IDCF 2017
Intensified Diarrhoea Control Fortnight
12-24 June 2017

OPERATIONAL GUIDELINES

Ministry of Health & Family Welfare,
Government of India

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

Contents

1. Introduction & rationale

Reduction of childhood mortality from 43 / 1000 live births in 2015[1] to 25 by 2025 is one of the prime goals of National Health Policy 2017. Childhood diarrhoeal diseases continue to be a major killer among under-five children in many states, contributing to 10 percent of under five deaths in the country. Around 1.2 lakhs children die due to diarrhoea annually in the country. Diarrhoeal deaths are usually clustered in summer and monsoon months andthe worst affected are children from poor socio-economic situations.

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

The effect of diarrhoeal mortality remains high in children and hence in continuation of the efforts in 2014, 2015 and 2016, it has been decided to organise an Intensified Diarrhoea Control Fortnight (IDCF) this year from 12 to 24June 2017, with the ultimate aim of 'zero child deaths due to childhood diarrhoea'.

Intensified Diarrhoea Control Fortnight (IDCF) consist of a set of activities to be implemented in an intensified manner from 11 to 24 June2017 for prevention and control of deaths due to dehydration from diarrhoea across all States & UTs. These activities mainly include- intensification of advocacy & awareness generation activities for diarrhoea management, strengthening service provision for diarrhoea case management, establishment of ORS-Zinc corners, prepositioning of ORS by ASHA in households with under-five children and awareness generation activities for hygiene and sanitation.

2. Objective and Strategy

2.1 Goal of IDCF

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

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

[1]Sample registration survey

2.2 Specific objectives of IDCF

- To improve usage of ORS and Zinc for childhood diarrhoea.
- To complement awareness activities (including Swachh) for prevention and management of diarrhoea in under-five children.

The diarrhoeal mortality in India still remains high in under-five children,Timely and appropriate treatment by ORS and Zinc can save many lives. At national level, there is an improvement of ORS coverage from 26 percent in 2005–06 to 50.6 percent in 2015-16 and Zinc from 0.3 percent in 2005-06 to 20.3 percent. However, this coverage needs further improvement to reach the target of 90 percent by 2025 as per the India Action Plan for Pneumonia and Diarrhoea (IAPPD). The state wise coverage of ORS and Zinc is in annexure 1. The ORS and Zinc use rate remains low in many states and districts. Effort were made in year 2014, 2015and 2016 through the intensified diarrhoea control fortnight to pre-position ORS and Zinc at the household level and raise awareness. **Intensified Diarrhoea Control Fortnight (IDCF) in 2017,will be held from 12 to 24 June.**

2.3 Strategy for the IDCF

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

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

3. Overview of activities in IDCF in 2017

- At community / village level
    - Distribution of ORS and demonstration
    - IPC activities by ANM on hygiene and sanitation along with management of diarrhoea
    - Handwashing demonstration in schools
    - Mobile health teams for urban areas

- At health facility level
    - Establishment of ORS and Zinc corners for treatment of diarrhoea
    - Promote standard case management of diarrhoeal cases
    - Cleaning of water tanks in health facilities

4. Pre- campaign planning

4.1 Setting up of the committees

4.1.1 IDCF coordination committee

IDCF coordination committee has been established at the MoHFW, Government of India to oversee the implementation of this fortnight. Similar committee should be established at State and District level.

At the State level, Principal Secretary Health or MD – NHM should preferably be leading the IDCF Steering Committee with support from key staff from Directorate of Health and Family Welfare.

At the District level IDCF committee should be formed, preferably led by District Magistrate and with support from Chief Medical and Health Officer of the district. At both the State and District level, Program Officer for Child Health and IEC Officer should be included in the Committee.

- **4.1.1a IDCF Steering Committee meeting**: The lead official from State and District shall call a meeting of the Committee *before, during and after* the fortnight to ensure effective implementation of the IDCF.
    - **Departments to be invited for the meeting:** Health and Family Welfare, State Health Resource Centre / ASHA Resource Centre, Department of Women and Child Development, Dept. of Panchayati Raj, Dept. of Water and Sanitation, Dept. of Tribal Welfare, Dept. of Social justice and Backward and Minority affairs /Municipalities, State / District IEC Department / Publication Bureau, Song and Drama division etc.

    - **Partners to be invited for the meeting:** IAP, IMA, UNICEF, WHO, CHAI, MI, Save the Children, JSI and Lead Development Partners of the State / District in supportive supervision of RMNCH+A activities. To improve the support to States, it is proposed that Lead Development Partners may work closely with the State Government during the State level briefing of Districts RMNCH+A partners to support respective state to plan, build capacity and monitor activities for the fortnight.

- **4.1.1b Orientation of district level officials**: Continuous efforts of orientation of district officials through meetings or video conference should to be conducted by State NHM to sensitize for planning of IDCF. Annex II provides suggested agenda items to be covered during meeting/ VCs (*Suggested agenda points for meeting:(Annexure II)*

4.2IDCF orientation

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

Location	Participants	Contents of orientation	Timeline
State/Regional level	RDD, CS, DIO, RPM, DPM, DCM, DSO, PO – ICDS	Managerial aspects of IDCF and planning, monitoring and IEC of IDCF.	8-12 May 2017
District level	BPO/ MOs / BCM / BCPM/ BHM/MO-CHC/PHC etc.		
Block/PHC level	AYUSH Medical Officer, Nursing staff, ANM, ASHA& AWW	Technical orientation on diarrhoea management along with programme orientation of IDCF which involves their roles and activities during IDCF.	13 May – 11 June 2017

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

4.3 Need assessment and planning for the supplies and logistic

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

District requirement:

On an average, one under-five child suffers from 2.44 episodes of diarrhoea per year. Each episode requires ORS and Zinc treatment. Each episode of diarrhoea will require on an average 2 packets of ORS and 14 tablets of Zinc.This should be taken into account for calculating annual requirement for the District for regular supply.

For the purpose of IDCF the calculation of requirement is as follows for a district of 20 lakh population.

Total under five children:2 lakh

Total number of households in the district: Total population/ 5 (average family size) = 4 lakhs

Number of ORS – Zinc corners:
Total OPDs and pediatric wards of medical colleges, district hospitals, CHCs, PHCs, subcentres = 500

Requirement for IDCF for a district of 20 lakh population

IDCF activities	Quantity
Pre-positioning of ORS	
ORS for pre-positioning in households by ANMs and mobile teams	2 lakh X 1 packet = 200,000 packets
Demonistration of ORS and Zinc in VHND by ASHA and mobile team	
ORS for demonstration in community	4,000 packets
Zinc for demonstration in community	4,000 tablets
Treatment of childhood diarrhoea cases	
ORS for ORS – Zinc corners	500 corners X 50 cases X 2 packets = 50,000 packets
Zinc for ORS – Zinc corners	500 corners X 50 cases X 14 tablets = 350,000 tablets
ORS for ANM	400 ANMs X 10 cases X 2 packets = 8,000 packets
Zinc for ANM	400 ANMs X 10 cases X 14 tablets = 56,000 tablets
ORS for ASHA	2000 ASHA X 10 cases X 2 packets = 40,000 packets
Zinc for ASHA	2000 ANMs X 10 cases X 14 tablets = 280,000 tablets
ORS for mobile team	10 teams X 10 cases X 15 days X 2 packets = 3,000 packets
Zinc for mobile team	10 teams X 10 cases X 15 days X 14 tablets = 21,000 tablets

So, ORS = 305,000 packets and Zinc tablets = 711,000

For treatment of diarrhoea cases, at any given time a minimum of 20 ORS packets and 140 Zinc tablets should be made available with each ASHA and ANM througout the year

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

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

4.4Strengthen and gear up facilities for the IDCF

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

4.5 Planning for IEC for the fortnight

The District IDCF committee would undertake:

1. Assessment of available IEC materials such as videos, hoardings, posters, pamphlets and IEC material for free distribution at ORS – Zinc Corners for placement at strategic locations, prior to the Fortnight.
2. Prototypes of additional IEC material are available on the website www.nrhm.gov.in. States are encouraged to use these materials widely for the IDCF campaign. If necessary, adaptation and translation/dubbing in regional language may be carried out at the local level for better awareness generation in the communities.
3. Any other media and mid-media planning for reinforcement of messages on diarrhoea prevention and control
4. However States mayalso use available material that is technically sound.

