Introduction

This guidance note has been prepared to provide a broad context in which actions for improving maternal and child health and survival must be intensified across the country. Based on public health and management principles, it is decided that 184 districts that are comparatively low performing should be prioritized for action. In order to accelerate progress in these districts, technical assistance and continuous mentoring support is considered to be a pre-requisite. To make this support readily available to districts, the partnerships between the State Government and the Development Partners is to be leveraged. The efforts of all development partners and other stakeholders across states and districts are to be harmonized and aligned with the government action under NRHM.

This note provides a brief overview of steps that need to be taken in each High Priority District in order to make assessment of existing gaps in implementation and to develop a District Action Plan which clearly specifies the technical support and facilitation required by the district to plug these gaps and improve overall coverage, utilization and quality of services. It is envisaged that this continuous process of identification of gaps, finding local solutions and monitoring the change will go a long way in bringing about the desired impact on the health of mothers and children.

Call to Action: Child Survival and Development Summit

In order to further accelerate the decline in maternal and child mortality and galvanize unified efforts of all stakeholders a 'Call to Action: For Every Child in India' summit was organized 7-9 February 2013 in Mahabalipuram, Tamil Nadu. The summit was led by the Ministry of Health and Family Welfare with participation from Department of the Women and Child Development, and diverse set of stakeholders including civil society, UN agencies, development partners, global experts, private sector and media.

National and international experts presented at the summit and the consensus was that while India has made impressive progress, it needs to focus on key high impact interventions, with special emphasis on weakly/poorly performing geographies. Such focused approach would lead to substantial gains in reduction of maternal, neonatal, infant and under 5 morbidity and mortality resulting from the most common causes.

Following the Summit, discussions were held in the Ministry regarding intensification of efforts across the country. Based on a composite health index, relative ranking of districts was done within a State and bottom 25% of the districts as well as those affected by Left Wing Extremism were selected across 29 states. These are designated as 184 High Priority Districts (HPDs) where attention must be focused and integrated planning and monitoring of RMNCH+A interventions should be undertaken.

In order to enhance technical assistance to these districts and make provision for coordinated planning and monitoring at state level, it was decided to leverage the existing strength and local presence of the Development Partner (DPs) agencies. A National Consultation was held on 10th April 2013 in which the lead development agencies working across the states agreed to 'harmonise' the efforts of all development partners working in the high priority districts and provide

technical assistance across the entire spectrum of RMNCH+A to assist the State governments in achievement of desired health outcomes. Harmonisation in this context means that strategies adopted/approved by the MOHFW/GOI should be universally promoted (in all the districts); and that irrespective of the thematic/organisational expertise of individual DPs, the technical assistance should extend across RMNCH+A interventions. However, States and development partner agencies have the flexibility to innovate and adopt differential approaches to Health Systems Strengthening and service delivery mechanisms. The list of HPDs, a guidance note on the District Intensification Plan and Lead Development partners identified for each state, is presented in the following sections.

Focus on specific geographies, and critical time-periods

Under 12th Five Year Plan, by 2017, India is committed to bring down the IMR to 25 per 1000 live births and MMR to 100, fertility rate to 2.1, and raise child sex ratio in age group 0-6 years to 950. This requires intensification of the efforts and making concerted focus in the weak performing districts in each of the states.

Annual Health Survey 2010-11 shows that the progress has been uneven both between and within the states. Hence there is a need to focus on these poor performing geographies and populations with highest burden of mortality. Besides the EAG states that are known to have higher burden of this mortality, there are other states too with at least a few weak performing districts, which can turnaround with additional support.

The recently released ***Strategic Approach to RMNCH+A in India, MOHFW, 2013***, provides a comprehensive framework for programming to improve women and children's health. In order to make progress on the most critical interventions, focus on the first 1000 days window of opportunity between pregnancy and the first 24 months of life is critical with a broader lifecycle approach.

Identification of HPD

Uniform and clearly defined criteria have been used for defining the identification of High Priority Districts. Relative ranking of districts has been done within a State (based on a composite index) and bottom 25% of the districts be selected as High Priority Districts for that State. It was decided that for the 9 EAG States & Assam, AHS data may be used and for the remaining States /UTs, DLHS-3 data may be used.

