DISTRICT HEALTH ACTION PLAN

2009-2010

DISTRICT HEALTH SOCIETY

KATIHAR.

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
APHC	Additional Primary Health Centre
APL	Above Poverty Line
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy
BCC	Behaviour Change Communication
BDC	Block Development Committee
BPL	Below Poverty Line
CBO	Community Based Organization
CDPO	Child Development Project Officer
CHC	Community Health Centre
CMO	Chief Medical Officer
DDC	Drug Distribution Centre
DAP	District Action Plan
DF	Deep Freezers
DH	District Hospital
DHAP	District Health Action Plan
DLHS	District Level Household Survey
DOTS	Directly Observed Treatment Short-course
EmOc	Emergency Obstetric Care
FGD	Focus Group Discussion
FRU	First Referral Unit
FTD	Fever Treatment Depot
GP	Gram Panchayat
HMS	Health Management Society
ICDS	Integrated Child Development Services
IDSP	Integrated Disease Surveillance Project
IEC	Information Education And Communication
ILR	Ice-lined Refrigerators
IOL	Intra-Ocular Lens
IUD	Intra-uterine Devices

IPHS	Indian Public Health Standards
LHV	Lady Health Visitor
MDT	Multi Drug Therapy
MMU	Medical Mobile Unit
MOIC	Medical Officer In-Charge
MPW	Multi Purpose Worker
MSG	Mission Steering Group
NBCP	National Blindness Control Programme
NGO	Non Government Organization
NLEP	National Leprosy Eradication Programme
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Disease Control Programme
PHC	Primary Health Centre
PPC	Post Partum Centres
PRI	Panchayati Raj Institution
RCH	Reproductive And Child Health
RKS	Rogi Kalyan Samiti
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infections
SC	Sub-centre
SC/ST	Scheduled Caste/ Scheduled Tribe
SHG	Self Help Group
SNP	Supplementary Nutrition Programme
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOT	Training of Trainers
UFWC	Urban Family Welfare Centre
VHC	Village Health Committee
VHSC	Village Health and Sanitation Committee
ZP	Zila Parishad

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I . Acknowledgements

The commitment to bridge the gaps in the public health care delivery system, has led to the formulation of District Health Action Plans. The collaboration of different departments that are directly or indirectly related to determinants of health, such as water, hygiene and sanitation, will lead to betterment of health care delivery, and to make this collaboration possible actions are to be outlined in the District Health Action Plan. Thus this assignment is a shared effort between the departments of Health and Family Welfare, ICDS, PRI, Water and Sanitation, Education to draw up a concerted plan of action.

The development of a District Action Plan for Katihar district of Bihar entailed a series of Consultative Meetings with stakeholders at various levels, collection of secondary data from various departments, analysis of the data and presentation of the existing scenario at a District-level workshop. The District level Workshop was organized to identify district specific strategies based on which the District Action Plan has been prepared by the District & Block Program Management Unit .

We would also like to acknowledge the much needed cooperation extended by the District Magistrate and Deputy Development Commissioner without whose support the conduct of the of district level workshop would not have been possible. Our thanks are due to All the Program officers and Medical officers of the district for their assistance and support from the inception of the project. The involvement of the all the Medical officers played a vital role throughout the exercise enabling a smooth conduct of consultations at block and district levels.

The present acknowledgement would be incomplete without mentioning the participation of representatives and officials from department of Integrated Child Development Services, Panchayati Raj Institution, Education and Water and Sanitation , who actively participated in consultations with great enthusiasm. Without their inputs it would not have been possible to formulate the strategic health action plan for the district. The formulation of this plan being a participatory process, with inputs from the bottom up, the participation of community members at village level proved very helpful. These consultations at grassroots level supplemented the deliberations at block and district levels, adding value to the planning process.

Finally, we would like to appreciate the efforts and supports of all those including PHRN Bihar , Team who were associated with the team for accomplishment of this task and brought the effort to fruition.

Additional Chief Medical Officer
(Dr. Sanjay Chaikyar)

Civil Surgeon cum CMO
(Dr. Kaushal Kishore Labh)

II. Executive Summary

The National Rural Health Mission launched for the period of seven years (2005-12), aims at providing integrated comprehensive primary health care services, especially to the poor and vulnerable sections of the society. NRHM is projected to operate as an omnibus broadband programme by integrating all vertical health programmes of the Department of Health and Family Welfare including Reproductive and Child Health Programme-II, National Vector Borne Disease Control Programme, Revised National Tuberculosis Control Programme, National Blindness Control Programme and National Leprosy Eradication Programme. The Mission envisions effective integration of health concerns, with determinants of health like hygiene, sanitation, nutrition and safe drinking water through decentralized management at district level. In order to make NRHM fully accountable and responsive, the need for formulation of a District Health Action Plan (DHAP) 2009-10 has been recognized The DHAP intends to provide a guideline to develop a viable public health delivery system through intensive monitoring and ensuring performance standards. It reflects the convergence of different aspects of health like potable water, sanitation, women and child development and school level education.

As a first step towards planning process, identification of performance gaps was attempted by carrying out a situational analysis. The public health infrastructure in the district indicates under-equipped health facilities with vacant staff positions.. Amdabad and Pranpur Blocks have been identified as the most vulnerable with scant outreach services due to difficult topography. From the convergence point of view involvement of ICDS and PRI within the framework of health is significant. Intervention by PRI through the constitution and activation of Village Health & Sanitation Committees is still in process, and in the meantime, ICDS workers integrate with health workers at village level through *Anganwadi* centre to ensure better accessibility to and availability of health services.

The formulation of the DHAP envisages a participatory approach at various levels. To make the plan more practicable and to ensure that grass root issues are voiced and heard, the initial stages of process of plan development included consultations at village and block levels. As NRHM emphasizes community participation and need-based service delivery with improved outreach to disadvantaged communities, village and block level consultations provided vital information to guide the district health action plan. The consultations endeavored to reach a consensus on constraints at community level and engender feasible solutions/intervention strategies. Priorities were set based on discussions on both demand and supply side concerns in the blocks. Furthermore, a

district level workshop was conducted to share findings of the village and block level process with a larger stakeholder group, and to finalize a strategic action plan.

During district level consultations involving a range of stakeholders from different levels, strategies have been formulated to achieve identified district plan objectives. For effective implementation, specific activities have been identified for each strategy and a time frame assigned for each activity.

To provide equitable reproductive and child health services with the objective of bridging the spatial variations and achieving the goals of the Mission, a comprehensive approach has been suggested through partnerships with private institutions, initiatives by other departments like ICDS, Education and civil society. Involvement of elected Panchayat representatives and community participation at large have specified for addressing and reducing gender discrimination issues (viz. advocacy on age at marriage, denial of sex-selection, equality of immunization etc). For enhancing availability, accessibility and acceptability of services, increase in female literacy, improved IEC for behaviour change and strengthening of health services as well as service providers are envisaged as major tools which can mitigate cultural, institutional and functional constraints.

The infrastructural scenario indicates that appointment of ASHAs, under NRHM, is not yet completed. Training for ASHAs is still pending. Rogi Kalyan Samittis are not full functional at all . The findings of the facility survey suggests that each & every Health facilities need to be upgraded as per IPHS. To make the health care mechanism more accountable, health institutions should be upgraded with adequate availability of staff and equipment and drugs. As a part of NRHM it is proposed to provide each health facility with an untied grant for maintenance and local health action. Thus the present work plan suggests proper monitoring and directions for use of the maintenance grant. It is also proposed to improve outreach activities in un-served and underserved areas, especially in those inhabited by vulnerable populations, through provision of Mobile Medical Units.
In conformity with the innovations expected in NRHM, mainstreaming of AYUSH for strengthening primary health delivery is also suggested.

For improving the performance indicators for child immunization, strengthening of the service delivery infrastructure and increase in manpower has been suggested. Additionally there is need for in-service training programmes for skill development of field staff. To increase immunization coverage, more outreach camps should be organized for better access by the underserved and un-served populations. NGOs and PRI are envisioned as playing a role in improving service delivery efficiency and effecting behaviour change.

Under National Disease Control Programmes, to improve the performance of NVBDCP (specifically indicator of Kala-azar & malaria) improvement in surveillance activities have been suggested for epidemic preparedness and response. Sensitization of the community (BCC) and social mobilization can be achieved effectively by involving Panchayat members. In addition, there is need for strengthening and upgrading the epidemiological capabilities of laboratories Moreover, inter-sectoral collaboration between the health department, water and sanitation department, PRI, education department, ICDS and NGOs has been envisaged for effective intervention.

For achieving the targets for RNTCP in the span of next one years increased BCC activities are suggested for higher acceptance of services and self reporting by patients. Infrastructural strengthening is also recommended with increased manpower and close monitoring. Moreover, the role of private practitioners is envisaged for IEC activities and for the sensitization of the community.

As evident from the situational analysis, all most all the posts are lying vacant for specialists. Thus filling vacant posts would be one of the activities for strengthening service delivery. To improve access to rural/ tribal or underserved areas more outreach camps should be organized. There should be adequate procurement, distribution and assurance of quality equipment and drugs. School health camps should be organized to target children 10-14 years of age for refractive errors. Further there is need for promotion of outreach activities by effective communication.

Existing knowledge and awareness about leprosy call for increased BCC activities to eliminate misconceptions and beliefs associated with the disease. This could be achieved by successful intervention of the Panchayat through activation of village health committees. Moreover there is need to reinforce the service delivery mechanism by providing quality services for counseling, diagnosis and treatment.