5. IDCF Campaign

5.1 Target beneficiaries

The target beneficiaries for the campaign include:

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

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

5.2Priority populations

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

Key locations reached through ICDF should include:

1. Areas with vacant sub-centres: ANM not posted for more thanthree months
2. Villages/areas with ANMs on long leave or other similar reasons.
3. Within villages houses that are located in or near unsanitary conditions.
4. High risk areas (HRAs) with populations living in areas such as:
   a. Urban slums
   b. Underserved and hard to reach populations (forested and tribal populations, hillyareas etc.).
   a. Other migrant settlements (fisherman villages, riverine areas with shifting populations)
   b. Nomadic sites
   c. Brick kilns
   d. Construction sites
   e. Orphanage
   f. Street children
5. Areas known for or with diarrhoeal outbreaks, in last two years.
6. Areas known for poor sanitation and water supply.
7. Small villages, hamlets, dhanis, purbas, basas (field huts), etc.

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

6. Detail of activities during IDCF 2017

The following activities to be undertaken during the fortnight:

6.1 At the community / village level

6.1.1 Distribution of ORS and demonstration of ORS and Zinc at the community level

- Every ASHA to distribute ORS packetsto all families with under five children.
- During the household visit ASHA will deliver key messages to the mothers / families (Key messages in box on Page 15).
- A group demonstration for the preparation of the ORS solution will be conducted by ASHA. It will involve gathering of members from 4-8 households and demonstrating the steps for preparation of ORS solution and Zinc solution. Understanding of the caregivers must be checked after the demonstration.

- ASHAs will also educate families on the importance of hygiene and sanitation.
- ASHA will undertake identification and referral of diarrhoeal cases to ANM/ health facilities and also educate mothers on the danger signs.
- ASHA will report all diarrhoeal deaths during the fortnight.
- At the end of Fortnight a report will be submitted by ASHA→ANM→BCM (Block DEO will compile the data)→ DCM (DM&E will compile the data)→State Health Society.
- The activity of the village to be monitored by ANMs

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

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

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

i. During the fortnight,ANM should conduct IDCF meeting in her Sub centre village and VHNDs (as per her existing micro-plan)to disseminate information on prevention & control of diarrhoea, especially involving care givers of under-five children.

ii. ANM should start the session with key message of the IDCF campaign highlighting importance of ORS and Zinc, continued feeding, hand-washing in control of childhood diarrhoea and use of toilets for defecation.

iii. ANM should carry out Participatory learning technique on sanitation & hygiene, as per Annexure XVI. Active participation of Department of Water and Sanitation at States/District level may be taken to carry out this activity.

6.1.3 Hand-washing demonstration in schools

i. This activity needs to be carried out in all primary and middle schools.

ii. Each school should have poster pasted at the hand washing area on steps for effective hand washing.

iii. After the morning assembly / prayers, message on importance of hand washing should be delivered to all the students.

iv. Before mid-day-meal, all children should be taught to wash hands with water and soap following the steps in the poster.

v. *Prabhat pheri* or rally by school children on topic of hand-washing to be carried out.

6.1.4 Mobile health teams for urban areasto cover children in urban slums, migrant population, street children, juvenile homes, orphanages etc.

i. Mobile teams should be formed, with the cooperation from Municipalities, for visiting slums, floating population etc.

ii. There should be high visibility of activities through posters, banners, FM radio should be undertaken.

iii. Urban ASHA (USHA), wherever available will work as outlined for rural ASHA.

6.2 At the facility level

6.2.1 Establishment of ORS- Zinc corners for treatment of diarrhoea:

i. ORS- Zinc corner should be established for treatment of diarrhoea in OPD and paediatric ward and for promotion in an easily noticeable area on entrance of hospital in the following health facilities/aanganwadis:

   a. Medical Colleges
   b. District Hospital
   c. Block CHC / PHC
   d. Subcentre
   e. Anganwadi centres
   f. Urban health posts / health centres
   g. Private medical practitioners

The private paediatricians / medical practitioners through IAP / IMA should be involved for setting up of ORS – Zinc corners in their clinics and wards.

iii. For all patients attending OPD for any ailment. In order to establish ORS- Zinc corner, refer to Annexure XV.

iv. During the IDCF and beyond, all facilities should have sufficient availability of ORS and Zinc dispersible tablets at all Health facilities.

v. Tertiary level facilities with Nutritional Rehabilitation Centres must be geared up for management of SAM children with diarrhoea as per GoI NRC guidelines.

vi. Arrangements for management of severely dehydrated cases as per IMNCI Plan C.

vii. Paste and display of facility appropriate treatment protocols in OPD and paediatric ward/General IPD (refer toolkit).Promoting prescription of ORS along with Zinc dispersible tablets for childhood diarrhoea by all healthcare providers.

6.2.2 Promote standard case management of diarrhoeal cases

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

i. Diarrhoea cases with no dehydration will be treated with ORS, extra oral fluids and Zinc as per IMNCI Plan A.

ii. Diarrhoea cases with some dehydration will be managed for rehydration with ORS under observation as per IMNCI Plan B; then shifted either to IMNCI Plan A to C.

iii. Diarrhoea cases with severe dehydration will be admitted and rehydrated with IV Ringer Lactate in wards (IMNCI Plan C), once rehydrated will shift to Plan A (ORS, extra oral fluids and Zinc).

iv. The above recommendation will be for treatment of all diarrhoea cases managed by both the government health staff and private medical practitioners- in routine system and during IDCF.

v. Medical officers and nursing staff at health facilities to be oriented on the treatment plan.(Ref.-IDCF toolkit).

vi. Pasting and display of facility appropriate treatment protocols in OPD and paediatric ward/General IPD:

- Plan A and B in OPD
- Plan C in wards

6.3 Intensive Awareness generation

6.3.1 State level Launch: The IDCF Fortnight should be launched by a Minister at State level and by noted political member at District and Sub District level. Raise visibility of the Fortnight by involving Chief Ministers/ Health Minister/ other ministers / MPs/MLAs/PRI

members. CMs / HMs may be asked to lead the movement and address the public through media with the message that No Child Should Die in the State due to Diarrhoea.