The following 6 indicators are to be used for 9 AHS States, (Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand) covering one impact and one outcome indicator representing each of the areas of maternal health, child health and family planning:

Indicator	Area
i. Maternal Mortality Ratio (MMR) ii. % of Safe Deliveries	**Maternal Health**
iii. Infant Mortality Rate (IMR) iv. % of Children 12-23 months fully immunized	**Child Health**
v. Total Fertility Rate (TFR) vi. Contraceptive Prevalence Rate (CPR) – Modern Method	**Family Planning**

For the remaining 26 non-AHS States / UTs, for which data on impact indicators is not available from AHS, 2 process / outcome indicators will be selected covering each of the three areas namely, maternal health, child health and family planning. It was decided to have following 6 indicators for non-AHS States:

Indicator	Area
i. % of mothers received at least 3 ANC visits ii. % of Safe Deliveries	**Maternal Health**
iii. % of Children 12-23 months fully immunized iv. % of Children aged 6 months and above exclusively breastfed	**Child Health**

v. % of births of order 3 and above

vi. Contraceptive Prevalence Rate (CPR) – Modern Method

} **Family Planning**

The ranking of the districts was done independently within each State and a list of the bottom 25% districts so identified was prepared. LWE and tribal districts falling in the bottom 50% districts were also included in the list. The districts included in the list will be called “High Priority Districts”. The list of districts is provided in the Annexure.

Guidelines for intensification of efforts in High Priority Districts

As the High Priority Districts are lagging behind in terms of health indicators and possibly most other development indicators, they need special focus and support in terms of planning and implementation. It is considered that maximum gains in reduction of fertility and mortality can be made by reaching out to underserved and vulnerable populations in these districts. As the name suggests (High Priority Districts), the States must prioritise action in these districts. Given below is the guidance for prioritisation of action in the health sector.

1. District Assessment

The first step in a HPD should be to conduct a detailed assessment of the district in terms of equity and access to health services and key social determinants of health (including nutrition, water and sanitation, connectivity, electricity and motorable roads). The vulnerable and marginalised populations in the district (eg; tribal, SC/ST) should be identified as also the blocks and villages/hamlets where these populations reside. This assessment can be based on the demographic, socio-economic and geographic profile of the district. The remoteness of the block/village and accessibility to basic health services, including maternal and child health services should also be assessed thus identifying ‘difficult to reach’ or ‘inaccessible’ (eg; hilly terrain, cut

off by rivers, dense forests, or unsafe on account of naxalite activity) areas. District Level Checklist should be used for systematic mapping of underserved districts and vulnerable social groups[1], including (but not limited to) the tribal areas.

Epidemiological profile of the district is equally important. The crude birth and death rate and major causes of mortality should be carefully assessed. The endemicity of communicable disease (eg; malaria, JE) and prevalence of non-communicable diseases, (eg; thalassemia, sickle cell disease), should be taken into account during planning for specific health interventions.

2. Assessment of local health system

Mapping of the health infrastructure (SC, PHC, CHC, DH), manpower (medical officers, specialists, staff nurses, ANMs, ASHAs), training facilities (ANM/GNM training schools, district training centre), and assessing the functionality of health facilities (IPD, OPD, minor & major surgeries, delivery points, FRUs conducting C section, 24x7 PHCs, newborn care facilities) should be undertaken as the next step. For the 82 LWE affected districts, many of these parameters are tracked by the Planning Commission on monthly basis along with progress on sectoral flagship schemes/programmes (including NRHM). The data for these 82 districts can be accessed from http://pcserver.nic.in/iapmis/ReportAllStatesNRHM.aspx

3. Differential Health Systems Planning for HPD

(i) **Financial allocations:** It is proposed that States allocate at least 30% higher resource envelope per capita for each HPD (within the overall State Resource Envelope under NRHM). This should be specified and earmarked as a part of the ROP and diversion of this envelope to other districts would not be permitted. In case of failure of the State to utilise these funds in the specified districts, the state would lose this unspent money.