To make the system more accountable, the District Health Action Plan proposes close monitoring and evaluation with continuous integration at each level (village, block and district). This will not only ensure streamlining of strategies but also check for effective collaboration of services related to immunization and institutional delivery, AYUSH infrastructure, supply of drugs, up gradation of PHCs to CHCs as per IPHS, utilization of untied funds, and outreach services through operationalization of the mobile medical units. The PRIs, RKSs, Quality Assurance Committees at the District level, District Health Missions, are to be the eventual monitors of the outcomes.

III. The Context

The importance of health in economic and social development for improving the quality of life has long been recognized. In order to energize the various components of health system, Government of India has launched the National Rural Health Mission (NRHM). This was launched in April 2005, to provide effective health care to the rural population throughout the country with special focus on 18 states which have weak public health indicators and/or weak infrastructure.

The Mission aims to expedite the achievement of policy goals by facilitating enhanced access and utilization of quality health services, with emphasis on the equity and gender dimensions.

Specific objectives of the Mission are:

- Reduction in child and maternal mortality
- Universal access to services for food and nutrition, sanitation and hygiene, safe drinking water
- Emphasis on services addressing women and child health; and universal immunization
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary health care
- Revitalization local health traditions and mainstreaming of AYUSH

NRHM will facilitate transfer of funds, functions and functionaries to PRIs and also the greater engagement of RKS, hospital development committees or user groups. Improved management through capacity development is also planned. Innovations in human resource management constitute a major challenge in making health services available to the rural/tribal population. Thus, NRHM aims at the availability of locally resident health workers, multi-skill training of health workers and doctors, and integration with the private sector for optimal use of human resources. The Mission aims to make untied funds available at different levels of the health care delivery system.

Core strategies of the Mission include decentralized public health management. This will be realized by implementation of District Health Action Plans (DHAPs), which will be the principal instrument for planning, implementation and monitoring, and which will be formulated through a participatory and bottom-up planning process. DHAP enable village, block, district and state levels to identify the gaps and constraints in order to

improve services with regard to access, demand and quality of health care. NRHM-DHAP is anticipated to form the cornerstone of all strategies and activities in the district.

The District Health Action Plan integrates the various interrelated components of health to facilitate access to services and ensure quality of care. These different components are as detailed below:

- ***Resources:*** health manpower, logistics and supplies, community resources and financial resources, voluntary sector health resources.
- ***Access to services:*** public and private services as well as informal health care services; levels of integration of services within public health system.
- ***Utilization of services:*** outcomes, continuity of care, factors responsible for possible low utilization of public health system.
- ***Quality of care:*** technical competence, interpersonal communication, and client satisfaction, client participation in management, accountability and redress mechanisms.
- ***Community:*** needs, perceptions and economic capacities, PRI involvement in health, existing community organizations and modes of involvement in health.
- ***Socio-epidemiological situation:*** local morbidity profile, major communicable diseases and transmission patterns, health needs of special social groups (e.g. *Adivasis*, migrants, very remote hamlets)

NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the need for situation analysis, stakeholder involvement in action planning, community mobilization, inter-sectoral convergence, partnerships with NGO and the private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving programme functionaries and community representatives at district level.

IV. Objectives of the DHAP

The aim of the present study is to prepare DHAP based on the broad objective of the NRHM . Specific objectives of the process are:

- To identify critical health issues and concerns with special focus on vulnerable /disadvantage groups and isolated areas and attain consensus on feasible solutions.
- To examine existing health care delivery mechanisms to identify performance gaps and develop strategies to bridge them
- To actively engage a wide range of stakeholders from the community, including the Panchayat, in the planning process
- To identify priorities at the grassroots level and set out roles and responsibilities at the Panchayat and block levels for designing need-based DHAPs
- To espouse inter-sectoral convergence approach at the village, block and district levels to make the planning process and implementation process more holistic

V . Methodology

Planning process started with the orientation of the different programme officers , MOICs , Block Health Manager and our health workers. Different group meetings were organized and at the same time issues were discussed and suggestions were taken. Simple methodology adopted for the planning process was to interact informally with the government officials, health workers, medical officers, community, PRIs and other key stake holders.

Data Collection:

Primary Data: All the Medical Officers were interacted and their concern was taken in to consideration. Daily work process was observed properly and inputs were taken in account. District officials including CMO, ACMO , DIO, DMO, DLO , RCHO and others were interviewed and their ideas were kept for planning process.

Secondary Data: Following books, modules and reports were taken in account for this Planning Process

- RCH-II Project Implementation Plan
- NRHM operational guideline
- DLHS Report
- Report Given by DTC
- Report taken from different programme societies e.g. Blindness control, District
- Leprosy Society, District TB Center , District Malaria Office
- Census-2001

- National Habitation Survey-2003
- Bihar State official website

Tools:

Main tools used for the data collection were:

- Informal In-depth interview
- Group presentation with different district level officials
- Informal group discussions with different level of workers and community representative
- Review of secondary data

Data Analysis:

Primary Data: Data analysis was done manually . All the interviews were recorded and there points were noted down. After that common points were selected out of that.

Secondary Data: All the manuals books and reports were converted in to analysis tables and these tables are given in to introduction and background part of this plan.

VI . SWOT Analysis of the District

STRENGTHS – WEAKNESSES – OPPORTUNITIES – THREATS :

❖ **STRENGTHS**

.1. **Involvement of C.S cum CMO : - C.S cum CMO** take interest, guide in every activity of Health programme and get personally involved.

2. Support from District Administration:- District Magistrate and Deputy Development Commissioner take interest in all health programmes and actively participate in activities. They provide administrative support as and when needed. They make involvement of other sectors in health by virtue of their administrative control.

3. Support from PRI(Panchayati Raj Institute) Members :- Elected PRI members of District and Blocks are very co-operative. They take interest in every healthprogrammes and support as and when required. There is an

excellent support from Chairman of Zila Parishad They actively participate in all health activities and monitor ,it during their tour programme in field

4. Well established DPMU and BPMU :- Since one year, all the posts of DPMU & BPMU are filled up. Facility for office and automation is very good. All the members of DPMU & BPMU work harmoniously and are hardworking.

5. **Effective Communication: -** Communication is easy with the help of internet facility at block level and land line & Mobile phone facility which is incorporated in most of PHCs of the district.

6 .Facility of vehicles: - Under the Muskan Ek Abhiyan programme every Block have the vehicles for monitoring .

7. **Support from media: -** Local newspapers and channel are very co-operative for passing messages as and when required. They also personally take interest to project good and worse things which is very helpful for administration to take corrective measures.

❖ **WEAKNESS**

1. **Lack of Consideration in urban area: - Urban** area has got very poor health infrastructure to provide health services due to lack of manpower. Even Urban Slum are not covered under Urban Health scheme (Urban Health Scheme is not implemented by the GOB for Katihar district) which cover urban Population.

2. **Non availability of specialists at Block level: -** As per IPHS norms, there are vacancies of specialists in most of the PHCs . Many a times only Medical Officer is posted, they are busy with routine OPD and medico legal work only. So PHC do not fulfill the criteria of ideal referral centers and that cause force people to avail costly private services.

3. **Non availability of ANMs at PHCs to HSCs level -** As per IPHS norms, there are vacancies of ANMs in most of the HSCs . Out of 345 Sanctioned post of contractual ANMs only ----- ANMs are Selected . So HSCs do not fulfill the criteria of ideal Health Sub Centre and that cause force people to travel up to PHCs to avail basic health services.

4. **Apathy to work for grass root level workers: -** Since long time due to lack of monitoring at various level grass root level workers are totally reluctant for work. Even after repeated training, desired result has not been achieved. Most of the MO, Paramedics , Block Health Managers & workers do not stay at HQ. Medical Officers,who are supposed to monitor the daily activity of workers

do not take any interest to do so. For that reason workers also do not deliver their duties regularly and qualitatively.

Due to lack of monitoring & supervision some aim, object & program is suffering.

5. Lack of proper transport facility and motarable roads in rural area :- There are lack of means of transport and motarable roads in rural areas . Rural roads are ruled by 'Jogad', a hybrid mix of Motor cycle and rickshaw, which is often inconvenient mean of transport. The fact that it is difficult to find any vehicle apart from peak hours is still the case in numerous villages.

6. Illiteracy and taboos:-The literacy rate in rural area has still not reached considerable mark. Especially certain communities have constant trend of high illiteracy. This causes prevalence of various taboos that keep few communities from availing benefits of health services like immunization or ANC, institutional delivery…etc.

❖ OPPORTUNITIES

1. Health indicator in Katihar district is not satisfactory . Services like Institutional delivery , Complete Immunization , Family Planning, Complete ANC, School Health activity , Kala-azar eradication may required to be improved. So there are an opportunity to take the indicator to commendable rate of above 75+% by deploying more efforts and will.

2. Introduction of PPP Scheme: Through introduction of PPP Scheme we can overcome shortfall of specialist at Block level.

3. **Involvement of PRIs: -** PRI members at district, Block and village level are very co-operative to support the programmes. Active involvement of PRI members can help much for acceptance of health care deliveries and generation of demand in community.

4. improvement of infrastructure: -. With copious funds available under NRHM, there is good opportunity to make each health facility neat and clean, Well Equipped and Well Nurtured.