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

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

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

6.3.4 Matrix of IEC activities:

	IEC activity to be undertaken	**Key person**
State level	a) T.V/ radio advertisements b) State level launch of IDCF by CM/ HM by inaugurating activities c) Facilitation of Districts by providing IEC material prototypes shared by GoI d) Facilitation of Districts by providing other printed material-orientation material, FAQs, IDCF guidelines, supportive supervision formats e) State level monitors to be sent to each District for observation of activities f) SMS delivery on diarrhoea control through MCTS.	MD(NRHM)
District Level	a) Launch of IDCF to be organised jointly by CMO office and Indian Academy of Paediatrics b) Launch of IDCF by MP/MLA c) Placing Banners/Posters at Strategic locations	CMO

Schools /Colleges	a) Organise WASH activities during the Fortnight in which soap, clean water is provided and hand-washing is observed before Mid Day Meal / School lunch ; Posters on Hand washing to be put in hand washing area b) Organise Speech/painting competition on diarrhoea and use of ORS and Zinc followed by a lecture by BMO/MO on Diarrhoea and ORS and Zinc c) Organise Speech competition on diarrhoea and use of ORS and Zinc followed by a lecture by BMO/MO on Diarrhoea and ORS/Zinc use	BMO/Active MO of CHC,PHC
Block Level	a) Special session on childhood diarrhoea- ORS/Zinc in meeting of Block PRI members (Funds from RPI system) b) Similar session in BDC meeting c) Daily miking for key messages d) Placing Banners/Posters at Strategic locations	BMO/BHO
Village level	Wall painting in each village on use of ORS/zinc, WASH	PHC MO
	Goshthi/village level discussion on Diarrhoea management	ANM/ MO
	Daily miking	PHC MO
Others	Messaging about ORS and Zinc through Munadis/NukkadNatakas/ Folk lore	MO

6.4 Multi-sectoral involvement

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

i. All linedepartments for launch activity: Departments such as WCD, Drinking Water and Sanitation, Rural Development, Panchayati Raj and Education along with IAP, development partners should be invited and commitment should be extracted for IDCF.

ii. Department of WCD, for establishing ORS-Zinc corners In AWCs: Instruction to be issued by the department to their staff informing the IDCF activities and their role.

iii. Education department, for handwashing demonstration and competitions at schools: Instruction to be issued by the department to their staff informing the IDCF activities and their role.

iv. Panchayati Raj: For dissemination of key messages through Panchayati Raj Institution, block development meetings.

v. Involvement of Indian Academy of Paediatrics (IAP) / Indian Medical Association (IMA) / other NGOs: IAP may be involved in this fortnight. The various activities proposed are :

- Facilitating launch though State and District Health Mission
- Organising sensitisation meeting of Chemists, local Practitioners regarding ORS and Zinc use and rational use of antibiotics in case of diarrhoea.

Key messages for awareness generation to be used during fortnight

To be used by all functionaries

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

7. Supportive supervision and monitoring

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

7.1 State level monitors:

- The state monitors need to priorities districts for monitoring IDCF. Priority should be accorded to HPDs, district that have more hard-to-reach areas, slums, migration points, flood prone, have out-break of diarrhea in last three years.
- A supportive supervision plan needs to be chalked out at the state level for daily monitoring of the chosen districts.
- Carry enough supportive supervision formats with you. Formats to carry are:
    - District level Supportive Supervision Checklist (one for each district)
    - Block / urban level Supportive Supervision Checklist (one per block / urban area, separate for week 1 and 2 @ one per day)
- During the meeting with district health officials, review the preparedness in terms of District level steering committee meetings (were they chaired by District Magistrate / Collector), stock position of ORS and Zinc, IEC materials, ORS – Zinc corners in OPD and wards, trainings, formats, involvement of WCD & PRI, mobile teams, NRC.
- On a daily basis visit, one block or urban area.
    - Prioritize visit to those block / urban areas that have more hard-to-reach areas, slums, migration points (railway station, bus stops, taxi stops), flood prone, have out-break of diarrhea in last three years.
    - Meet the Block Medical Officer / Municipal Medical Officer
    - For ORS – Zinc corner prioritize visit to those health facilities that have high patient load viz: Medical college, district hospital, children hospital, block level health facilities etc
    - Visit those villages where VHNSC meeting is planned on the day of visit. Visit the schools of those villages too.
- The monitor needs to apprise the District Magistrate / District Collector of their findings. During the meeting with the DM / DC, highlight 2-3 key actions that the DM / DC needs to ensure to make IDCF a success with the goal of not a single diarrhea death throughout the year.
- Submit the filled formats to National and State IDCF secretariat.

7.2 District level monitors:

- Prioritize visit to those block / urban areas that have more hard-to-reach areas, slums, migration points (railway station, bus stops, taxi stops), flood prone, have out-break of diarrhea in last three years.
- Carry enough supportive supervision formats with you. Formats to carry are:
    - Block / urban level Supportive Supervision Checklist (one per block / urban area, separate for week 1 and 2 @ one per day)
- Meet the Block Medical Officer / Municipal Medical Officer to review the preparedness
- For ORS – Zinc corner prioritize visit to those health facilities that have high patient load viz: Medical college, district hospital, children hospital, block level health facilities etc
- Visit those villages where VHNSC meeting is planned on the day of visit. Visit the schools of those villages too.

8. Reporting

- Each ASHA shall provide the filled monitoring formats at the end of the IDCF to the ANM (Within first two days of post Fortnight) i.e. by June 26.
- ANM will submit the compiled report to the Block within the next two days of receiving from ASHA i.e by June 28
- The Block DEO will collate the reports and submit it to the district M and E in another 2 days i.e. by June 30
- The district M&E will submit the compiled duly signed copy to the State level in another 3 days after receiving from the Block by July 1
- State IDCF reports would be sent to National level by 3rd July 2017.
  (Reporting formats are in AnnexuresIX-XI)

9. Financial guidelines

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

S. No.	Activity	Estimated expenditure per District (Rs.)
1.	**ASHA incentive** for prophylactic distribution of ORS @ Rs. 1 per ORS packet delivered to family with under-five children. [For 100 under-five children per village and approximate 2000 ASHA funds are Rs. 2 lakhs] **Budget Line: B.1.1.3.5**	**Rs. 2,00,000 ***
2.	**Printing Costs:** - monitoring formats - printing of training material (as in toolkit) **Budget Line: B.10.3.5**	**Rs. 18,000 *(Training material printing to be given only to ANM/MO/BMO. ASHA to use her module 6 & 7)**
3.	**Procurement of ORS- for distribution:** [For a district with 20 lakhs population—around 2 lakh under-five children requiring 1 packet@ Rs. 2 (suggestive price per packet)**Budget Line:B.16.2.5**	**Rs. 4,00,000 ***
4.	**Daily Mobility Support** for field level monitoring- 2 hired vehicles from for two weeks: 2 Vehicle per district (Rent per day Rs. 1000/vehicle; Fuel Rs.1000/day/vehicle) =Rs. 2000*10 days **Budget Line: A.10.7**	**Rs. 40,000**
6.	**IEC material printing:** Banners/Posters/Pamphlets for ASHA, Munadi, Nataks**This budget may be expended at State level as printing/Audio visual Airtime cost takes place at State level. Otherwise District may use this fund for printing. Dedicated funds should be provided for village level miking and wall paintings). Budget Line: B.10.3.5**	**Rs. 1,00,000**
7.	**One day orientation meeting** at PHC/Block levels @Rs. 50/ participants for around 3000 health care providers (apart from printing of training material. **Budget Line: A.9.11.3**	**1,50,000***
	Total	**Rs. 9 lakh per district (approx.)***

