Follow		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
PHC															
SC1															
SC2															
SC3															
SC4															
SC5															
SC6															
Tota															
Overall Total															

Part B: Screening for Common Cancers

Name of the Sub Centre/ PHC	No. of persons screened for Cancers			No. of persons suspected and refered to PHC/ CHC/ GH						No. of known Cancer patients		
				Oral			Breast	Cervical	Total			
	Male	Female	Total	Male	Female	Total				Male	Female	Total
Name Of the PHC												
SC 1												
SC2												
SC3												
Sub Centre total												
Overall Total												

Signature:

Name and Designation _____

Date of reporting_____

**This report should be generated from PHC OPD screening data and also by compiling data of Form 1 of all sub-centres under the PHC.*

This report should be verified and signed by Medical Officer I/c PHC.

This report should be sent to Block PHC/CHC by 5th day of every month.

Form 3A

National Programme for Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS
Reporting performa for NCD Clinic at Community Health Centre (CHC)/ Sub District Hospital(S

Name and Address of the SDH / CHC _____ Block/ Taluk/ Mandal/ Zone_____ District_____State_____
Month_____ Year_____

Indicator		During the Reporting Month		
		Male	Female	Total
I. Common NCDS under NPCDCS				
1.Total no. of persons attended NCD Clinic (New and Follow up)				
2. No. newly diagnosed with	A. Diabetes Only			
	B. Hypertension Only			
	C. HTN & DM			
3. No. of persons suspected and referred for	A. Cardiovascular diseases			
	B. Stroke			
	C. Oral Cancer			
	D. Breast cancer			
	E. Cervical cancer			
	F. Other cancers			
4. No of newly diagnosed patients initiated on treatment	A. Diabetes Only			
	B. Hypertension Only			
	C. HTN & DM			
5. Patients on treatment Follow Up	A. Diabetes Only			
	B. Hypertension Only			
	C. HTN & DM			
6. Total No. of persons referred to District Hospital/ Higher Centres				
7. No. of persons counselled for health promotion & prevention of NCD				
II. Comorbid Conditions				
8. Among all confirmed Diabetic patients **[New (2A+2C) & Follow up (5A+5C)]**	A. No. of known TB cases on ATT			
	B. No. screened for TB Symptoms			
	C. No. suspected for TB & refered to DMC/ PI			

Signature:
Name and Designation
Date of reporting_____

**This report should be generated from CHC OPD screening data.*
This report should be verified and signed by Medical Officer I/c CHC.
This report should be sent to District NCD Cell by 7th day of every month.

Form 3B

National Programme for Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)

Reporting performa for Community Health Centre (CHC)/Block PHC/ SDH

Name and Address _____ **Block/ Taluk/ Mandal/ Zone**_____ **District**_

Month_____**Year**_____

Total No. of PHC in the District _____. **Total No. Of PHCs reported**_____

Part A : Screening for HTN and Diabetes

Source Of Data	Total NCD Checkups Done			No. of new persons Suspected fo and refered for Confirmation			No. of new persons Suspected HTN and refered for Confirmatio			No. of known cases of DM on Fol up			No. of known cases of HTN on Fo up		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Compiled data from all PH & Sub Centres															

PART B: Screening for Common Cancers

Source of Data	No. of persons screened for Can			No. of persons suspected with Cancer and refered to PHC/ CHC/ c						No. of Known Cancer patients		
				Oral			Breast	Cervical	Total			
	Male	Female	Total	Male	Female	Total				Male	Female	Total
Compiled data from all PH & Sub Centres												

Signature:
Name and Designation _____
Date of reporting_____

**This report should be generated by compiling data of Form 2 of all PHCs under the Block/Taluk/Mandal.*
This report should be verified and signed by Medical Officer I/c .
This report should be sent to District NCD Cell by 7th day of every month.

Form 4
National Programme for Prevention & Control of Cancer, Diabetes, CVDs & Stroke (N
Reporting performa for District NCD Clinic