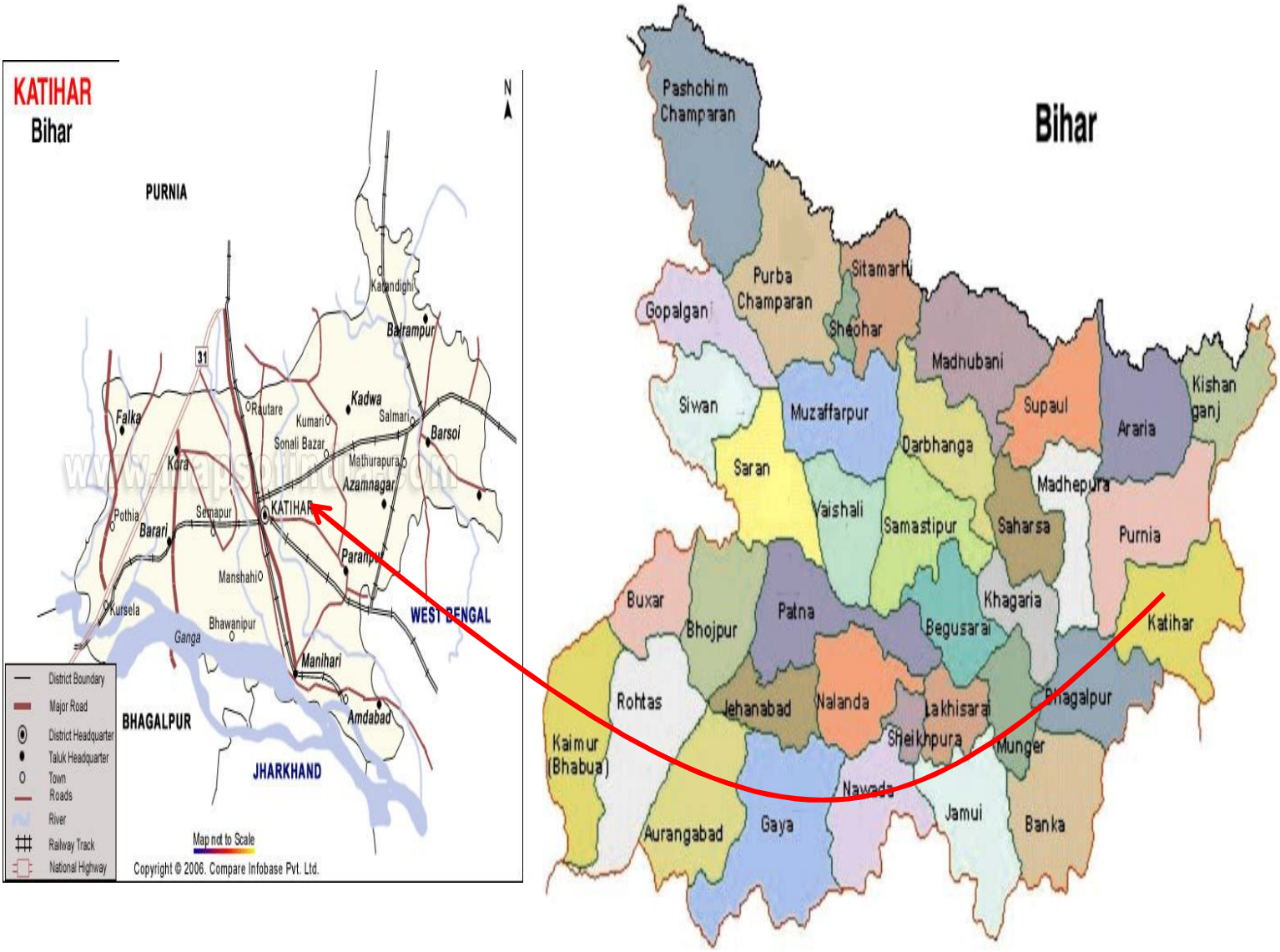
❖ THREATS

1. Flow of information if not properly channeled to the grass root stakeholder

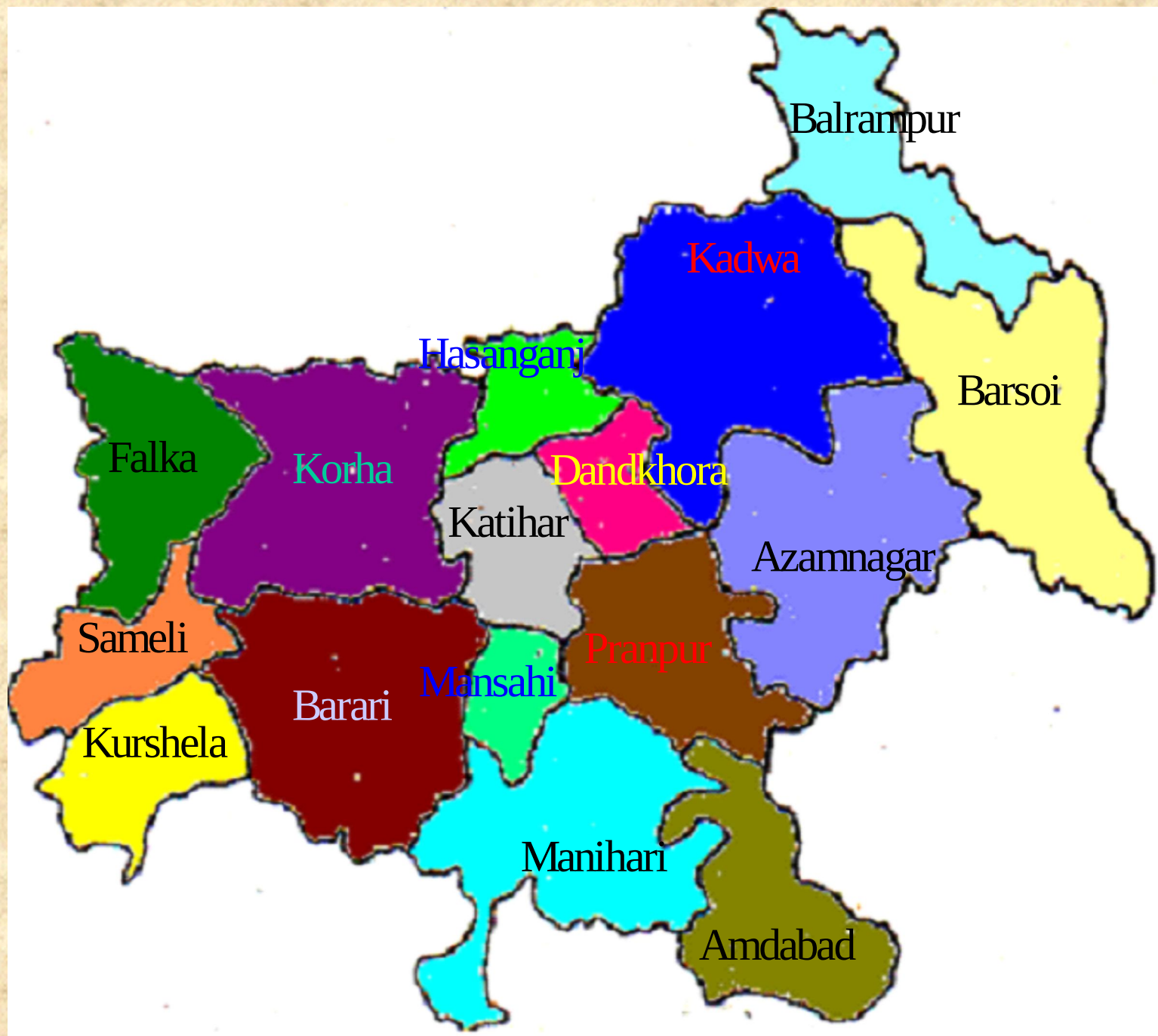
2. Natural calamities like every year flood adversely affected the progress of Health Programme .