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

10. District Operational Plan/Timelines

Sl No.	Activity	Person Responsible	Terms of Reference/ Activities	Output	Timeline
1.	**Formation of District IDCF steering committee**	**CMHO**	• **Constitution of IDCF Steering Committee** chaired by District Collector to oversee the implementation • **Regular meetings of Steering Committee** before, during and after the fortnight for oversight, inter-sectoral coordination and reviewing progress	District IDCF Steering Committee functional	By 10thMay 2017
2.	**Identification of IDCF District Nodal person**	**District Steering committee**	• The nodal person identified for IDCF will be responsible for overall planning and implementation of IDCF activities in the district • S/he will be responsible for organizing Steering Committee meeting, assessing and ensuring the supply of ORS-Zinc in the district, planning and organising District & Block sensitization workshop, development of proper micro-plans, identification of monitors and finalization of supportive supervision plan, ensuring timely availability & distribution of recording, reporting & supportive supervision formats and IEC materials	District Nodal Officer identified	By 10thMay 2017
3.	**Assessment and replenishment of ORS and Zinc Supply**	**District Nodal person with district pharmacist & Block MO I/c**	1. **District Nodal person shall assess the requirement of the ORS and Zinc supply for pre-positioning and treatment.** **For calculations refer to page 7** 2. **Assessing Stock position of ORS and Zinc at district and replenishing the stock based on the requirement** 3. **Replenishing ORS and Zinc stocks at Block (both facility & community level)** 4. **Distribution of ORS and Zinc to ASHAs based on micro plan provided by ASHA**	1. Requirement of ORS and Zinc tablet for IDCF 2. Stock position and estimated requirement 3. Blocks have sufficient supply of ORS and Zinc 4. ASHAs have sufficient ORS and Zinc supply	By 12thMay 2017 By 26th May 2017 By 2ndJune 2017 By 9thJune 2017
4.	**Printing of**	**District Nodal**	1. **Printing of recording, reporting and monitoring formats**	• Recording formats	By 15th

Sl No.	Activity	Person Responsible	Terms of Reference/ Activities	Output	Timeline
	formats-Recording, Reporting format	**person**	**2. Distribution of formats duringorientation of service providers**	• Reporting formats • Supportive supervision formats	June 2017
5.	**Sensitization workshop**	**District Nodal person**	**1. Planning & organising District sensitization workshop** a. Block Health Officials(BMOs, MOs, BPM / BHM, BCM) Representation from ICDS(CDPO), Education, PRI, local IAP, PHED and NGOs b. Orientation on activities to be implemented micro planning and reporting & monitoring mechanisms c. Sensitization on diarrhoea prevention & management d. Planning for block level sensitization meeting e. Orientation &distribution of reporting & monitoring formats f. Development of supportive supervision plan g. Distribution of IEC materials **2. Planning and organising Block Orientation workshop** a. CHC/PHC MOs, LHVs, AYUSH doctors, ICDS Supervisor, ANMs, ASHAs b. Orientation on activities under IDCF and microplanning c. Orientation on diarrhoea prevention & management d. Distribution of IEC materials	1. Block level sensitization meeting plan 2. Orientation of service providers	By 17th May 2017 By 19th May 2017
6.	**Micro-planning**	**District Nodal person, District ASHA nodal person & Block Medical Officer**	1. Orientation of Block health officials on importance /need of micro-planning during district sensitization meeting 2. Orientation of ASHAs on micro-planning during Block Orientation Workshops and finalizing timeline for submission of micro-plans by ASHAs 3. ASHAs to prepare and submit micro-plan to Block in-charge 4. Block In-charge to submit compiled micro-plans to District Nodal Officer 5. Review of all micro-plans	Microplans developed and reviewed	By 17th May 2017 By 19th May 2017 By 24thMay 2017

Sl No.	Activity	Person Responsible	Terms of Reference/ Activities	Output	Timeline
					By 26thMay 2017
7.	**IEC activities**	**District Nodal person & District IEC Officer**	1. Printing of IEC material- Posters/Leaflets (District should also utilise existing IEC material on Diarrhoea along with newly printed IEC material. 2. Distribution of IEC material to Blocks	Printed IEC material distributed	By 2ndJune 2017
8.	**Operationalizing ORS-Zinc Corners at selected health facilities**	**District Nodal person & Facility In-charges of selected facilities**	**1. Selection of public health facilities –** District Hospitals, Sub Divisional Hospitals/Civil Hospitals, CHCs, High case load PHCs **2. Selection of private nursing homes/clinics in consultation with local IAP/IMA branches** 3. **Ensuring space, necessary infrastructure and logistics**(table/chairs, one bench/bed, ORS, Zinc tablets, supply of safe drinking water, necessary utensils like one litre vessel, spoons, glasses, bowls& cups, treatment protocols, IEC materials for display and distribution, nearby toilet & handwashing facilities), **trained staff** for fully functional ORS-Zinc corners 4. **Orientation of service providers –**MOs and Staff nurses to manage the ORS-Zinc corners	No. of operational ORS-Zinc corners at health facilities	1stJune onwards
9.	**Distribution of recording and reporting formats**	**District Nodal Officer, District M&E Officer, District/Block Entry Operators, District ASHA Coordinator /BCM**	1. Recording and reporting formats distributed to Blocks and ASHAs 2. Orientation on reporting formats and submission instructions 3. ASHAs to submit reports to ANM who submits compiled reports at Block level 4. Block DEO collates and compile block report and Block In-charge shares the compiled report with district 5. CMO shares compiled district report with State	Distribution of all recording, reporting and monitoring formats	By 9th June 2017
10	**IDCF Supportive supervision**	**District Nodal person**	1. Preparation of supportive supervision plan at district and Block level	Supportive supervision plan	By 2nd June 2017

Sl No.	Activity	Person Responsible	Terms of Reference/ Activities	Output	Timeline
			a. Identification of district and block level monitors b. Preparation of supportive supervision plan c. Sharing of supportive supervision formats 2. Supportive supervision of community and facility level activities 3. Sharing of supportive supervision reports /feedback for necessary facilitative actions on daily basis and setting up troubleshooting mechanisms	developed and monitors identified	During the Fortnight
11.	**District Launch Meeting**	**CMO & District Nodal Officer**	1. Organising District IDCF Launch preferably inauguration by local MLA/MP 2. Representation from ICDS, Education, PRI, IAP, IMA, NGOs	District IDCF launch	12th June 2017

Annexure I: Prevalence of childhood diarrhoea and coverage of ORS &Zinc in States & UTs as per NFHS 4, 2015-16