[1] By vulnerable groups we mean SC, ST, minorities, urban poor, women, adolescent girls and boys, occupation based groups, migrants, etc.

(ii) **Relaxation of norms**

This is allowed for tribal areas under NRHM. Similar relaxation of norms may be extended to all HPD.

- **ASHA recruitment:** The general norm is 'one ASHA per 1000 population'.In HPD, the norm could be relaxed eg; to one ASHA per habitation, in remote, inaccessible areas/blocks.
- **Health Infrastructure as per IPHS norms:** Population norms for establishment of sub-centre could be relaxed when needed based on 'time to care' norm.
- **Upgradation of Sub centers:** As Sub centre is envisaged as the first health post and will possibly be the only health infrastructure within close access, follow up on construction / renovation, equipment and manpower is important. It is being proposed that a full-fledged village health team be located at the SC to address the basic health needs for the local population.
- **Medical Mobile Units:** Till the time SC or PHC are established, underserved, areas may be reached through MMUs and HPDs may be allowed to have more MMUs than other districts.

(iii) **Performance based incentives:** Special incentives to medical and para- medical staff for performing duties in difficult areas (eg; identified health facilities; facilities remote from DHQ) may be incorporated. Appropriate financial and non-financial incentives schemes for attracting qualified human resource to work in HPDs maybe introduced with time-bound targets and performance benchmarks for addressing the key issues and optimum utilization of funds to ensure effective implementation of NRHM.

(iv) **Priority interventions across RMNCH+A**

Based on the major causes of maternal and child mortality, the priority interventions across RMNCH+A should be put in place. These include the following:

- Antenatal care package; tracking of high risk pregnancies;

  line listing of anemic women and their management
- Strengthening of delivery points in terms of infrastructure, manpower, equipment, supplies

- Essential newborn care at NBCC established at all delivery points
- Initiation of home visits to new-borns (HBNC scheme)
- Implementation of JSSK and JSY
- Prioritisation of training of ANMs, SNs for Skilled Birth Attendance, NSSK, IMNCI, IUCD insertion, starting from those deployed at delivery points
- Roll out of National Iron Plus Initiative covering all women in the reproductive age group, adolescents, pregnant and lactating women, and children (6-60 months; 6-10 years)
- Intensification of Routine Immunisation
- ORS and Zinc use in diarrhoea; antibiotics for ARI
- Establishment of Nutrition Rehabilitation Centres and community based programme for management of SAM
- Doorstep delivery of contraceptive by ASHAs and services for IUCD insertion
- Behaviour Change Communication for compliance with healthy practices at home/community
- Counselling for prevention and appropriate management of RTI/ STIs; Strengthening of Adolescent friendly health services.

(v) **Special strategies, incentives, packages, schemes for HPDs**
Cash assistance for home delivery by SBA

Pregnant women, who are 19 years of age and above and prefer to deliver at home in presence of SBA, may be given suitable incentives. The disbursement of such assistance should be carried out at the time of delivery or around 7 days before the delivery by an ANM/ ASHA/any other link worker.

The SBA can also be provided incentive to conduct home deliveries in selected villages /areas due to reasons of inaccessibility, remoteness, and security risks *(however list of villages hamlets where home delivery by skilled birth attendant can be promoted should be pre-identified and notified by the district/state).*

Accrediting private health institutions

In order to increase the access delivery care institutions, functioning private institutions that meet the criteria set out by GOI, can be accredited to provide delivery services, abortion care and newborn care. The state and district authorities should draw up a list of criteria/protocols for such accreditation; which could be inspected by team from State Medical Colleges. These institutions could be reimbursed for the health facilities provided to local population on pre-agreed rates.

Equipping Sub-centers (SC) for normal delivery

Women living in tribal and hilly districts find it difficult to access a PHC/CHC for maternal care or delivery. A well-equipped SC is a better option in such areas.

(vi) **Improving demand for services**

Community outreach: Social mobilisation is an important strategy to increase demand for health services. In addition, creating awareness on health issues in general and on social determinants of health and information about available health services will be important aspects for frontline workers and social mobilisers. The local population may not recognise the need for health services or there may be lack of trustin service providers or even the allopathic system of medicine. Due emphasis should be given to platforms like VHND which bring both information and services to the villages.