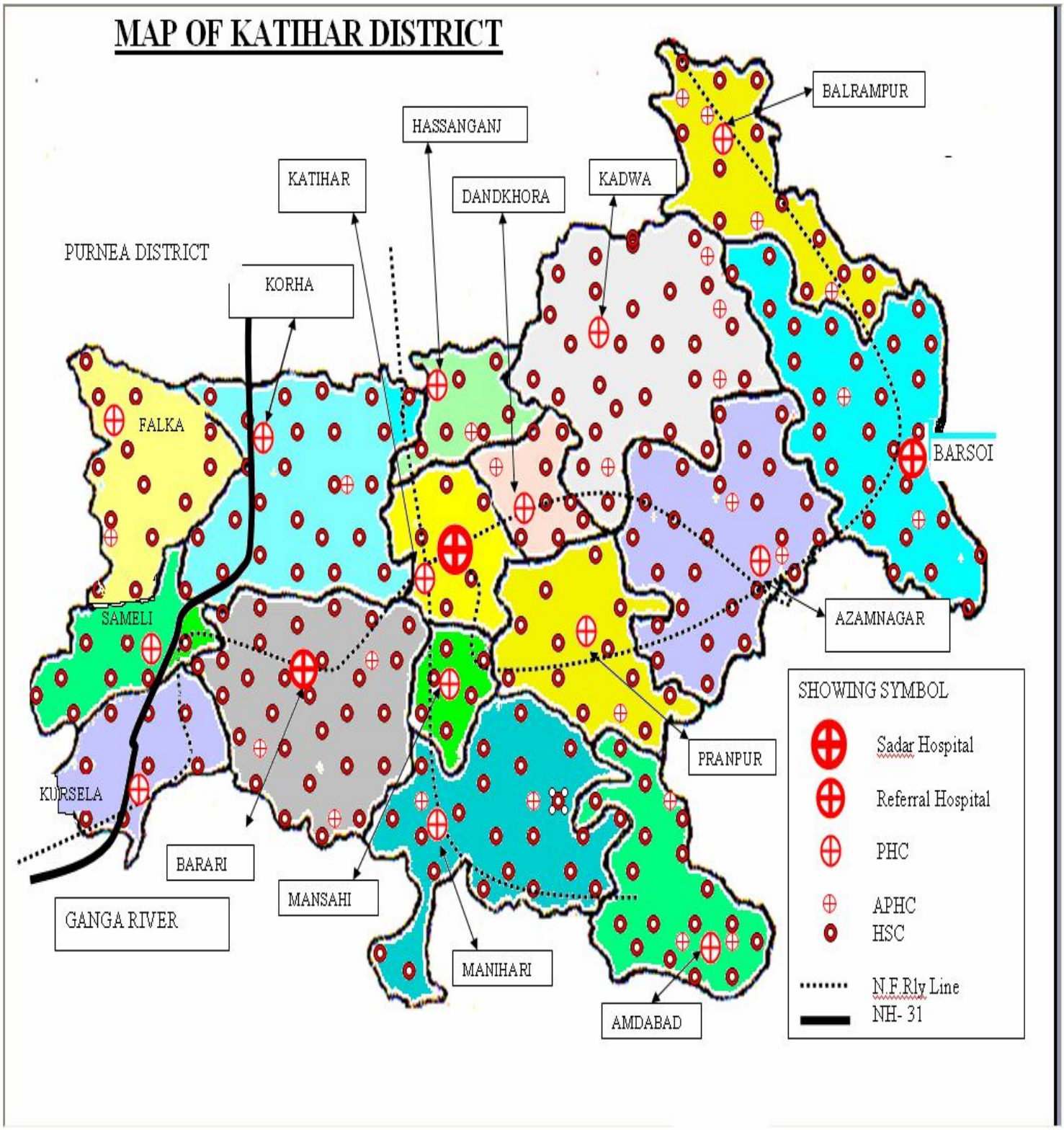
VII. Profile of the District

Katihar as a district came into existence on 2nd October; 1973, It is situated in the plains of North Eastern part of Bihar State, surrounded by Purnea district in the North and West Bhagalpur and Sahebganj district in the South and West Bengal in the East. Katihar district is situated between Latitude 25^0 42' - 26^0 22' N and Longitude 87^0 10' - 88^0 05' E. The topography of the Katihar district has been very much affected by the floods of river Ganga, Mahananda and Koshi. The district has alluvial soil and due to deposit of sand-silt by rivers and soil in southern and the western part has become sandy. The land is slightly higher in the North and gradually slopping towards the South. The slop is gradual. There is no hill in the district except a small hillock in Manihari Block which is composed of nodular lime stone. It is intersected by Ganges, Mahananda and Koshi rivers.



Katihar District




MAP OF KATIHAR DISTRICT
BALRAMPUR
HASSANGANJ
KATIHAR
DANDKHORA
KADWA
PURNEA DISTRICT
KORHA
FALKA
BARSOI
SAMELI
AZAMNAGAR
PRANPUR
KURSELA
BARARI
MANSAHI
GANGA RIVER
MANIHARI
AMDABAD
SHOWING SYMBOL
Sadar Hospital
Referral Hospital
PHC
APHC
HSC
N.F.Rly Line
NH- 31

Demographic profile of the Katihar

Katihar

Area	3,057 Sq.Kms.
Population	28,40,404
SC Population	2,83,083
ST Population	1,67,059
Male Population	14,80,294
Female Pupulation	13,60,110
Sex Ratio	919/1000
Literacy Combined	35.29
Male literacy	45.51
Female literacy	24.03
No. of Sub Divisions	03
No. of Blocks	16
No. of Nagar Panchayats	01
No. of Gram Panchayats	239
No. of Revenue Villages	1548

Health Related Data

Following are the State Government Health System available in the District-:

No. of Primary Health Centre	16
No. of Referral Hospitals	03 (Manihari not functional)
No. of District Hospital	01
No. of Additional Primary Health Centre	25
No. of Health Sub Centre	257

Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Deputy Development Commissioner , Civil Surgeon, ACMO, all programme officers , DPMU Personnel as well as the MOICs and BPMUs Personnel .

The Plan has been prepared after a thorough situational analysis of district health scenario this document has been prepared. In the plan, it is addressing health care needs of rural poor especially women and children, the teams have analysed the coverage of poor women and children with preventive and promotive interventions, barriers in access to health care and spread of human resources catering health needs in the district. The focus has also been given on current availability of health care infrastructure in pubic/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.

VIII . Situational Analysis

In the present situational analysis of the blocks of Katihar district , the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from DLHS-3 , as well as other sources. These indicators help in pointing to the health scenario in Katihar from a quantitative point of view, while

they cannot by themselves provide a complete picture of the status of health in the district. However, it is useful to have outcome data to map the effectiveness of public investment in health. Further, when data pertaining to vital rates are analyzed in conjunction with demographic measures, such as sex ratio and mean age of marriage, they throw valuable light on gender dimension.

Table below indicates the Health indicators of Katihar district .

KEY HEALTH INDICATORS:--

Following are the Health indicators of the district according to DLHS-3	
Marriage and Fertility, (Jan 2004 to 2007-08)	
Percentage of girl's marrying before completing 18 years	43.7
Percentage of Births of Order 3 and above	53.0
Sex Ratio at birth	97
Percentage of women age 20-24 reporting birth of order 2 & above	72.0
Percentage of births to women during age 15-19 out of total births	98.3
Family planning (currently married women, age 15-49)	
Current Use :	
Any Method (%)	26.0
Any Modern method (%)	20.3
Female Sterilization (%)	16.6
Male Sterilization (%)	0.0
IUD (%)	0.4
Pill (%)	1.6
Condom (%)	1.4
Unmet Need for Family Planning:	
Total unmet need (%)	43.7
For spacing (%)	17.5
For limiting (%)	26.2
Maternal Health:	
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	21.2
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	32.5
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)#	61.9
Institutional births (%)	12.4
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	3.9
Mothers who received post natal care within 48 hours of delivery of their last child (%)	15.3
Child Immunization and Vitamin A supplementation:	
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)	32.6
Children (12-23 months) who have received BCG (%)	75.8
Children (12-23 months) who have received 3 doses of Polio Vaccine (%)	46.6
Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	48.2
Children (12-23 months) who have received Measles Vaccine (%)	44.8
Children (9-35 months) who have received at least one dose of Vitamin A (%)	48.4

Children (above 21 months) who have received three doses of Vitamin A (%)	9.0
Treatment of childhood diseases (children under 3 years based on last two surviving children)	
Children with Diarrhoea in the last two weeks who received ORS (%)	32.6
Children with Diarrhoea in the last two weeks who were given treatment (%)	80.9
Children with acute respiratory infection/fever in the last two weeks who were given treatment (%)	75.9
Children had check-up within 24 hours after delivery (based on last live birth) (%)	12.9
Children had check-up within 10 days after delivery (based on last live birth) (%)	13.6
Child feeding practices (Children under 3 years)	
Children breastfed within one hour of birth (%)	13.4
Children (age 6 months above) exclusively breastfed (%)	14.8
Children (6-24 months) who received solid or semisolid food and still being breastfed (%).	85.0
Knowledge of HIV/AIDS and RTI/STI among Ever married Women (age 15-49)	
Women heard of HIV/AIDS (%)	20.4
Women who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)	31.5
Women having correct knowledge of HIV/ AIDS (%)	93.0
Women underwent test for detecting HIV/ AIDS (%)	3.4
Women heard of RTI/STI (%)	26.6
Knowledge of HIV/AIDS among Un-married Women (age 15-24)	
Women heard of HIV/AIDS (%)	37.6
Women who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)	31.1
Women having correct knowledge of HIV/ AIDS (%)	92.7
Women underwent test for detecting HIV/ AIDS (%)	0.0
Women heard of RTI/STI (%)	15.2
Women facilitated/motivated by ASHA for	
Ante-natal Care (%)	1.8
Delivery at Health Facility (%)	1.5
Use of Family Planning Methods (%)	0.3

Availability of facilities and location of facilities

As per existing IPHS norms one HSC is planned for every 5000 population and for tribal areas the 3000 population, one PHC for every 30,000 population and for tribal area 20,000 population one CHC for every 1, 20,000 population. For tribal areas the norm is one CHC per 80,000 populations.

The number of gap is in the number of sectors without HSCs, without PHCs, we have major gap in CHCs where in practice the norm followed is one CHC per administrative block. There is no CHC in the Katihar district . Amongst existing facilities there is considerable loss of utilization due to improper location and improper distribution. And this is compounded by improper choice of village within the section or sector and the choice of venue within the village. Sub centers were most affected by such poor location.

The existing process of choice of venue is flawed and a specific alternative policy on this is required.

Gaps in Health Infrastructure:

Out of 16 blocks in Katihar district are proposed to be converted to CHCs. Currently 16 PHCs, 3 referral hospitals, 25 APHCs and 257 HSCs are functioning in the district. District hospital is located at Katihar block.