State	Prevalence of diarrhoea in last two weeks preceding survey (in percentage)			Children with diarrhoea in the last 2 weeks who received ORS and Zinc (in percentage)					
	URBAN	RURAL	TOTAL	URBAN (coverage in percentage)		RURAL (coverage in percentage)		TOTAL (coverage in percentage)	
				ORS	Zinc	ORS	Zinc	ORS	Zinc
Andaman & Nicobar Islands	6.6	4.4	5.3	*	*	88.8	3.8	65.0	8.3
Andhra Pradesh	5.7	6.9	6.6	54.9	33.5	45.3	29.1	47.6	30.1
Arunachal Pradesh	7.0	6.3	6.5	76.6	62.8	66.1	45.8	62.8	66.1
Assam	3.6	2.9	2.9	58.7	26.9	50.9	21.3	51.9	22.0
Bihar	8.0	10.7	10.4	62.1	27.2	43.8	19.5	45.2	20.1
Chandigarh	NA	NA`	4.6	NA	NA	NA`	NA	*	*
Chhattisgarh	11.3	8.6	9.1	68.3	67.8	67.9	26.8	29.7	28.9
Daman & Diu	2.3	7.3	3.8	*	*	*	*	*	*
Dadra & Nagar Haveli	5.5	3.3	4.2	*	*	*	*	*	*
Delhi	10.6	8.6	10.6	62.2	*	61.9	25.7	*	25.5
Goa	3.0	5.2	3.8	*	*	*	*	*	*
Gujarat	7.7	8.8	8.4	49.7	13.2	44.0	19.9	46.2	17.4
Haryana	7.6	7.7	7.7	67.0	19.5	57.1	23.3	60.6	21.9
Himachal Pradesh	10.5	6.3	6.6	*	64.2	62.7	*	16.5	15.0
Jammu & Kashmir	4.8	8.3	7.5	68.4	69.3	69.1	26.5	41.4	39.1
Jharkhand	6.1	7.1	6.9	49.1	44.0	44.8	18.0	19.3	19.1
Karnataka	4.8	4.3	4.5	44.9	29.1	58.7	38.1	52.8	34.3
Kerala	2.7	4.0	3.4	40.5	54.9	49.4	5.4	19.4	14.1
Lakshadweep	4.0	25.8	5.2	*	*	*	*	*	*
Maharashtra	6.8	9.9	8.5	63.8	15.2	58.8	11.9	60.5	13.0
Manipur	6.2	5.5	5.8	60.4	15.2	60.1	13.4	60.2	14.1
Meghalaya	8.6	10.9	10.6	77.6	54.5	77.4	58.4	77.5	58.0
Madhya Pradesh	9.7	9.4	9.5	62.8	26.1	52.5	26.8	55.2	26.6
Mizoram	7.6	7.6	7.6	76.3	62.8	69.9	31.7	26.5	29.3
Nagaland	5.3	4.9	5.0	43.5	39.7	40.8	18.7	15.4	16.3
Odisha	7.3	10.2	9.8	68.6	13.5	68.6	17.5	68.6	17.0
Punjab	7.6	5.9	6.6	64.9	28.1	67.3	25.5	66.2	26.7
Puducherry	9.0	14.7	11.3	79.4	78.3	58.3	56.0	71.2	69.6
Rajasthan	8.9	6.9	7.4	64.6	18.9	53.2	17.0	56.2	17.5
Sikkim	0.3	2.6	1.8	*	*	*	*	*	*
Telangana	8.1	8.6	8.4	61.8	30.2	52.5	32.7	56.8	31.6
Tamil Nadu	8.2	7.8	8.0	65.0	46.6	58.7	36.3	61.8	41.3
Tripura	3.5	5.3	4.9	*	*	46.4	19.1	46.3	19.1
Uttarakhand	17.3	16.8	17.0	63.8	37.9	52.4	26.7	56.1	30.4
Uttar Pradesh	14.2	15.2	15.0	47.4	35.6	37.9	15.8	11.8	12.6
West Bengal	5.8	5.8	5.9	69.7	25.6	62.8	19.0	64.7	20.8
NATIONAL AVERAGE	8.2	9.6	9.2	58.5	23.7	47.9	19.1	50.6	20.3

NA: Not applicable

* Percentage not shown; based on fewer than 25 unweighted cases

Annexure II. Agenda for the IDCF planning meeting

1. Review progress / achievement of IDCF 2016.
2. Clarity on role of each department to make IDCF a success.
3. Selection and role clarity of nodal officer from each department to coordinate with other depgartments.
4. Micro planning: Micro plan has to be prepared to facilitate ASHA visits during the fortnight. Line list available at the village level with ASHA and AWW can be used to identify the houses of under five children and prepare the visit plan during the fortnight.
5. District level plan: Should contain details on ORS – Zinc Corners/ Health Facilities/ Schools, etc which are part of the IDCF Fortnight.
6. Stock assessment of essential commodities viz: ORS packets and Zinc dispersible tablets
7. Stock assessment of IEC materials: already available materials on ORS – Zinc use, hand washing etc. should be listed and distribution plan prepared. Additional materials should also be used after replication and adaptation to local context. Prototypes of additional IEC materials are available on the website **www.nhm.gov.in**
8. Involvement of mass media e.g. TV, radio, etc.
9. Mechanism for involvement of other sectors- WCD, Education, PRI, Water & Sanitation, IAP, private practitioners, noted NGOs
10. Chalk out daily supportive supervision and troubleshooting mechanism
11. Plan for State/District / Block level inauguration of the IDCF by elected representatives.

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

State: _____ Total under five population of the State: _____

Nodal Officer of the State: _____ Phone No._____

IDCF Secretariat

Names	Designation	Phone No	Responsibility in IDCF

Supply plan for State

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

Commodity	Total available Stock in State	Total required by districts
ORS		
Zinc		

Date of IDCF steering committee meeting: _____

State level orientation plan

Venue: _____ Date: _____

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

Supply requirement:

Commodities	**For distribution by ASHA and mobile teams**	**For demonstration of ORS and Zinc by ASHA and mobile teams**	**For ORS – Zinc corners**	**For treatment by ANM**	**For treatment by ASHA**	**For mobile teams**	**Requirement for IDCF**	**Current stock in block**	**To indent**
	A	**B**	**C**	**D**	**E**	**F**	**G = A + B + C + D + E + F**	**H**	**I = G –H**
ORS (formula for calculation)	Under 5 population X 1 packet	No. of VHND sessions X 1	No. of ORS Zinc corners X 50 cases X 2	No. of ANM X 10 cases X 2 packets	No. of ASHA X 10 cases X 2 packets	No. of mobile teams X 10 cases X 15 days X 2 packets			
ORS (calculate)									
Zinc (formula for calculation)		No. of VHND sessions X 1	No. of ORS Zinc corners X 50 cases X 14	No. of ANM X 10 cases 140 tablets	No. of ASHA X 10 cases 14 tablets	No. of mobile teams X 10 cases X 15 days X 14 tablets			
Zinc (calculate)									

ORS – Zinc corners plan:

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

Number of special VHND / RI session to be conducted by ANM during IDCF: _____

IEC plan

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

Printing of formats

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

Mobile team plan

Sr. No.	District	No. of slums / hard-to-reach areas	No. of vehicles / teams

Supportive supervision from State level

Sr. No	Names	Designation	Phone No	District to be visited	Date of visit

Signature of MD – NHM: _____

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

District: _____Total under five population of the district: _____

Nodal Officer of the district: _____ Phone No._____

IDCF Secretariat

Names	Designation	Phone No	Responsibility in IDCF

Date of IDCF steering committee meeting: _____

District level orientation plan

Venue: _____ Date: _____

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

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

Name of block:_____Venue:_____Date:_____

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

Supply requirement:

Commodities	For distribution by ASHA and mobile teams	For demonstration of ORS and Zinc by ASHA and mobile teams	For ORS – Zinc corners	For treatment by ANM	For treatment by ASHA	For mobile teams	Requirement for IDCF	Current stock in block	To indent
	A	B	C	D	E	F	G = A + B + C + D + E + F	H	I = G –H
ORS (formula for calculation)	Under 5 population X 1 packet	No. of VHND sessions X 1	No. of ORS Zinc corners X 50 cases X 2	No. of ANM X 10 cases X 2 packets	No. of ASHA X 10 cases X 2 packets	No. of mobile teams X 10 cases X 15 days X 2 packets			
ORS (calculate)									
Zinc (formula for calculation)		No. of VHND sessions X 1	No. of ORS Zinc corners X 50 cases X 14	No. of ANM X 10 cases 140 tablets	No. of ASHA X 10 cases 14 tablets	No. of mobile teams X 10 cases X 15 days X 14 tablets			
Zinc (calculate)									

ORS – Zinc corners plan:

Facilities	Number	Planned ORS – Zinc corners	For display		
			Plan A protocol	Plan B protocol	Plan C protocol
Medical College (OPD)					
Medical College (ward)					
District Hospital (OPD)					
District Hospital (ward)					
Block CHC / PHC (OPD)					
Block CHC / PHC (ward)					
Additional PHC					