IEC/BCC: A need based and culturally sensitive communication programme should be developed for the HPDs. Locally appropriate communication strategies should be used and the plan clearly reflected in the District Action plan.

Involving NGOs for community mobilisation, service delivery: Locally active NGOs may play a pivotal role to make the information and services more accessible to the underserved or vulnerable populations, due to their long presence and acceptability in such areas.

(vii) **Multisectoral planning**

Health of the population cannot be improved in isolation; other services like transport, telephone/mobile connectivity, water, sanitation, girls' education and nutrition services are required in the area. This requires convergence with other departments to promote better resource utilization.

In the 82 districts identified as tribal and LWE by Planning Commission, a block grant of Rs.25 crore and Rs.30 crore per district during 2010-11 and 2011-12 respectively was provided. A Committee headed by District Collector/District Magistrate and consisting of the Superintendent of Police of the District and the District Forest Officer is responsible for implementation of this scheme. The District-level Committee has the flexibility to spend the amount for development schemes according to need as assessed by it.

The Committee draws up a plan consisting of concrete proposals for public infrastructure and services such as School Buildings, Anganwadi Centres, Primary Health Centres, Drinking Water Supply, Village Roads, Electric Lights in public places such as PHCs and Schools etc. The major flagship schemes are being implemented in these districts and tracked closely by the Planning Commission. Health and therefore NRHM is an integral part of this planning.

In other districts (other than 82 LWE districts), similar mechanism could be put in place where NRHM could coordinate with other key departments (Women & Child Development (ICDS), Drinking Water & Sanitation, PRI, Education, etc.) for an integrated action. Some of these districts are likely to figure in the list of 200 Priority Districts for multisectoral plan for nutrition, priority districts for ICDS and Total Sanitation Campaign. The allocation of resources by other Ministries can be optimally utilised if a common needs assessment is conducted for the district and emerging needs can be seen in context of NRHM and complementarity sought through other flagship programmes.

(viii) **Monitoring:**

Close monitoring of the progress and outputs should be undertaken, based on the HMIS. Facility based tracking should be the focus in states/districts where facility based reporting has already been initiated. District Score cards, filled in every quarter, can be another tool that can provide a snapshot of progress made in the district and also to compare changes over time. Regularity of monthly review meetings are to be ensured by CMHO/District Collector.

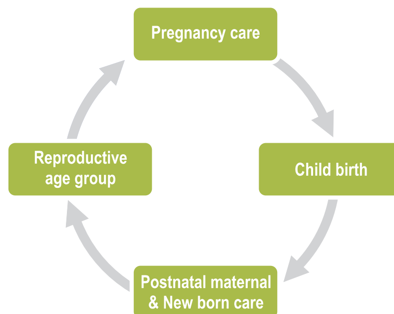
District score card or HMIS based dashboard monitoring system is a mechanism to improve accountability in the public health system and catalyse states into using the HMIS data for improved decision-making; a comparative assessment of district performance in terms of service delivery "dashboard" indicators on a quarterly /year to quarter basis.

Proportion of:

- 1st Trimester registration to total ANC registration
- Pregnant women received 3 ANC 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 ANC registration

Proportion of:

- Post-partum sterilization to total female sterilization
- Male sterilization to total sterilization
- ICUD insertions in public plus private accredited institutions to all family planning methods (ICUD plus permanent)



Proportion of:

- SBA attended home deliveries to total reported home deliveries
- Institutional deliveries to total ANC registration
- C-Section to reported deliveries

Proportion of:

- Newborns breast fed within 1 hour to total live births
- Women discharged in less than 48 hours of delivery in public institutions to total number 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

The methodology described below can be used for preparing All India / State or State/District score card.