Health Sub-centres

S.No	Block Name	Population	Sub-centres required	Sub-centers Present	Sub-centers proposed	Further sub-centers required	Status of building	
							Own	Rented
1	Amdabad	156803	31	17	9	5	7	4
2	Azamnagar	293377	59	30	19	10	6	5
3	Balrampur	145432	29	13	12	4	4	2
4	Barari	262415	52	28	16	8	7	3
5	Barsoi	311682	62	27	25	10	7	5
6	Dandkhora	64168	13	8	3	2	4	2
7	Falka	144299	29	14	10	5	4	2
8	Hasanganj	50747	10	6	3	1	2	1
9	Kadwa	319427	64	27	27	10	9	7
10	Katihar(R)	88982	18	5	10	3	1	0
11	Korha	250173	50	25	17	8	11	5
12	Kursela	62766	13	8	3	2	4	1
13	Manihari	177180	35	22	8	5	4	0
14	Mansahi	74158	15	7	6	2	3	2
15	Pranpur	133623	27	11	12	4	2	2
16	Sameli	79721	16	9	4	3	4	1
	Total	2840404	523	257	184	82	79	42

Additional Primary Health Centers (APHCs)

No	Block Name	Population	APHCs required	APHCs present	APHCs proposed	Further APHCs required
1.	Amdabad	156803	5	**3**	**0**	2
2.	Azamnagar	293377	10	**2**	**5**	3
3.	Balrampur	145432	5	**4**	**0**	1
4.	Barari	262415	9	**3**	**3**	3
5.	Barsoi	311682	10	**2**	**6**	2
6.	Dandkhora	64168	2	**1**	**1**	0
7.	Falka	144299	5	**1**	**2**	2
8.	Hasanganj	50747	2	**1**	**1**	0
9.	Kadwa	319427	11	**4**	**4**	3
10.	Katihar®	88982	3	**0**	**1**	2
11	Korha	250173	8	**1**	**5**	2
12	Kursela	62766	2	**0**	**1**	1
13	Manihari	177180	6	**2**	**2**	2
14	Mansahi	74158	2	**0**	**1**	1
15	Pranpur	133623	4	**1**	**2**	1
16	Sameli	79721	3	**0**	**1**	2
	Total		87	25	35	27

As per the IPHS norms still 16 CHCs (existing PHCs will be converted into CHCs) and 62 more PHCs (including existing 25 APHCs will be converted into PHCs) are required to be setup. As in case of HSCs, total HSCs are required 523. Katihar district has 257 existing HSCs. So, Katihar district need 262 more HSCs than the existing numbers.

All the existing CHCs (existing PHCs) are functioning in the Government building and based on their foundation, area covered electrification, water facility, etc. All PHCs are in average condition except Sameli , Dandkhora and Falka . PHC Katihar has no building (Own building) .

CHC/ Block PHC	Building		Building Condition	Power Supply (in hrs)	Gen set	Water Supply	Tele phone	Sanitation (Toilet / Bath)		No. of Beds	Waste Manag ement
	Govt.	Rented						Patient	Staff		
Amdabad	1	0	Poor	24	1	Hand Pump	Y	Y	Y	6	N
Azamnagar	1	0	Average	24	1	Hand Pump	Y	Y	Y	6	N
Balrampur	1	0	Average	24	1	Hand Pump	Y	Y	Y	6	N
Barari	1	0	Average	24	1	OHT	Y	Y	Y	30	N
Barsoi	1	0	Average	24	1	OHT	Y	Y	Y	30	N
Dandkhora	1	0	Good	24	1	OHT	Y	Y	Y	6	N
Falka	1	0	Good	24	1	OHT	Y	Y	Y	6	N
Hasanganj	1	0	Average	24	1	Hand pump	Y	Y	Y	6	N
Kadwa	1	0	Average	24	1	Hand pump	Y	Y	Y	6	N
Katihar	1	0	Average	24	1	Hand pump	Y	Y	Y	6	N
Korha	1	0	Average	24	1	OHT	Y	Y	Y	6	N
Kursela	1	0	Average	24	1	Hand pump	Y	Y	Y	6	N
Manihari	1	0	Average	24	1	Hand pump	Y	Y	Y	6	N
Mansahi	1	0	Average	24	1	OHT	Y	Y	Y	6	N
Pranpur	1	0	Average	24	1	Hand pump	Y	Y	Y	6	N
Sameli	1	0	Good	24	1	OHT	Y	Y	Y	6	N

Every PHCs are having power supply up to 24 hours (average) and Every PHCs have water supply through Over head tank / Hand Pump . The telephone facility is available in each and every PHC. Every PHCs have sanitation facility but needs maintenance properly. Further more, almost all the PHCs are lacking in proper disposal of waste

Only 4 PHCs having Government vehicle services and Government ambulance services are available in only 4 PHCs other PHCs having outsourced ambulance (PPP) . So, there is requirement of ambulance in 12 PHCs and there is requirement of vehicles in 12 PHCs.

PHC level Vehicle details

Sl. No.	CHC/ Block	Ambulance		Vehicles
		Own	Outsourced	
1	Amdabad	0	1	0
2	Azamnagar	0	1	0
3	Balrampur	0	1	0

4	Barari	1	0	1
5	Barsoi	1	0	0
6	Dandkhora	0	1	0
7	Falka	0	1	1
8	Hasanganj	0	0	0
9	Kadwa	0	1	1
10	Katihar	0	0	0
11	Korha	1	0	1
12	Kursela	0	1	0
13	Manihari	1	0	0
14	Mansahi	0	0	0
15	Pranpur	0	1	0
16	Sameli	0	0	0

The gaps in accommodation are huge. PHCs do not have the required number of quarters for Doctors as well as nurses .Whatever the existing quarters are there, they are in a very sorry stage. There is acute shortage of quarters for Paramedics and other staff at all the PHCs. In the campus residential accommodation for all staff is required not just for few is very necessary if we really want to have our PHCs working for 24 hours a day and 7 days a week.

Most of the quarters for the Doctors, Nurses, paramedics and other staff needs to be immediately renovated and quarters need to be constructed according to the minimum manpower norms for CHCs.

As far as APHCs are concerned, All the 25 APHCs are functioning without any facilities with damaged building .Building condition is very poor. All APHCs are devoid of electricity, lacking of water supply because Hand pumps are not functioning properly. There are no residential facilities for staff.

Existing building need to be taken over and upgraded according to the IPHS norms. All APHCs , which do not have facility for electricity should be immediately provided with the electricity. Existing APHCs, which do not have any kind of water supply need to be provided with a bore from where they can have their own water supply round the clock. Staff quarters need to be built for all the Existing APHCSs and Proposed 35 APHCs. This will definitely help in the long run of a dream of APHCs functioning for 24 hours a day and 7 days a week.

Out of 257 existing Health Sub-Centre 79 HSCs are have own building , 42 HSCs are running in rented building . Almost all the Government buildings are in poor conditions and immediately need renovation / new constructions are required. Rennovation/ Constructions works is going on at 36 HSCs.
As per IPHS norms 262 new more sub-centers are required to provide better health facility to the community.

Manpower Availability and Gaps in manpower

There are major gaps in Human resource in Health sector in Katihar District . As Per IPHS norms there are 4 specialist and 01 Physician at every PHC(CHC) . As per norms in Katihar for 16 PHCs there are 78 post of Contractual MOs is sanctioned , out of which 67 are specialist MOs and rest of the 11 should be of general MOs . Out of 78 MOs there are only 29 MOs are posted , out of which only 01 is specialist MO and rest of the MOs are general MBBS who has been appointed as stop gap arrangement due to non availability of Specialist MOs.

Slno.	Name of the Post	Sanctioned Post	Posted	Vaccant
1	Medical Officers (R)	120	76	44
2	Medical Officers (C)	78	29	49
3	Grade – A Nurse (R)	28	17	11
4	Grade – A Nurse (C)	104	69	35
5	LHV	63	28	35
6	Pharmacists	46	2	44
7	Lab Technicians	42	3	39
8	X- Ray Technicians	4	4	0
9	Sanitation Inspector	12	2	10
10	ANM (R)	362	325	37
11	ANM (C)	345	88	257
12	Computer	11	9	2
13	Store Keeper	3	2	1
14	O.T Assistant	3	01	2
15	Driver	11	8	3
16	BHW	43	32	11
17	BHI	11	2	9
18	HW	48	1	47
19	Dresser	42	11	31
20	MWA	43	36	7
21	FWA	35	27	8
22	BEE	12	0	12
23	HE	19	17	2

IX. Strengthening Infrastructure and Human Resource

Health Sub Center

Objective	Constraints	Strategies	Activities	Indicator
To make all the HSCs functional	Out of 257 HSC only 85 having own building & 42 are running in rented building	Strengthening all the existing HSCs that's have own building by proper utilization of Untied fund	Running water facility by using untied funds	No. of HSCs have running water facility
	Lack of appropriate furniture and stationery		Procurement of furniture and stationery as per IPHS norms	No. HSCs that are provided furniture & stationery
	Lack of equipments		Procurement of equipment as per IPHS norms	No. of equipment procured
			Supply of equipment to HSCs	No. of HSCs have supply of those equipments
	Lack of Human resource out of 345 sanctioned post of ANM (R) 257 post are vaccant	Recruitment and selection of ANM (R)	Publication of vacancies in the newspaper	No.of advertisement published
	Rate of turn-up in interview is very low		Organise Walk-in - interview on every first week of the month for the selection of ANM	No. of Interview held per month
			Hiring of 25 ANMs for out reach services.	No. of ANM selected