Facilities	Number	Planned ORS	For display		
(OPD)					
Additional PHC (ward)					
Sub centre (OPD)					
Private clinics (OPD)					
Private clinics (ward)					

Number of special VHND / RI session to be conducted by ANM during IDCF: _____

IEC plan

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

Printing of formats

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

Mobile team plan

Sr. No.	Block	No. of slums / hard-to-reach	No. of vehicles /

		areas	teams

Supportive supervision from district level

Sr. No	Names	Designation	Phone No	Blocks / urban area	Date of visit

Signature of District Collector:_____

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

Block: _____ Total under five population of the block: _____

Medical Officer of the block: _____ Phone No._____

Block level orientation plan

Venue: _____ Date: _____

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

Supply requirement:

Commodities	For distribution by ASHA and mobile teams	For demonstration of ORS &Zinc by ASHA & mobile teams	For ORS – Zinc corners	For treatment by ANM	For treatment by ASHA	For mobile teams	Requirement for IDCF	Current stock in block	To indent
	A	B	C	D	E	F	G = A + B + C + D + E + F	H	I = G –H
ORS (formula for calculation)	Under 5 population X 1 packet	No. of VHND sessions X 1	No. of ORS Zinc corners X 50 cases X 2	No. of ANM X 10 cases X 2 packets	No. of ASHA X 10 cases X 2 packets	No. of mobile teams X 10 cases X 15 days X 2 packets			
ORS (calculate)									
Zinc (formula for calculation)		No. of VHND sessions X 1	No. of ORS Zinc corners X 50 cases X 14	No. of ANM X 10 cases 140 tablets	No. of ASHA X 10 cases 14 tablets	No. of mobile teams X 10 cases X 15 days X 14 tablets			
Zinc (calculate)									

ORS – Zinc corners plan:

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

Number of special VHND / RI session conducted by ANM during IDCF where importance on diarrhoea control to be emphasised: ……..

IEC plan

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

Requirement of formats

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

4	District reporting format	

Mobile team plan

Sr. No.	Name of slum or hard-to reach area	No. of vehicles / teams	Name of team members	Date of visit

Supportive supervision from block level

Sr. No	Names	Designation	Phone No	Village / slum / hard – to- reach	Date of visit

Signature of Block Medical Officer:_____

Annexure VI: Village level plan for IDCF and implementation checklist

(For ANM)

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

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

ANM visit plan during IDCF

	June 12	June 13	June 14	June 15	June 16	June 17	June 18
Village/ urban area							
VHND village(as per routine microplan) (Write Yes /No)							
No. of under 5 children in the village							
Name of ASHA and mobile no							
	June 19	June 20	June 21	June 22	June 23	June 24	
Sub Centre							
VHND village (as per routine microplan) (Write Yes /No)							
No. of under 5 children in the village							
Name of ASHA and mobile nob							

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

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

(For ASHA)

District: _____Block:_____Village: _____Total population:_____Families with under 5 children: _____

ASHA:_____ Mob. No. :_____ Total under five children: _____

Listing of children (**to be done before the campaign i.e. 22 - 26 May**)							Home visit (**12 June**– 24 June) **to be filled during the campaign**				
Sr. No	Father name	Mother name	Child detail				Date of visit	Distribution of ORSwith demonstration **(✓ if yes)**	Does the child suffer from diarrhoea **(✓ if yes)**	**ORS &Zinc given to the child with diarrhoea (✓ if yes)**	Whether danger sign and referred **(✓ if yes)**
			Name	Age	Gender (✓ wherever applicable)						
					M	F					
Total											

Signature of ASHA: _____ _____ SIgnature of ANM:_____

Annexure VIII: Mobile team plan and reprortingfor IDCF

Name of block / municipal area : _____Name of Medical Officer I/c of IDCF:_____ Mobile No.: _____

Plan							Actuals			
Team No	Name of team members	Vehicle No	Mobile No.	Date of planned visit	Place of visit	Estimated under 5 children in the place	Date of visit	No. of children distributed ORS	No of children treated with ORS	No of children treated with Zinc

Signature of Medical Officer I/c of IDCF: _____

Annexure IX: Sub-centre reporting format

District: _____ Block:_____ Subcenter: _____

ANM Name:_____Mob. No. :_____

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

Signature of ANM: _____

Block:_____ Name of BMO:_____

Sr. No.		Number
1	Total No. of villages	
2	No of villages where ORS was distributed	
3	No. of under five children in the villages	
4	No. of children distributed with ORS	
5	No. of children reported with Diarrhoea during IDCF	
6	No. of children with Diarrhoea provided with ORS	
7	No. of children with Diarrhoea provided Zinc for 14 days	
8	No. of children detected with Danger signs and referred by ASHA	
9	No. of villages where VHNSC session on sanitation was conducted	
10	No. of ORS – Zinc corner established (including block level)	
11	No. of ORS – Zinc corner established in private medical practitioners	
12	No. of schools where handwashing demonstrated	
13	Number of health facilities where Plan A was displayed	
14	Number of health facilities where Plan B was displayed	
15	Number of health facilities where Plan C was displayed	
16	No. of slums / hard-to-reach areas	
Performance of Mobile teams		
17	No. of mobile teams formed	
18	No. of children received ORS from mobile teams	
19	No. of children with Diarrhoea provided with ORS	
20	No. of children with Diarrhoea provided Zinc for 14 days	
21.	No. of one day orientation meeting conducted at PHC	
22	No. of one day orientation meeting held at block level	

Signature of BMO: _____

1	Name of District / State:	
2	Name of Nodal Officer Implementing IDCF Email: Phone:	…… …… ……..
3	No. of Districts conducted IDCF 2017/Total No. of Districts	...../…….
4	State launch undertaken as per guidelines (Yes/No)	
5	No. of Districts where District launch was undertaken	
6	No. of ASHAs oriented on IDCF/ No. of ASHA in district / State	……/……..
7	No. of ANMs oriented on IDCF/ No. of ANMs in district / State	……/……
	No. of MO's oriented on IDCF / No. of MOs in district / State	……/……
8	No. of Staff Nurses oriented on Diarrhoea management/ No. of Staff Nurses in district / State	……/……
9	Dates of IDCF observation:	
10	No. of vehicles hired for field supportive supervision	
11	No. of HPDs where supportive supervision was undertaken by Development Partners /Total no. of HPDs	...../…….
12	Total No. of villagesin district / State	
13	No of villages where ORS was distributed	
14	No. of under five children in the villages	
15	No. of children distributed with ORS	
16	No. of children reported with Diarrhoea during IDCF	
17	No. of children with Diarrhoea provided with ORS	
18	No. of children with diarrhoea provided Zinc for 14 days	
19	No. of children detected with danger signs and referred by ASHA	

20	No. of villages where VHNSC session on sanitation was conducted	
21	No. of ORS – Zinc corner established (including block / district level)	
22	No. of ORS – Zinc corner established in private medical practitioners	
23	No. of schools where hand-washing demonstrated	
24	Number of health facilities where Plan A was displayed	
25	Number of health facilities where Plan B was displayed	
26	Number of health facilities where Plan C was displayed	
Performance of Mobile Teams		
27	No. of slums / hard-to-reach areas	
28	No. of mobile teams formed	
29	No. of children received ORS from mobile teams	
30	No. of children with Diarrhoea provided with ORS	
31	No. of children with Diarrhoea provided Zinc for 14 days	
32	No. of one day orientation meeting conducted at PHC	
33	No. of one day orientation meeting held at block level	
34	No. of one day orientation meeting held at district level	