1.1. Let X_{id} represent the value of the i-th indicator in the d-th district of a state (i=1,2,3……….16: d=1,2,3…………, n) (n being the number of districts in a State). For each of the indicators, a **normalized index value** is worked out. If an indicator X_i is positively associated with development, like safe deliveries, then

$$\text{Index Value } X_{id} = \frac{(X_{id} - Min(X_{id}))}{(Max(X_{id}) - Min(X_{id}))}$$

Where Min (X_{id}) and Max (X_{id}) are, respectively, the minimum and maximum of (X_{i1}, X_{i2}, …………………. $X_{i,n}$) that particular indicator across districts.

If, however, X_i is negatively associated with development, as, for example, 'women discharged in less than 48 hours to delivery in Public institutions to total number of deliveries in public institutions' or 'newborns weighing less than 2.5 kg to newborns weighed at birth', etc. which should decline as the district develops, then the index value for X_{id} can be derived as:

$$\text{Index Value } X_{id} = \frac{Max(X_{id}) - X_{id}}{(Max(X_{id}) - Min(X_{id}))}$$

*The index values of each of the 16 indicators for a district are then combined by using simple average to arrive at **composite index value** for each district as follows:*

$$\text{Composite Index for } d^{th} \text{ (d=1,2,......,n) District} = \frac{\sum_{i=1}^{16} IX_{id}}{16}$$

The composite indices for each of the four phases (Pregnancy care, Child Birth, Postnatal maternal & new born care, Reproductive age group) are also obtained by simple average of the index values of individual indicator falling in respective phases.

1.2. The composite index may be taken as an index of overall progress of that district on the above mentioned parameters. Based on the quartile values of index for each of the four Phases / overall Index, the States / districts have been categorized into four categories, i.e., very low performing, low performing, promising and good performing.

Role of development partners/agencies (DPs)

Development partners can play a significant role at national, state and district level as the country gears up to accelerate the pace of implementation and bring down the number of maternal, neonatal, infant and under 5 mortality. This calls for optimal utilization of development partner presence and support in high priority districts. The aim should be to establish a mechanism for a harmonized and rationalized support to national and state government efforts for achieving the MDG and 12th Five Year Plan goals.

In an effort to ensure optimal benefit from DP support, the GOI proposes the following:

- **Lead Development Partners and District monitors:**

Each state will have one Lead Development Partner to serve as single point of contact and accountability. The lead partner will coordinate with other partners/ agencies working in the state to harmonize the actions across high priority districts and provide the required technical support to the State NRHM. The Lead DP would call for a meeting with all the DPs in that state at least once in a month so that the state progress can be reviewed and coordination issues, if any can also be sorted out.

The Lead DP will bring together all the DPs engaged with a particular state and each HPD would be assigned to one technical expert, named as District Monitor (DM), drawn from DPs in that state. The District Monitors would be responsible for overall monitoring of RMNCH+A interventions in that district under the guidance of Lead DP.

The District Monitors (DMs) would conduct field visits at-least once a month and submit the report in the prescribed format, validating the interventions being carried out in the district by the district health authorities. They would work in tandem with, but not under the directions of District Chief Medical Officers and District Collectors.

To ensure uniformity in the reporting and monitoring, a common reporting/monitoring format would be developed and the same would be used by all the DPs across the country. This data would be collected and collated and analysed by the Lead DP at the state level and shall be sent across to the National level Secretariat, who in-turn would collate the country data and share with the RCH division in the Ministry.

- **National and State level RMNCH+A team/unit**

These units will be constituted with DPs seconding or hiring staff to closely support the NRHM team at district, state and national levels to assist in planning, implementation, and monitoring of strategies to deliver the priority interventions in around 184 high priority districts.

At the state level, the RMNCH+A Unified Response Team (comprising of SPMU and development partners) will:

– Conduct a rapid assessment of the current status in HPDs, resource mapping, bottlenecks in service delivery mechanism and identify ways to address them with support from DP state consortium.

– Map technical expertise available in the state both in public and private sector and facilitate inputs from these agencies into the national programme.

– Plan, monitor, analyse progress and conduct quarterly reviews using dashboards and score cards.

– Support follow-up with districts and serve as a resource to solve problems and to ensure that districts get timely support from the state to implement the most critical interventions in priority districts within the state.

