Guidance Note for Block Monitoring Visits in High Priority Districts

August 2013

Block Monitoring Visits

I. Why Block Monitoring Visits?

The RMNCH+A strategic approach for improving maternal health and child survival envisages support from Development Partners, State and District Programme Management Unit for integrated planning, implementation and monitoring of the RMNCH+A interventions across high priority districts. In order to ensure that districts get timely support to implement the most critical interventions, the Development Partners are expected to offer need based district level assistance and work alongside district and block level stakeholders to identify key bottlenecks and address them systemically.

It has been observed from the field visits that there exist interblock variations within the districts in terms of health infrastructure and service delivery. This could be due to clustering of vulnerable and marginalized populations, geographical inaccessibility, or security concerns (eg; LWE affected), on account of which these blocks remain relatively underserved.

Under the District Intensification Plan, the block is envisaged as the primary unit for implementation and management of RMNCH+A interventions, the capacities for which are to be developed locally through mentoring support by the district and state management units and the development partner.

II. Purpose of Block Monitoring Visits

The purpose of Block Monitoring Visits will be to:

1. make a quick assessment of the infrastructure, human resources, and provision of services (both at facility and community level) ;
2. assess service delivery (quality and coverage) at block level;
3. review progress of community outreach and community/home based interventions;
4. validate the data reported into HMIS; and
5. gauge the client (beneficiary) satisfaction level with RMNCH+A services.

III. Steps in Block Monitoring Visit

It is proposed that District Monitors, assigned by various Development Partners, visit one block each month in each high priority district. They will be joined on these visits by government representatives from district and state, and where directed by the SPMU, experts, resource persons from mentoring institutions and NGO representatives may also be

part of the team. The dates for block monitoring visits should be informed in advance to all team members. The schedule of visit for three or six months may be drawn up so that the District Monitors can schedule it in their monthly work plans and availability of all team members is ensured.

Following the visit, the District Monitors, along with the team members are expected to prepare a visit report that includes:

1) Major actionable points & level at which the action is to be taken (i.e. facility, block, district or State);
2) Stakeholders (Development Partner/s, DPMU, SPMU, other experts or resource persons, NGOs) responsible for providing technical support along with timelines; and
3) Actions taken on previously identified bottlenecks and visit reports.

IV. Reporting format

The Reporting Format below provides a broad guidance on the parameters to be assessed during monthly visits to the blocks and to be reported thereafter. Additional components may be included by the District Monitors/SLPs based on experiences from the field visits so that most relevant and critical issues are reported.

The reports should be forwarded by the District Monitors to the concerned authorities at District and State level within one week of completing the visit and through the State Lead Partner Agency to the National RMNCH+A Unit (NRU) in the first week of the following month.

Note: Specific tools and checklists may be used to assess the various parameters included in the reporting format. These can include facility assessment tools/monitoring checklist, community /household visit tool, tools for assessment of labour rooms, newborn care facilities, hygiene and sanitation facilities, and so on.

The data may be accessed from District /Block Management Unit before or during the visit and validated in the field/health facility.

Block Monitoring Visit: Reporting Format

Name of the Block/s & District visited:

Dates of Visit:

Name of team leader & organization:

Names of team members & organizations:

I. Block Profile

i. Demographic information	Census 2011				
Whether it has areas that are difficult to reach (due to hilly or difficult terrain)	Name of the villages that are difficult to reach				
Whether block has more than 50% Tribal Population	Yes/No				
Whether the block is LWE affected	Yes/No				
Total Population	Male	Female	Total	Urban	Rural
Population of children under 5 years					
Literacy rate					

ii. Infrastructure	Sanctioned	Presently Functional
Number of Sub-Health Centers		
Number of 24x7 Primary Health Centers		
Community-Health Centers		
FRU (facility providing C section/ EMONC)		
Any adolescent health clinic/s		
SNCU (Yes/No)		
Any NBSU		
Any NRCs		
Any health facility with blood bank		
Any facility with blood storage unit		
Block covered by functional MMUs (Mobile Medical Units) Yes/No		
iii. Human resources	**Sanctioned posts**	**In position**
BPMU staff		
ASHAs		
ASHA Supervisors		
1st ANM		
2nd ANM		
Staff nurses		
FRU		
24X7 PHCs		
LHVs		
MPWs (male)		
Medical Officers		
FRU		