Signature of Child Health Nodal Officer_____

Annexure XII: District level Supportive Supervision Checklist

For State level monitors

Name of monitor:_____**Designation:**_____**Organization:** _____**Mob. No:** _____

Name of district:_____ **Date of visit:** _____

Planning at district level *(Monitor should meet DM, CMO, RCHO and other district level officers)*			
Name of CMO/RCHO/ District Nodal Person for IDCF and mobile nos.:			
IDCF Steering Committee meeting held with Chair by DM *(verify minutes)*		District operational plan available	
☐ Yes ☐ No Committee not formed		☐ Yes ☐ No	
District level orientation on IDCF held			☐ Yes ☐ No
Participants / departments in district orientation on IDCF *(circle applicable after verification of minutes of meeting)*		H&FW (BMO / Municipal MO / BCM) / WCD / PRI / Water and Sanitation / Tribal Welfare / Education / District IEC	
Assessment of requirement of ORS and Zinc done by district officials			☐ Yes ☐ No
If shortfall of ORS then, procurement of ORS done / supply received from state level ☐ Yes ☐ No ☐ NA		If shortfall of Zinc then, procurement of Zinc done / supply received from state level ☐ Yes ☐ No ☐ NA	
Availability and supply ensured of *(circle applicable)*		MCP card / MUAC tape / Weighing machine	
District received communication regarding IDCF from State HQ			☐ Yes ☐ No
District issued communication regarding IDCF to block			☐ Yes ☐ No
District launch of IDCF by prominent person			☐ Yes ☐ No
Financial norms for IDCF			
District has clarity on financial norms for ASHA incentives for IDCF			☐ Yes ☐ No
District received funds for IDCF			☐ Yes ☐ No
IEC planning			
IEC material on IDCF eg Banner, Posters, audio video clippings received from state: ☐ Yes ☐ No ☐ District produced			
IEC material on IDCF distributed to blocks			☐ Yes ☐ No
Supportive supervision			
District supportive supervision plan is in place with clear role and logistic arrangement			☐ Yes ☐ No
Supportive supervision formats printed and given to blocks			☐ Yes ☐ No
Review mechanism of implementation of IDCF from district level (circle applicable)		Daily evening meeting of supervisors with CMO / Daily phone communication with supervisors / review meeting after week	
Implementation plan *(verify)*			
No. of blocks in the district		No. of urban areas in the district	
No. of blocks submitted microplan		No. of urban areas submitted microplan	
No. of blocks that have constituted mobile team for IDCF		No. of urban areas that have constituted mobile team for IDCF	
District officials of WCD & Education dept. have instructed blocks, AWCs, Schools to participate in IDCF campaign (verify communication)			☐ Yes ☐ No

Signature_____

Annexure XIII: Block / urban level Supportive Supervision Checklist

For State and District level monitors

Name of monitor:_____**Designation:**_____**Organization:**_____**Mob. No:** _____

Name of district:_____**Name of block / urban area:**_____ **Date of visit:** _____

Planning at block / urban level	
Name of BMO / Municipal MO and mobile no.:	
BMO / Municipal MO attended the district level steering committee meeting on IDCF	☐ Yes ☐ No
Block / urban area level filled operational plan available	☐ Yes ☐ No
ASHA level filled listing of under children available for all villages	☐ Yes ☐ No
Block level filled VHNSC plan available for all villages	☐ Yes ☐ No
Block reporting format available	Yes No
Sub-center reporting formats distributed to all sub-centers	Yes No
Funds for ASHA incentives received	Yes No
ORS – Zinc corner *(prioritize visit to Medical College, District Hospital, Children Hospital, Block Hospital)*	
Established in OPD area	Yes No
ORS available	☐ Yes ☐ No
Zinc available	☐ Yes ☐ No
Drinking water available	☐ Yes ☐ No
All the corner staff trained on diarrhea management within last 1 month	☐ Yes ☐ No
Plan B treatment protocol displayed	☐ Yes ☐ No
ORS – Zinc poster displayed	☐ Yes ☐ No
Established in ward	☐ Yes ☐ No
ORS available	☐ Yes ☐ No
Zinc available	☐ Yes ☐ No
Drinking water available	☐ Yes ☐ No
All MO & nurses of ward trained on diarrhea management within last 1 month	☐ Yes ☐ No
Plan C treatment protocol displayed in ward	☐ Yes ☐ No
ORS – Zinc poster displayed	☐ Yes ☐ No
Last case of diarrhea was prescribed Zinc during discharge *(verify record)*	Yes No
Mobile team	
Mobile teams required for the block	Yes No
Mobile teams constituted	Yes No
Mobile teams have visited slums / orphanages / migrant population / HTRAs *(verify record)*	Yes No
Supportive supervision	
District monitor has visited the block for monitoring	Yes No
Supportive supervision plan available	Yes No
Supervisors visiting as per plan	Yes No

Visit villages where VHNSC meeting is planned on day of supportive supervision	**Village 1**	**Village 2**	**Village 3**	**Village 4**
Name of village visited				
VHNSC meeting held on sanitation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of ASHA and mobile no.				
ASHA trained on her role in IDCF within last 1 month	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ORS – Zinc distribution by ASHA / ANM is as per plan	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ASHA used the IDCF leaflet during counselling of mothers				
No. of houses with under 5 children visited by monitor (at least 3 houses where ASHA has already visited)				

Of the above, no. of houses where ORS was distributed by ASHA				
No. of houses (respondents) whosaw any poster/ hoarding, TV commercial or radio spot on diarrhea during the IDCF				
No. of houses (respondents) who known what to do if their child has diarrhea*(seek health advise from ASHA/ AWW, ORS + Zinc)*				
No. of houses (respondents) who know where to get ORS and Zinc from *(Health centers, ASHAs/ ANM)*				
No. of houses (respondents) who know what can they do to prevent diarrhea*(hand wash, disposal of feces)*				
	School 1	**School 2**	**School 3**	**School 4**
Name of school visited				
After morning assembly / prayers, importance of hand washing is communicated to students.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Poster on hand-washing pasted at the hand washing area	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Before mid-day-meal, all children taught to wash hands	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
School activities conducted around hygiene and sanitation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Supportive supervision	
District monitor has visited the block for monitoring	☐ Yes ☐ No
Supportive supervision plan available	☐ Yes ☐ No
Supervisors visiting as per plan	☐ Yes ☐ No

Signature_____

Annexure XIV: Village level Supportive Supervision Checklist

For Block level monitors

Name of supervisor:_____ **Designation:**_____ **Mob. No:** _____

Name of district:_____ **Name of block:** _____ **Date of visit:** _____

Visit villages where VHNSC meeting is planned on day of supportive supervision	**Village 1**	**Village 2**	**Village 3**	**Village 4**
Name of village visited				
VHNSC meeting on sanitation held	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Name of ASHA and mobile no.				
ASHA trained on her role in IDCF within last 1 month	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Knows the activities to be done in IDCF *[(1) Distribution of one ORS packet to each mother/care giver having children under 5 years (2) Treat child with diarrhea having no danger signs (3) Counsel Mothers/Care givers on feeding practices (4) Refer Child to facility in case child detected with danger signs during diarrhea]*	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Listing of children as per format available with ASHA	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Knows definition of diarrhea[*when the stools have changed from usual pattern and are many and watery (more water than fecal matter}]*	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Knows the danger signs of dehydration *[Any two of the following for some dehydration eg. Restless/Irritable, Sunken Eyes, Drinking eagerly/Thirsty & Skin Pinch goes back slowly and any two of the following for Severe Dehydration eg. Lethargic or unconscious, Sunken eyes, Not able to drink or drinking poorly & skin pinch goes back very slowly (more than 2 seconds)]*	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Knows referral to facility in case of danger signs of diarrhea*[as per above danger signs]*	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Knows correctly the treatment of diarrhea if the child has no danger signs *[(1) Give Extra Fluids/ORS (2) Give Oral Zinc Tablets (3) Continue Feeding (4) Advise Mother when to return –Child becomes sicker/not able to drink or breast feed/blood in stool/drinking poorly/develops fever]*	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Knows correctly how to prepare ORS *[assessment based on demonstration of preparation of ORS]*	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Knows correctly the doses of Zinc *[2-6 months- 10 mg. and 6 months to 5 years- 20 mg]*	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Knows how to administer Zinc *[to be dissolved in breast milk/ plain water]*	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
ORS – Zinc distribution by ASHA is as per plan	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
No. of houses with under 5 children visited by monitor [*atleast 3 houses where ASHA has already visited]*				
Of the above, no. of houses where ORS was				