	Lack of Nursing skill	Skill development programme for contractual ANM	Selection of Training sites	No. of training sites selected
			Development of training sites	No. of training sites developed
			Identification of Trainer	No. of trainer identifed
			Training of ANM on SBA and other primary health services	No. of ANM trained on SBA
Construction/ Rennovation of Existing HSCs and proposed 184 HSCs	unavailability of Land only 18 HSCs have availability of land	Community mobilization for land donations	Involvement of opinion leader, and PRIs for Community mobilization for land donations .	No. of meetings held with and by the opinion leaders and PRIs for land donations
				Land donated for HSCs (No.)
			Meeting with C.O/B.D.O in the chairmanship of District Magistrate for availability of land	No. of meetings held
				Land available for HSCs (No.) by the administrative
		To make 169 building less HSCs Functional in rented building .	Provision for rented building	Fund available or not
			Fund availability	
			Procurement of furniture and equipment	No. of furniture and equipment

			as per IPHS norms	procured
	Irregular/non payment of rent of 42 rented building	Regularising the rent payment	Regularising the payment of rent through PHC untied fund/RKS fund	Rent paid through PHC untied fund/RKS fund in no.
Strenghtening the HSCs by 100% utilization of untied funds	Late disbursement of untied funds by DHS to PHCs again delay by the PHC	Timely disbursement of fund	Disbursement of fund on time by the DHS to PHC and PHC to HSC	No. of Bank Account opened
	No bank account in the name of ANM		Opening of Bank Account in the name of ANM	
	Lack of awareness about the nature of job done from the untied funds	Capacity building of account holder	Training of account holder on account operation , book keeping and nature of jobs done by the untied fund.	No. of training held
Strenghtening the Service delivery at HSC level	Non availability of drug kits as per IPHS Norms	Strenthtening of DHS on Drug Procurement	Identification of Need	No.of need/indent identified/ received
			Procurement of drugs and equipments by the DHS	No. of Drugs and equipment procured
			Supply of drugs and equipments as per need	No. of drugs and equipment Supplied to HSCs
	No supply of even basic drugs at HSC	Appointment of contractual Storekeeper at DHS	Provision by the S.H.S ,Bihar for the contractual appointment of	

			Storekeeper	
	Irregular presence of staffs	Social Audit	Community mobilisation	Rate of absenteism is decreased
			Construction of Staff Quarter	No. of quarter prepared
	No ANC at HSC level	Phasewise strengthening of 85 HSCs for conducting ANC atleast one day in a week as per IPHS norms.	Training of ANMs on ANC and SBA	No. of training held
			Supply of drugs and equipments as per need	No. of drugs and equipment Supplied to HSCs
Promotion of Social audit	Lack of knowledge and level of awareness about the service delivery system	IEC/BCC activities to increase the level of awareness .	Displaying all the services (Citizen's charter) provided by the HSCs at Sub centre as well as prominent places of the villages	No. of Citizen's charter diplayed
		Strenghtening Village Health and Sanitation Committee .	Formation of Village Health and Sanitation Committee	No. of VHSC formed
			Opening of Bank Account of Village Health and Sanitation Committee	No. of bank Account opened for VHSC

			Capacity building of account holder of village Health and Sanitation Committee on account operation & nature of works may be done by the untied funds	No. of training held

Additional Primary Health Centers

There are 25 APHC functioning in the district and 34 more proposed to be established in next 5 years but as per IPHS norms 27 more APHCs required

Objective	Constraints	Strategies	Activities	Indicator
To make all the 25 existing APHCs functional	Lack of proper building/infrastructure	Strenghtening all the existing APHCs that's have own building by proper utiilisation of Untied fund	Running water facility by using untied funds	No. of APHCs have running water facility
	Lack of appropriate furniture and stationery		Procurement of furniture and stationery as per IPHS norms	No. APHCs , those provided furniture & stationery
	Lack of equipments		Procurement of equipment as per IPHS norms	No. of equipment procured
			Supply of equipment to APHCs	No. of APHCs have supply of those equipments
	Lack of Human resource out of 104 sanctioned post of contractual Grade-A 35 post are vaccant	Recruitment and selection of Human resource	Publication of vacancies in the newspaper	No.of advertisement published

	Out of 50 sanctioned post of ANM(regular) 15 Post are vacant		Organize Walk-in - interview on every first week of the month for the selection of Con. Grade-A nurse	No. of Interview held per month
	Out of 50 sanctioned post of Medical officers 31 posts are vacant			No. of Grade -A selected
	Most of the APHC staffs are deputed to respective PHC hence APHC are defunct	Diminish the deputation policy	sending back to staff at their respective APHCs	Increase in Human Resource
	Lack of Nursing skill	Skill development programme for contractual Grade-A nurse	Selection of Training sites	No. of training sites selected
			Development of training sites	No. of training sites developed
			Identification of Trainer	No. of trainer identifed
			Training of Grade-A on SBA and other primary health services	No. of Grade-A trained on SBA
Construction/ Renovation of Existing APHCs and proposed 34 APHCs	unavailability of Land	Community mobilization for land donations	Involvement of opinion leader, and PRIs for Community mobilization for land donations .	No. of meetings held with and by the opinion leaders and PRIs for land donations
				Land donated for APHCs (in No.)
			Meeting with C.O/B.D.O in the chairmanship of District Magistrate for availability of land	No. of meetings held
				Land available for APHCs (in No.) by the administrative initiative

Strengthening the Service delivery system at APHC level	Non availability of drug kits as per IPHS Norms Irregular presence of staffs No ANC & OPD at 20 APHCs		Identification of Need	No. of need/indent identified/ received
		Strengthening of DHS on Drug Procurement	Procurement of drugs and equipments by the DHS	No. of Drugs and equipment procured
			Supply of drugs and equipments as per need	No. of drugs and equipment Supplied to APHCs
		Social Audit	Community mobilization	Rate of absenteeism is decreased
		Phase wise strengthening of all the APHCs for conducting OPD & ANC at least 3 day in a week	Deployment of staff including MO ,ANMs , Grade-A nurse , Pharmacists etc.	No. of Staff Deployed
Promotion of Social audit	Lack of knowledge and level of awareness about the service delivery system amongst the masses	IEC/BCC activities to increase the level of awareness .	Displaying all the services (Citizen's charter) provided by the APHCs at centre as well as prominent places of the villages	No. of Citizen's charter displayed
		Strengthening Village Health and Sanitation Committee .	Formation of Village Health and Sanitation Committee	No. of VHSC formed

			Opening of Bank Account of Village Health and Sanitation Committee	No. of bank Account opened for VHSC
			Capacity building of account holder of village Health and Sanitation Committee on account operation & nature of works may be done by the untied funds	No. of training held

Primary Health centers: There are 16 PHCs in Katihar district , 03 Referral hospitals and a District hospital. Out of 03 Referral Hospital Manihari Referral Hospital is not functional and the Barari and Barsoi PHC are too, not functional because they are situated within distance of one K.M from their respective Referral Hospital. Primary Health Center , Katihar , Sadar Block only rendered the services of OPD.

Objective	Constraints	Strategies	Activities	Indicator
To make all the 16 existing PHCs functional as per the IPHS norms (30 bedded)	Lack of proper building/infrastructure	Up gradation of PHCs into 30 bedded CHCs by phase wise manner	Selection or making priority list of PHCs which has been up graded into CHCs in phase wise manner.	How many PHCs has been selected for up gradation
			Preparation of estimate for up gradation of PHCs into CHCs	No. of PHCs have got administrative and technical approval for up gradation
				No. of PHCs has been upgraded into CHCs
	Lack of appropriate furniture and stationery		Procurement of furniture and stationery as per IPHS norms	No. of PHCs , those provided furniture & stationery as per IPHS norms
	Lack of equipments	Strengthening all the existing PHCs that's have own building by proper utilization of Untied fund	Procurement of equipment as per IPHS norms	No. of equipment procured
			Supply of equipment to PHCs	No. of PHCs have supply of those equipments
	Lack of Human resource- out of 67 sanctioned post of Contractual Specialist Doctors only 01 Specialist MO Posted	Recruitment and selection of Human resource	organise online appointment once in every month for appointment of contractual Doctors	No. of On-line Selection processes conducted
				No. of contractual Doctors appointed.