24X7 PHCs			
AYUSH MOs			
Specialists (at any health facility in the block)			
Obstetricians & Gynaecologist			
Anaesthetist			
Paediatrician			
Surgeons			
iv. Health service provision	# designated as delivery point	# having SBA & NSSK trained ANM/ SNs	# having functional NBCC
Sub-Health Centers			
24x7 Primary Health Centers			
Other PHCs			
Community-Health Center			
Number of facilities in the block conducting C-section	**CHC**	**24x7 PHCs**	**SC**
Number of facilities with fixed day family planning services			
Number of facilities with RMNCH+A counsellors			
Number of functional Anganwadi centers			
% villages with functional VHSNC			
No of Villages with ***NO Access*** to any public health facility within 30 minutes walking distance	**Names of the villages**		

II. ASSESSMENT OF SERVICE DELIVERY AT BLOCK LEVEL

Overall	
• % delivery points having full complement of trained HR for key RMNCAH services	
• % delivery points having appropriate equipment, adequate drugs, vaccines , contraceptives and other essential commodities for RMNCH+A services	
Maternal Health	
• JSSK: % drop-back availed by pregnant women (total women who availed drop back facility of JSSK/total women who delivered in the facility*100)	
• JSY: % eligible women given JSY benefits(as applicable rural/urban/HPS/LPS) before/while leaving the institution after delivery	
• Severe Anaemia: % severely anaemic women identified and referred/treated (as applicable)	
• Abortion: No. of women provided MTP services Ist trimester, 2nd Trimester	
Child Health	
• % NBCCs operational (against total delivery points)	
• % newborns admitted in newborn facilities (NBSU) against total deliveries	
• % out-borns in NBSU	
• % of eligible children screened under RBSK	
Adolescent/Pre-pregnancy	
• WIFS % beneficiaries administered IFS	
• % uptake of sanitary napkins (against plan)	
• AH clinic utilization: No. of Adolescents availing services per month	
Family Planning	
• % PP-IUDs out of total IUDs	
• No of fixed day sites operating regularly	
Trainings	
• % ANMs/SNs trained in SBA against the total number required at Delivery points	
• % ANMs/SNs trained in NSSK against the total number required at delivery points	
• % ASHA conducting home visits after HBNC training	
• % ANMs trained in IUCD insertion	
Finance	
• % utilization of RKS funds	
• % utilization of NRHM funds	
Community	
• % VHNDs held against planned	
• % new-borns visited by ASHAs at home	
• % ASHA involved in door step delivery of contraceptives	
Pilots/Schemes being implemented in the district	**Status of implementation (Coverage as well as quality) Provide both quantitative and qualitative data**
JSSK	
JSY	

Doorstep delivery of contraceptives	
Menstrual Hygiene Scheme	
RBSK (Rashtriya Bal Swasthya Karyakram)	
WIFS	
School Health Programme	
Maternal Death Review	
Infant/Child Death Review	
Any other pilot/scheme	

III. VALIDATION OF KEY RMNCH+A INDICATORS IN HMIS (FROM DATA SOURCES)

The visiting team should validate the HMIS reporting of following indicators from the registers/primary data source available at the facility/block management unit.

Pregnancy Care	**Data validation findings**
• 1st Trimester registration to ANC registration	
• Pregnant women received 3 ANC check-ups to total ANC registration	
• Pregnant women given 100 IFA to total ANC registration	
• Cases of pregnant women with Obstetric Complications and attended to reported deliveries	
• Pregnant women receiving TT2 or Booster to total number of ANC registered	
Child Birth	
• SBA attended home deliveries to total reported home deliveries	
• Institutional deliveries to ANC registration	
• C-Section to reported deliveries	
Post natal Mother& Child care	
• Newborns breast fed within 1 hour to total live births	
• Women discharged in less than 48 hours of delivery in public institutions to total no. of deliveries in public institutions	
• Newborns weighing less than 2.5 kg to newborns weighed at birth	
• Newborns visited within 24hrs of home delivery to total reported home deliveries	
• Infants 0 to 11 months old who received Measles vaccine to reported live births	
Reproductive Age Group	
• Post-partum sterilization to total female sterilization	
• Male sterilization to total sterilization	
• IUD insertions in public plus private accredited institution to all family planning methods (IUD plus permanent)	

IV. KEY FINDINGS AND ACTIONS

	5 major actionable points agreed upon for action after block monitoring visit & level at which the action is to be taken i.e. facility, block, district or State to be mentioned
1	
2	
3	
4	
5	

	Action taken on last visit report (Date of the last visit)
1	
2	
3	
4	
5	

Date of preparation of report:

Signatures of team members:

1.

2.

3.

4.

5.

6.