Name of Health Facility where located :_____District _____ State_____-

Month_____Year_____

All information below are for the reporting month

Indicator		During the Reporting Month		
		Male	Female	Total
I. Common NCDS under NPCDCS				
1. Total no. of persons attended NCD Clinic in the reporting month (New and Follow up)				
2. No. newly diagnosed with	A.Diabetes Only			
	B. Hypertension Only			
	C. HTN & DM (Both)			
	D. CVDs			
	E. Stroke			
	F.Oral Cancer			
	G. Breast cancer			
	H.Cervical cancer			
	I.Other cancers			
3. Suspected and referred cases of CVDs & Can Resource limited settings where there are No ca to perform confirmatory diagnosis)	A CVDs			
	C. Stroke			
	D. Oral Cancer			
	E. Breast cancer			
	F. Cervical cancer			
	G. Other cancers			
4.No of newly diagnosed patients initiated on Treatment	A.Diabetes Only			
	B. Hypertension Only			
	C. HTN & DM (Both)			
	D. CVDs			
	E. Stroke			
	F. Cancer (Including Day Care Centres)			
5. No. of Patients treated at CCU	A. CVDs			
	B. Stroke			
6. No Of patients on follow up	A. Diabetes Only			
	B. Hypertension Only			
	C. DM & HTN (Both)			
	D. CVD (Only OPD data)			
	E. Stroke (Only OPD data)			
	F. Cancer (Including Day Care Centres)			
7.No. of person referred to Tertiary hospital/TCCC	A.Diabetes			
	B. Hypertension			
	C. CVD			
	D.Stroke			
	E. Cancer			
8. Patients attended Day Care facility for Cancer care				
9. No. of persons counselled for health promotion & prevention of NCDs				
11. No. of patients underwent physiotherapy				
II. Comorbid Conditions				
8. Among all confirmed Diabetic patient [New (2A+2C) & Follow up (6A+6C)]	A. No. of known TB cases on ATT			
	B. No. screened for TB Symptoms			
	C. No. suspected for TB & refered to DMC/ PI			

Signature:
Name and Designation _____

Date of reporting_____

**This report should be generated from District NCD Clinic /OPD screening data of District Hospitals.*
This report should be verified and signed by Medical Officer I/c .
This report should be sent to District NCD Cell by 7th day of every month.

Form 5A

National Programme for Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)

Reporting performa for District NCD Cell

District_____ State_____

Month_____Year_____

Indicator		During the Reporting Month			Cumulative since April during current Financial ye		
		Male	Female	Total	Male	Female	Total
I. Common NCDS under NPCDCS							
1. No. of persons attended NCD Clinics (New and follow up)							
2. No. newly diagnosed with	A. Diabetes Only						
	B.Hypertension Only						
	C. HTN & DM						
	D. CVDs						
	E. Stroke						
	F.Oral Cancer						
	G. Breast cancer						
	H. Cervical cancer						
	I. Other cancers						
3. Number of persons suspected (Confirmatory Diagnosis not available/ Pending)	A. CVDs						
	B. Stroke						
	C.Cancers						
4. No. of newly diagnosed patients on Treatment	A. Diabetes Only						
	B.Hypertension Only						
	C. HTN & DM						
	D. CVDs						
	E. Stroke						
	F.Oral Cancer						
	G. Breast cancer						
	H. Cervical cancer						
	I. Other cancers						
5. No. of persons on treatment follow up	A. Diabetes Only						
	B.Hypertension Only						
	C. HTN & DM						
	D. CVDs						
	E. Stroke						
	F.Oral Cancer						
	G. Breast cancer						
	H. Cervical cancer						
	I. Other cancers						
6. No.of person referred to Tertiary hospital/TCCC	A. Diabetes (Complications)						
	B. Hypertension (Complications)						
	C. CVDs						
	D. Stroke						
	E. Oral Cancers						
	F. Breast Cancer						
	G. Cervical Cancer						
	H. Other Cancers						
7. No. of Patients treated at CCU	A. CVDs						
	B. Stroke						
8. No of cancer patients treated in Day Care facility							
9. No. of persons counselled for health promotion & prevention of NCDs							
10. No. of patients underwent Physiotherapy							
II. Co-morbidities							
1. Among all confirmed Diabetic patients **[New (2A+2C) & Follow up (5A+5C)]**	A. No. of known TB cases on ATT						
	B. No. screened for TB Symptoms						
	C. No. suspected for TB & refered to DMC/ PI						

Signature:

Name and Designation _____

Date of reporting_____

**This report should be generated by compiling data of Form 3A (CHC NCD Clinics) and Form 4 (District NCD Clinic) data*

This report should be verified and signed by District Nodal Officer.

This report should be sent to State NCD Cell by 10th day of every month.

Form 5B

National Programme for Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)

Reporting performa for District NCD Cell

Name and Address of the District NCD Cell District_____ State_____

Month_____**Year**_____

Total No. of PHC in the District **Total No. Of PHCs reported**

Part A : Screening for HTN and Diabetes

Source Of Data	Total NCD Checkups Done			No. of new persons Suspected for DM refered for Confirmation			No. of new persons Suspected for H and refered for Confirmation			No. of known cases of DM on Follow-up			No. of known cases HTN on Follow-up		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Compiled data from all CHCs															

PART B: Screening for Common Cancers

Source of Da	No. of persons screened for Cancers			No. of persons suspected with Cancer and refered to PHC/ CHC/ other						No. of Known Cancer patients		
				Oral			Breast	Cervical	Total			
	Male	Female	Total	Male	Female	Total				Male	Female	Total
Compiled data from all CHCs												

Signature:
Name and Designation _____
Date of reporting_____

**This report should be generated by compiling data of Form 3B of all Blocks/Mandals/Taluks under the District*
This report should be verified and signed by District Nodal Officer.
This report should be sent to State NCD Cell by 10th day of every month.