- Serve as a technical resource in adapting implementation guidelines, tool kits, planning and management of capacity building of district level managers. It will also work very closely with designated medical colleges in the state/district.
- Place and offer need based district level support to ensure execution of critical interventions

Detailed Terms of Reference for each of these proposed structures can be developed in order to bring about clarity on the roles, responsibility and management structure for DPs and all stakeholders to respond effectively, while ensuring synergy to accelerate large scale and sustainable results along the continuum of care.

List of High Priority Districts

(Bottom 25% districts within a State taken according to raking based on Composite Index) plus LWE or Tribal districts falling in bottom 50%

S.No.	State	District		Ranking of District within State	Classifi-cation	Remarks
1	Assam	1	Golaghat	18		
2	Assam	2	Nagaon	19		
3	Assam	3	Kokrajhar	20		
4	Assam	4	Hailakandi	21		
5	Assam	5	Dhubri	22		
6	Assam	6	Karimganj	23		
7	Bihar	1	Jamui	29	**IAP**	**LWE**
8	Bihar	2	Saharsa	30		
9	Bihar	3	Purnia	31		
10	Bihar	4	Sitamarhi	32	**IAP**	
11	Bihar	5	Sheohar	33		
12	Bihar	6	Purba Champaran	34		
13	Bihar	7	Araria	35		
14	Bihar	8	Katihar	36		
15	Bihar	9	Kishanganj	37		
16	Bihar	10	Gaya	22	**IAP**	**LWE**
17	Chhattisgarh	1	Bilaspur	13		
18	Chhattisgarh	2	Dantewada*	14	**IAP**	**LWE, T**
19	Chhattisgarh	3	Bijapur	#	**IAP**	**LWE**
20	Chhattisgarh	4	Jashpur	15	**IAP**	**T**
21	Chhattisgarh	5	Surguja	16	**IAP**	**LWE, T**
22	Jharkhand	1	Paschimi Singhbhum*	15	**IAP**	**LWE, T**
23	Jharkhand	2	Saraikela-Kharsawan	#	**IAP**	
24	Jharkhand	3	Godda	16		

S.No.	State	District		Ranking of District within State	Classifi-cation	Remarks
25	Jharkhand	4	Sahibganj	17		
26	Jharkhand	5	Pakaur	18		
27	**Jharkhand**	**6**	**Palamu***	**11**	**IAP**	**LWE**
28	Jharkhand	7	Latehar#		**IAP**	
29	Jharkhand	8	Lohardaga	12	**IAP**	
30	Jharkhand	9	Gumla*	14	**IAP**	**LWE, T**
31	Jharkhand	10	Simdega	#	**IAP**	
32	Jharkhand	11	Dumka	13	**ITDP**	
33	Madhya Pradesh	1	Raisen	35		
34	Madhya Pradesh	2	Tikamgarh	36		
35	Madhya Pradesh	3	Sidhi*	37	**IAP**	
36	Madhya Pradesh	4	Singrauli	#	**IAP**	
37	Madhya Pradesh	5	Sagar	38		
38	Madhya Pradesh	6	Damoh	39		
39	Madhya Pradesh	7	Satna	40		
40	Madhya Pradesh	8	Dindori	41	**IAP**	**T**
41	Madhya Pradesh	9	Shahdol*	42	**IAP**	
42	Madhya Pradesh	10	Anuppur	#	**IAP**	
44	Madhya Pradesh	12	Chhatarpur	44		
45	Madhya Pradesh	13	Panna	45		
46	Madhya Pradesh	14	Barwani	30		**T**