			Empanelling Gynaecologists for PHCs to provide ANC/PNC services at fixed day	No. of Gynae empanelled for ANC/PNC
			Hiring Paediatrician for PHCs to OPD services at fixed day.	No. of Paediatrician hired
		Hiring private specialist Doctors , where post is vacant	Empanelling Gynaecologists on CALL BASIS for conducting institutional deliveries, providing Essential and Emergency Obs Care at government facilities	No. of Gynae empanelled on call basis for CEmoc/BEmoc
			Hiring Anesthetists for facilities that have vacant Anesthetist positions	No.of Anesthetists hired
	Out of 46 sanctioned post of Pharmacists 44 post are vacant , out of 42 sanctioned post of Lab. Technician 39 are vacant .		Appointment of Pharmacists and Lab. Technician on contract basis	No. of Pharmacists and Lab. Technician on appointed contract basis
	Irregular Human resource policy (transfer & Posting)		Preparation of a Proper standing order for transfer and Posting of Doctors	

	Lack of Proper training to Health personnel on latest technique	Skill development programme for Health Personnel	Selection of Training sites	No. of training sites selected
			Development of training sites	No. of training sites developed
			Identification of Trainer	No. of trainer identifed
			Training of ANM/Grade-A on SBA and other primary health services	No. of Grade-A and ANM trained on SBA
			Training of MOs on CEmoc/BEmoc	No. of MOs trained on CEmoc/BEmoc
			Training of MOs on Anesthesia	No. of MOs trained on Anesthesia
Construction/ Renovation of Existing PHCs	Delay/ performance of works is very slow by Public Work Department (Building Division)	Constitution of Separate Engineering department for construction/renovation of Health facilities	Appointment of Civil Engineers.	No. of Engineers appointed
Strengthening the Service delivery system at PHC level	Non availability of drug kits as per IPHS Norms Irregular presence of staffs	Strengthening of DHS on Drug Procurement	Identification of Need by MOICs with the help of BHM/ MOs	No. of need/indent identified/ received

Promotion of Social audit	Lack of knowledge and level of awareness about the service delivery system amongst the masses	IEC/BCC activities to increase the level of awareness .	Procurement of drugs and equipments by the DHS	No. of Drugs and equipment procured
			Supply of drugs and equipments as per need	No. of drugs and equipment Supplied to APHCs
			Displaying all the services (Citizen's charter) provided by the PHCs at centre as well as prominent places of the villages	No. of Citizen's charter displayed
			Capacity building of Member of RKS on Various issues such as aims & objective of RKS , nature of works may be done by the RKS funds	No. of training held

REPRODUCTIVE AND CHILD HEALTH

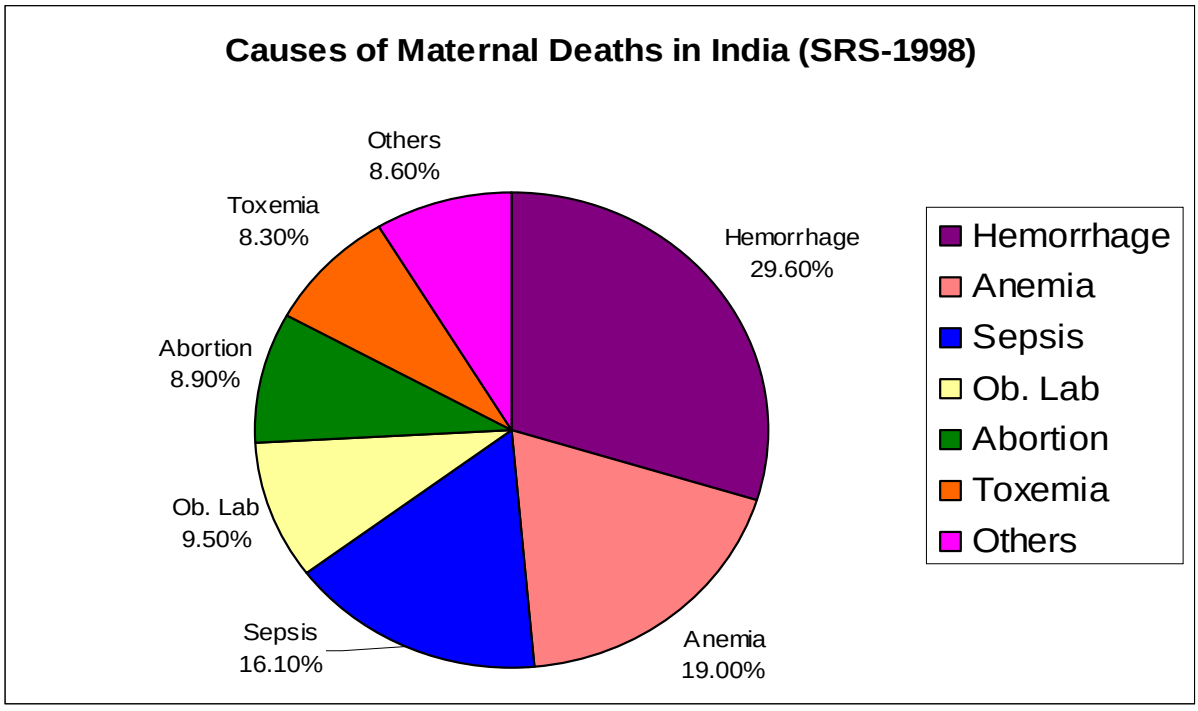
A.1 Maternal Health

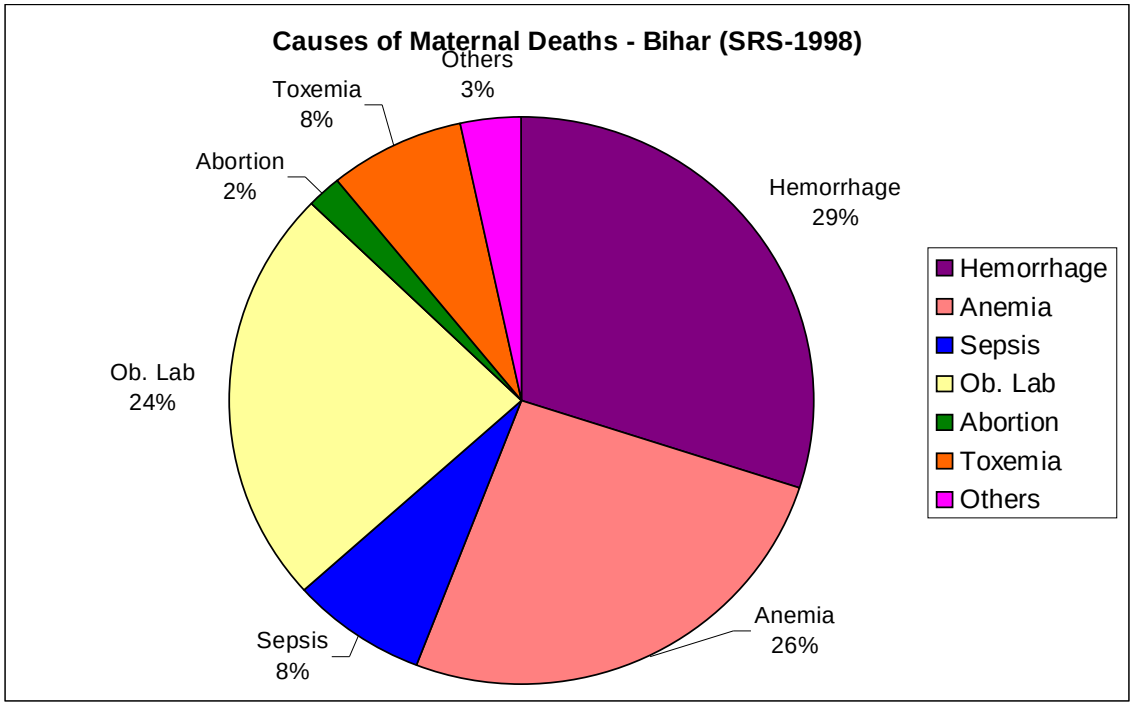
Under the RCH program all aspects of women's reproductive health across their reproductive cycle, from puberty to menopause are covered. RCH program addresses the needs that have emerged over years of implementing Family Welfare Program.

Under this Programme the emphasis shifted to decentralize planning at district level based on assessment of community needs and implementation of programme at fulfillment of these need. New interventions such as control of reproductive tract infection, gender issues, male participation and adolescent health and the Family welfare program are also taken

Components of RCH

Effective Maternal & Child health care;
Increased access to contraceptive care;
Safe management of unwanted pregnancies;
Nutritional services to vulnerable groups;
Prevention and Treatment of RTI/STI;
Reproductive Health Services for adolescents;
Prevention and treatment of Gynecological Problems;
Screening and treatment of cancers; especially uterine, cervical and breast.





Goals

The overall goal is to improve the quality of life of the people living in Katihar district of Bihar by Reproductive and Child Health and stabilization of population

Reduce MMR from 389 (1998) to 100 per 100000 live births by 2010

Maternal Health

Goal/Objectives	Constraints	Strategies	Activities	Indicator
1. To improve coverage of antenatal care to 32.5 % to 100% by 2010.	Lack of awareness about importance of ANC .	Awareness generation about importance of ANC at Community level	Social mobilization to create demand in the community for ANC clinics	Increase in ANC registeration

			Use local resources in terms of ASHA , AWC and Panchayat members to inform the ANMs about teenage pregnancy and first time pregnancy	No. of teenage & first time pregnancy reported
			BCC in the community on the importance of seeking timely ANC	No. of BCC activities held
			Organizing weekly ANC clinics to improve early ANC registration and antenatal services.	No. of Weekly ANC Clinics organised
To strengthen HSC and APHC for providing outreach maternal care	Lack of adequate infrastructure & Human resources	Organising Regular ANC clinics at Health Centers level	Urgent need to fill vacant Posts.	No. of Vacancy filled
			Plan for establishment of APHCs or sub-centre to cover underserved areas and change the uneven distribution of public health institutions	No. of APHCs and Sub center made functional
		Organising out reach ANC sessions	Organizing out reach ANC sessions in sub center/villages by LHVs assisted by ANMs on fixed days	No. of out reached ANC sessions organised and no. of ANC registeration
			Organizing ANC clinic sessions in remote areas through mobile health units.	No. of ANC sessions held by mobile health units and No. of ANC registeration
			Empanelling Gynaecologists for gynaecology OPD in under or un served areas	No. of visits made & cases attained by Pvt. Gynecologist