Form 6

National Programme for Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)
Reporting performa for State NCD Cell

Name of the State: …… **Reporting Month: ……Year……..**
No. of district NCD Cells…….. **No. Of District NCD Cells reported ……..**

Part A. Programme Data (Compiled data of Form 5A)

Indicator		During the Reporting Month			Cummulative since April (Finanacial Year Data)		
		Male	Female	Total	Male	Female	Total
i). Common NCDS under NPCDCS							
1. Total no. of persons attended NCD Clinics (New and Follow Up)							
2. No. newly diagnosed with	A. Diabetes Only						
	B.Hypertension Only						
	C. HTN & DM (Both)						
	D. CVDs						
	E. Stroke						
	F.Oral Cancer						
	G. Breast cancer						
	H. Cervical cancer						
	I. Other cancers						
3. No of new patients initiated on treatment	A. Diabetes Only						
	B.Hypertension Only						
	C. HTN & DM (Both)						
	D. CVDs						
	E. Stroke						
	F.Oral Cancer						
	G. Breast cancer						
	H. Cervical cancer						
	I. Other cancers						
4. No of Patients on Follow up	A. Diabetes Only						
	B.Hypertension Only						
	C. HTN & DM (Both)						
	D. CVDs						
	E. Stroke						
	F.Oral Cancer						
	G. Breast cancer						
	H. Cervical cancer						
	I. Other cancers						
5. No. of Patients Referred to Tertiary Care/TCCC	A. Diabetes						
	B. Hypertension						
	C. CVDs						
	D. Stroke						
	E. Cancers						
6. No of patients treated at CCU	A. CVDs						
	B. Stroke						
7. No. of persons attended day care centre							
8. No. of Persons counselled for health promotion and prevention of NCDs							
9. No. of patients attended physiotherapy							

ii). Comorbid Conditions

10. Among all confirmed Diabetic patients **[New (2A+2C) & Follow up (4A+4C)]**	A. No. of known TB cases on ATT						
	B. No. screened for TB Symptoms						
	C. No. suspected for TB & refered to DMC/ PI						

B. Other Programme Markers (Compiled data of Form 5B)

Total No. of NCD check ups done							
Total No. Of Persons Suspected and refered for	Diabetes only						
	Hypertension Only						
	Oral Cancers						
	Breast Cancers						
	Cervical Cancers						
	Other Cancers						
No. of diagnosed patients on follow up in PHC and Sub centres	HTN /Diabetes/ Both HTN and DM						
	Cancer patients						

C. Physical targets and achievements

Name of Facility	Annual Target for the year 2016-17	Achievement during the reporting month	Cumulative achievement since 1st Apr 2016	Cumulative achievement since beginning	Remarks
District NCD Cells					
District NCD Clinics					
District CCU facilities					
District Day Care Centres					
CHC NCD Clinics					
Others					

Signature:
Name and Designation _____
Date of reporting_____

**This report should be generated by compiling data of Form 5A & Form 5B of all Districts in the State*
This report should be verified and signed by State Nodal Officer.
This report should be sent to National NCD Cell by 15th day of every month.

National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)

NPCDCS Register for screening common NCDs in Government Health facilities (To be filled by Sub centre, PHC, CHC and District NCD clinics)

State:	Type of Facility:	Name of Facility:	In-charge of Facility:	Total Population:	
Date:		NPCDCS Code			

Left side of Register | Right side of Register

Sl No	Patient ID (NPCDCS No	Personal Details			Personal History					Family History					Patient Examination									Screening Outcome			Other Co-morbidities Screening	
						Tobacco																						
		Name / Address	Age/ Sex	Contact No.	Any known NCD (DM/ HTN/ CVD/ Ca)	Smoking	Smokeless (Chewing, snuffing)	Alcohol consumption in last one month	Less Physical activity (Sedentary lifestyle)	Diabetes	High Blood Pressure	CVD	Stroke	Cancer	Height	Weight	BMI (Wt. in Kg / Ht. in m^2)	Blood pressure	Blood Sugar Fasting/ Random (To mention FBS/RBS	Oral cavity examination	Breast Examination	Visual inspection of Cervix	Any other investigation/ finding	Final diagnosis at NCD clinic	Date of starting treatment	Status after treatment Initiation	Screened for TB symptoms	On ATT
					Please mention Disease	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	(metre)	(kg)	(kg/m^2)	mm/ Hg	mg/ dl	Normal/ Abnormal	Normal/ Abnormal	Normal/ Abnormal				Referred/ or FU/ Lost to FU/ Died/	Yes/ No	Yes/ No
1																												
2																												
3																												
4																												
5																												

Developed with support from WHO Country Office for India