S.No.	State	District		Ranking of District within State	Classifi-cation	Remarks
47	Madhya Pradesh	15	Mandla	32	**IAP**	**T**
48	Madhya Pradesh	16	Jhabua*	33		**T**
49	Madhya Pradesh	17	Alirajpur	#		
50	Odisha	1	Nuapada	24	**IAP**	
51	Odisha	2	Koraput	25	**IAP**	
52	Odisha	3	Rayagada	26	**IAP**	**LWE, T**
53	Odisha	4	Nabarangapur	27	**IAP**	**T**
54	Odisha	5	Malkangiri	28	**IAP**	**LWE, T**
55	Odisha	6	Kandhamal	29	**IAP**	**T**
56	Odisha	7	Baudh	30		
57	Odisha	8	Gajapati	22	**IAP**	**LWE, T**
58	Rajasthan	1	Bundi	25		
59	Rajasthan	2	Karauli	26		
60	Rajasthan	3	Jaisalmer	27		
61	Rajasthan	4	Udaipur	28		
62	Rajasthan	5	Rajsamand	29		
63	Rajasthan	6	Dhaulpur	30		
64	Rajasthan	7	Jalor	31		
65	Rajasthan	8	Barmer	32		
66	Rajasthan	9	Banswara	19		**T**
67	Rajasthan	10	Dungarpur	24		**T**
68	Uttar Pradesh	1	Faizabad	54		
69	Uttar Pradesh	2	Sant Kabir Nagar	55		
70	Uttar Pradesh	3	Hardoi	56		
71	Uttar Pradesh	4	Barabanki	57		
72	Uttar Pradesh	5	Pilibhit	58		
73	Uttar Pradesh	6	Kheri	59		

S.No.	State	District		Ranking of District within State	Classifi-cation	Remarks
74	Uttar Pradesh	7	Sitapur	60		
75	Uttar Pradesh	8	Bareilly	61		
76	Uttar Pradesh	9	Gonda	62		
77	Uttar Pradesh	10	Kaushambi	63		
78	Uttar Pradesh	11	Etah*	64		
79	Uttar Pradesh	12	Kanshiram Nagar	#		
80	Uttar Pradesh	13	Shahjahanpur	65		
81	Uttar Pradesh	14	Siddhartha Nagar	66		
82	Uttar Pradesh	15	Bahraich	67		
83	Uttar Pradesh	16	Budaun	68		
84	Uttar Pradesh	17	Balrampur	69		
85	Uttar Pradesh	18	Shrawasti	70		
86	Uttar Pradesh	19	Sonbhadra	47	**IAP**	**LWE**
87	Uttarakhand	1	Pauri Garhwal	11		
88	Uttarakhand	2	Tehri Garhwal	12		
89	Uttarakhand	3	Haridwar	13		
90	Andhra Pradesh	1	Vizianagaram	18		
91	Andhra Pradesh	2	Cuddapah	19		
92	Andhra Pradesh	3	Kurnool	20		
93	Andhra Pradesh	4	Mahbubnagar	21		
94	Andhra Pradesh	5	Visakhapatnam	22		
95	Andhra Pradesh	6	Adilabad	23		
96	Arunachal Pradesh	1	Lohit (Tawang excluded)	10		
97	Arunachal Pradesh	2	Changlang (Lower Dibang Valley excluded)	3		
98	Arunachal Pradesh	3	East Kameng	15		**T**
99	Arunachal Pradesh	4	Upper Siang	16		**T**

S.No.	State	District		Ranking of District within State	Classifi-cation	Remarks
100	Arunachal Pradesh	5	Lower Subansiri*	11		**T**
101	Arunachal Pradesh	6	Kurung kumey	#		
102	Arunachal Pradesh	7	Upper Subansiri	12		**T**
103	Delhi	1	North West	8		
104	Delhi	2	North East	9		
105	Gujarat	1	Panch Mahals	20		
106	Gujarat	2	Sabar Kantha	21		
107	Gujarat	3	Banas Kantha	22		
108	Gujarat	4	Kachchh	23		
109	Gujarat	5	The Dangs	24		**T**
110	Gujarat	6	Dohad	25		**T**
111	Gujarat	7	Valsad	15		**T**
112	Gujarat	8	Narmada	17		**T**
113	Haryana	1	Jind	16		
114	Haryana	2	Hisar	17		
115	Haryana	3	Panipat	18		
116	Haryana	4	Palwal	#		
117	Haryana	5	Mewat	20		
118	Himachal Pradesh	1	Mandi	10		
119	Himachal Pradesh	2	Lahul & Spiti	11		**T**
120	Himachal Pradesh	3	Chamba	12		
121	Himachal Pradesh	4	Kinnaur	9		**T**