distributed by ASHA				
No. of houses (respondents) whosaw any poster/ hoarding, TV commercial or radio spot on diarrhea during the IDCF				
No. of houses (respondents) who known what to do if their child has diarrhea*(seek health advise from ASHA/ AWW, ORS + Zinc)*				
No. of houses (respondents) who know where to get ORS and Zinc from *(Health centers, ASHAs/ ANM)*				
No. of houses (respondents) who know what can they do to prevent diarrhea*(hand wash, disposal of feces)*				
	School 1	**School 2**	**School 3**	**School 4**
Name of school visited				
After morning assembly / prayers, importance of hand washing is communicated to students.	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Poster on hand-washing pasted at the hand washing area	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
Before mid-day-meal, all children taught to wash hands	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No
School activities conducted around hygiene and sanitation				

Signature:_____

Annexure XV : Set up of ORS – ZINC CORNER

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

Location:

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

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

Timings:

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

Materials required for management of ORS – Zinc corner

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

Counselling at the ORS – Zinc corners:

- The doctor / staff should counsel the mother in person using MCP card and administration of Zinc for 14 days.

- ORS – Zinc corner is a good place to display informative materials. Banner and poster on ORS – Zinc, hand washing and continued feeding should be displayed at the corner.

Activities:

- At least one litter of ORS solution should be prepared daily after washing hands with soap and water. The solution should be kept at the ORS – Zinc corner. It should be readily available to the mother when required. Replenish the solution whenever required. More than 24 hours prepared solution should be discarded and not be used. After the mother has washed her hands thoroughly with soap and water, provide the ORS solution in bowl / cup or glass with spoon to enable her to administer the solution.

- In case of a diarrheal episode during ORS administration, the child and mother and the area should be thoroughly cleaned. After washing hands again with soap and water the mother should administer ORS.

- If the child vomits, the child and mother and the area should be thoroughly cleaned. After washing hands again with soap and water the mother should administer ORS more slowly.

- In case of no-dehydration diarrhoea,
    - Administer ORS solution at the corner for some time till the child is comfortable.
    - Explain the mother on how to prepare the ORS solution, if possible demonstrate.
    - Demonstrate on how to prepare age appropriate Zinc tablet solution in a spoon.
    - Administer the first dose of Zinc tablet solution.
    - Explain when to administer ORS and Zinc.
    - Provide at least one ORS packet and 13 tablets of Zinc to take home.
    - Advice on age appropriate feeding during diarrhoea
    - Advice when to return

- In case of some-dehydration diarrhoea,
    - Administer ORS solution at the corner for 4 hours
    - Re-asses the child for status of dehydration.
    - In case of no dehydration, follow the above steps for no-dehydration diarrhoea.
    - In case of severe-dehydration, the child needs to be admitted for Plan C treatment.

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

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

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

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

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

    c. ANM will communicate on danger signs of diarrhoea.

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

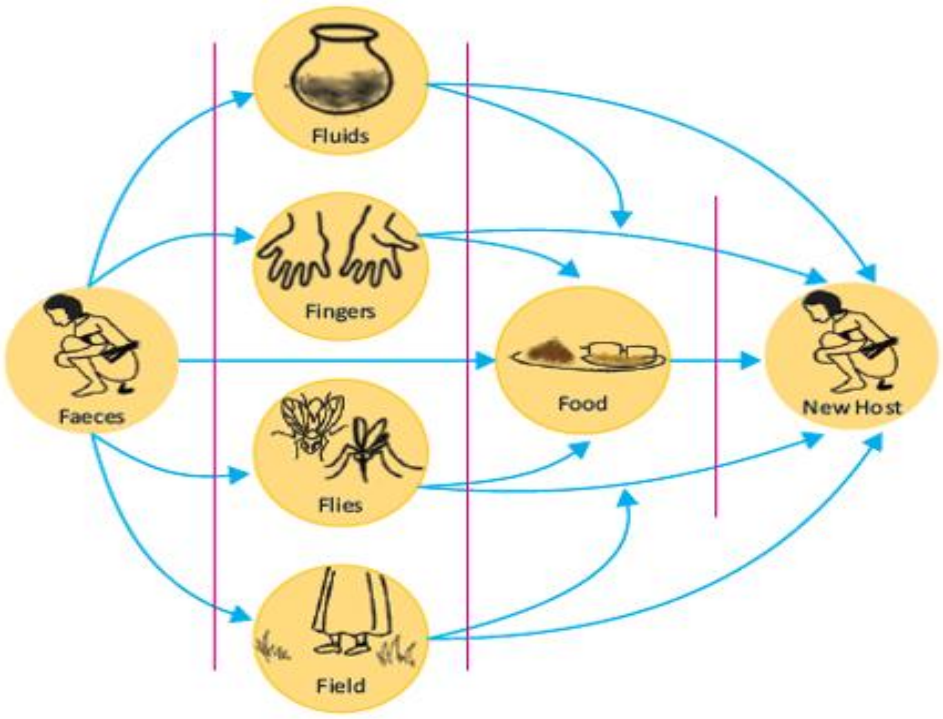
    e. If there are cases of diarrhoea then ANM or ASHA will assess the child and provide ORS – Zinc. If child is severely dehydrated then referral will be ensured.

2. PLA technique to be used for advocacy around sanitation & hygiene: PLA (Participatory Learning Approach) techniques should be carried out such as mapping of open defecation areas in and surrounding the village and plan for stopping open defecation should be chalked out, with active participation of VHSNC members and representatives from Department of Drinking Water and Sanitation.
   2.1 The ASHA / ANM will ask the participants to narrate the ailments caused due to water contamination. This could be Diarrhea, Typhoid, Intestinal worms, Abdominal pains, Vomiting etc.

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

explain how contaminated human faeces get into water and food from open defecation through flies.

F – Diagram on transmission of diarrhoeal infection



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

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

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

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

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

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

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

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

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

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

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

IDCF Secretariat

In case of any further information may contact:

1. **Dr. Ajay Khera, Deputy Commissioner (Child Health & Immunization)**
   Email: ajaykheramch@gmail.com
   Telefax: 011-23061281
2. **Dr. Sila Deb, Deputy Commissioner (Child Health)**
   Email: drsiladeb@gmail.com
   Telefax: 01123061218
3. **Sahil Chopra, Consultant-Child Health**
   Email: idcfsecretariat@gmail.com
   Telefax:85058-23933

IDCF Toolkit

Contents:

1. Orientation module
2. Communication Kit for Awareness campaign

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