S.No.	State	District		Ranking of District within State	Classifi-cation	Remarks
122	Jammu & Kashmir	1	Rajauri	12		
123	Jammu & Kashmir	2	Doda*	13		
124	Jammu & Kashmir	3	Ramban	#		
125	Jammu & Kashmir	4	Kishtwar	#		
126	Jammu & Kashmir	5	Punch	14		
127	Jammu & Kashmir	6	Leh (Ladakh)	7		**T**
128	Karnataka	1	Gadag	21		
129	Karnataka	2	Bijapur	22		
130	Karnataka	3	Bagalkot	23		
131	Karnataka	4	Bellary	24		
132	Karnataka	5	Koppal	25		
133	Karnataka	6	Gulbarga*	26		
134	Karnataka	7	Yadgir	#		
135	Karnataka	8	Raichur	27		
136	Kerala	1	Kasaragod	12		
137	Kerala	2	Malappuram	13		
138	Kerala	3	Palakkad	14		
139	Maharashtra	1	Nanded	27		
140	Maharashtra	2	Bid	28		
141	Maharashtra	3	Jalgaon	29		
142	Maharashtra	4	Dhule	30		
143	Maharashtra	5	Aurangabad	31		
144	Maharashtra	6	Jalna	32		
145	Maharashtra	7	Gadchiroli	33	**IAP**	**LWE**
146	Maharashtra	8	Hingoli	34		

S.No.	State	District		Ranking of District within State	Classifi-cation	Remarks
147	Maharashtra	9	Nandurbar	35		**T**
148	Manipur	1	Ukhrul	8		**T**
149	Manipur	2	Tamenglong	9		**T**
150	Manipur	3	Senapati	5		**T**
151	Manipur	4	Chandel	6		**T**
152	Manipur	5	Churachandpur	7		**T**
153	Meghalaya	1	West Khasi Hills	6		**T**
154	Meghalaya	2	South Garo Hills	7		**T**
155	Meghalaya	3	Jaintia Hills	4		**T**
156	Meghalaya	4	West Garo Hills	5		**T**
157	Mizoram	1	Lawngtlai	7		**T**
158	Mizoram	2	Mamit	8		**T**
159	Mizoram	3	Lunglei	5		**T**
160	Mizoram	4	Saiha	6		**T**
161	Puduchherry	1	Yanam	4		
162	Punjab	1	Sangrur*	16		
163	Punjab	2	Muktsar	17		
164	Punjab	3	Gurdaspur	18		
165	Punjab	4	Barnala	19		
166	Punjab	5	Mansa	20		
167	Sikkim	1	West	4		
168	Tamil Nadu	1	Vellore	24		
169	Tamil Nadu	2	Madurai	25		
170	Tamil Nadu	3	Krishnagiri	26		
171	Tamil Nadu	4	Tiruvannamalai	27		
172	Tamil Nadu	5	Trichy	28		

S.No.	State	District		Ranking of District within State	Classifi-cation	Remarks
173	Tamil Nadu	6	Thirunelveli	29		
174	Tamil Nadu	7	Virudhunagar	30		
175	Tripura	1	Dhalai	4		**T**
176	West Bengal	1	Koch Bihar	15		
177	West Bengal	2	Murshidabad	16		
178	West Bengal	3	South 24 Parganas	17		
179	West Bengal	4	Maldah	18		
180	West Bengal	5	Uttar Dinajpur	19		
181	Nagaland	1	Kiphre (Mokukchung excuded)	6		
182	Nagaland	2	Tuengsang (Pheren excluded)	4		
183	Nagaland	3	Mon	10		
184	Nagaland	4	Wokha (Kohima excluded)	3		

**: Parent district*

#: District carved out of parent district

IAP = Integrated Action Plan(30 Districts) which include backward, tribal and LWE(Left Wing Extremism) districts

ITDP = Integrated Tribal Development Project

Note: *1. The districts of Nagland State are based on composite index of HMIS Key Indicators as DLHS-3 Survey was not conducted in the State*

2. List of 184 HPD districts revised as per the decision taken by the Committee on 30.8.2013 to replace the existing districts of Arunachal Pradesh and Nagaland as requested by States