	Irregular supply of drugs & equipments	To streamline the logistics system and its management	Appointment of storekeeper on contract basis	No. of Store keeper appointed
			Need based drug, Instrument procurement and transportation.	No. of drugs procured
To improve the service delivery system	Lack of Nursing Skill	Capacity building of staff at Maternal Health	Identification of training sites and trainers (SBA Training)	No. of training sites and trainers identified.
			Development of training sites	No. of training sites developed
			Training of ANM & Grade-A on ANC and SBA	No. of ANM & Grade-A trained on ANC and SBA
	Apathy behaviour of health personnel towards the beneficiary	Changing the attitude of service providers and improving their counseling skills	BCC and counselling sessions for service providers	No. of such sessions held and no. of ANC registeration
To strengthen PHC s for providing maternal care	Lack of staff and specialist MOs	Organizing weekly ANC clinics in PHCs	Deployment of Gynaecologist from District hospital and Referal hos. to PHCs for organising weekly ANC clinics.	No. of Weekly ANC clinics organised at PHCs
			Have a fixed day and time at PHC and Sub Centers for conducting ANC clinics	Calender for ANC prepared or not and ANC clinics organised or not as per schedule

		Regular visit at PHC .DH/Ref. Hospital by private gynecologist.	Developing linkages with private practitioners for early ANC registration and providing ANC services	No. of linkages established with Pvt. Practitioners
			Involvement of NGOs	No.of NGOs identified and involved
			Empanelling Gynaecologists for gynaecology OPD in PHC	No. of visits made & cases attained by Pvt. Gynecologist
	Hard to reach areas	Provision of Mobile Medical Unit	Have a regular mobile team visiting difficult / remote areas on fixed day and time.	No. of hard to reach villages visited by MMU
		Accreditation of private providers for eligible for benefits under JBSY.	Identification of Pvt. Service providers	No. of Pvt. Service providers identified and accrediated
			Accrediation of Pvt. Health facility under JBSY .	
To increase the institutional deliveries to 12.4% to 75 % by 2010	Lack of infrastructure /Facility at APHC and PHCs	Make all the existing 25 APHCs functional for 24*7 Delivery services.	Appointment and availability of Staff nurses & ANM to all PHCs/APHCs.	No. of Vaccant post filled
			Training of Staff nurses & ANM for skilled birth attendants	No. of ANM & Grade-A trained on SBA
			Establishment of Urban Health Centre and deployment of Human resources for delivery services.	No. of Urban Health centre established and conducting Ins. Delivery

			Appointment and availability of ANMs to all HSCs (Trained Skilled birth attendants)	No. of Vacant post filled
			Improve labour rooms/maternity wards and service environment in PHCs as per IPHS.	No. of labour rooms/maternity wards are upgraded
			Supply and support – drugs and supplies, equipment/instrument..	No. of drugs and equipments supplied to Health facility.
			Monitoring of services through Block medical officers and Block Health Managers.	Increase in ANC registeration
			Accrediation of Pvt. Health facility under JBSY .	No. of Pvt. Service providers identified and accrediated
To increase access to Emergency Obstetric Care for complicated deliveries.	At Katihar ,Govt. health facilities have not at all any infrastructure at all in terms of staffs and equipment to tackle CEmOC	Strengthen FRUs and PHCs for CEmOC services	Equipping the FRUs and PHCs to provide basic and/ or comprehensive emergency obstetric health care.	No. of FRUs and PHCs are equipped for Bemoc/CEmoc
			Appointing required health professionals such as gynecologists, anesthetists and staff nurses to provide EmOC/BEmOC services	No. of Specialist and other para medical staff appointed
			Empanelling Gynecologists on CALL BASIS for conducting institutional deliveries, providing Essential and Emergency Obs Care at government facilities	No. of visits made by & cases taken up by Pvt. Gynecologists

			. Hiring Anesthetists for facilities that have vacant Anesthetist positions	No. of Anesthetist hired
			Ensuring adequate and safe blood supplies by strengthening existing blood banks /storage or opening new blood banks/storage in the district.	No. of Blood banks/storage strengthen/established
			Establishing linkages/Accreditation with private nursing homes having adequate facilities to provide emergency obstetric care services	No. of Private nursing home accrediated for Cemoc
Monitoring & evaluation of Services		Monitor quality of services & utilization	Make district quality assurance committee functional. Quarterly visit of District Hospital/Ref. Hospital and PHCs for monitoring of quality of services provided	No. of Visits made by District Quality Assurance Committee No. of District Hospital/Ref. Hospital and PHCs monitored by the QAC

POST PARTUM CARE

DLHS-3 report regarding Postpartum services show that 15.3 % women received PNC withing 48 hours of delivery on the other hand 61.9 % of women got atleast one TT injection during their pregnancy it reveals that services given to pregnant women in this regards are much higher than PNC and for that the cause could be poor home visits by the ASHA/AWW/ANMs

To increase coverage of post partum care to 15.3 % to 100% .by 2010	At Katihar 99.9 % of the pregnant mother leave the health institution immediately after the bith of baby	Provision for at least 48 Hours stay at health institutions after delivery	Availability of bed and other facilities for the mother and neonates	No. of bed available for PNC
			Provision for JBSY benefits, only for those who resided in health facilities at least for 48 hours after the delivery	Increase in PNC
			Provision for MAMTA for PNC & Neo Natal care at every PHCs/ Referal Hospital.	No. of Facility have MAMTA
	Lack of follow up of cases	Follow-up (PNC) and monitoring by Link workers and health workers	Monitoring and follow up of cases by ASHA/LHV and ANM during their home visits especially for post natal care	
			Monitoring of ASHA/LHV and AN M home visits by Block Health Managers.	Increase in coverage of PNC
				No. of home visits made
			Provide neonatal care and integrated mother-child care during PNC visit.	Increase in PNC and Neonatal care

			Link up the AWW along with the ANM to use IMNCI protocols and visit neonates and mothers within three days and six weeks of delivery.	
			Use of Algorithm during PNC home visits by ANMs for IMNCI.	No. of home visits made within three days and six weeks of delivery
			Sensitizing the MOs/ANM/LHV/AWWs on the need for providing care to women and new born during post natal period (as part of IMNCI training):	
	Lack of coordination between the ICDS and Health deptt.	Convergence between the ICDS & health Department for better coordination.	Link up the AWW along with the ANM, LHV ,HW, to use IMNCI protocols and visit neonates and mothers within three days and 3 checks up	Decrease in MMR and IMR
	Lack of adequate staff for PNC and follow up of cases	Involvement of alternate trained staff in PNC	Involvement of Gramin Dais and ASHA in PNC	Increase in coverage of PNC
			Incentives for Dais & ASHA for PNC	No. of Dais & ASHA engaged for PNC
	Lack of knowledge about the importance of PNC amongst beneficiary	IEC/BCC for awareness generation about the PNC	Undertake BCC among women on the need of contacting health personnel after home delivery.	No. of BCC activities undertaken
	Poor monitoring of services	Monitoring & evaluation by MOs and Block Health	Monitoring by Medical officer, BHM and MOIC of home visits made by	No. of Home visits

			made by the health workers for PNC
Managers	ANM ,LHV , ASHA and Gramin Dais for postpartum care	Increase in PNC	

SAFE ABORTION SERVICES

The outcomes of pregnancy are live births, stillbirths, spontaneous abortion and induced abortion. There were out of total reported pregnancies. About 90 percent of these ended as live births. The percentages of pregnancies that ended in spontaneous and induced abortions were five each, while the rest resulted in stillbirths. The incidence of pregnancy wastage in the absence of external intervention is more among women in the age group of 20-29 and 35-39 and many times it leads to maternal mortality and life time risk to the mother. To reduce this , a fully equipped MTP centre should be available at every PHC & CHC level.

Objective	Constraints	Strategy	Activities	Indicator
To increase access to early & safe abortion services	Lack of MTP services at health facilities	Procurement of essential equipment such as Vacuum extractor & Manual Vacuum aspirator	Ensure availability of MTPs in all FRU and PHCs	No. of Health facility where MTPs services available
	Lack of training about the MTP technique	Capacity building of Health personnel on MTP	Identification of Master trainers for MTP	No. of Master trainer identified
			Training of Trainers on MTP	No. of TOT organised
			Training of health personnel on MTP	No. of Health personnel trained on MTPs

		Use of private facilities for MTP training.	No. of Private facilities used for MTP training
	Accrediation of Private service providers/NGO Hospital for MTP	Encourage private practitioners to get their facilities recognized for providing MTP services.	No. of Private practitioners recognized for MTPs services.
Lack of knowledge about the legal status of MTP	Conduct IEC/BCC activities	Disseminate information regarding the legal status of MTP and its availability by CBV, FHW, ANM, and ASHA by one to one meeting and group meeting .	No. of BCC activities conducted
		Establishment of hoarding at prominent places displaying the information regarding the legal status of MTP	No. of Hoarding established
Lack of knowledge about the safe abortion services	Conduct BCC activities	Conduct IEC/BCC activities for spreading awareness regarding safe abortion services in the rural community.	No. of BCC activities conducted
		Promote culture of counseling among the providers.	No. of Grass root workers to be strengthened in MTP counseling.
		Grass root workers to be strengthened in MTP counseling.	

A.2 Child Health

Infant and under five mortality rates are excellent indicators of health status of the children. In India there is no system for collection and analysis of data on morbidity during childhood. In the absence of morbidity data, available mortality data and analysis of causes of death have been utilized for drawing up priority interventions for improving child health. Ongoing major intervention programmes in child health include:- Essential new born care. Programmes for reducing mortality due to ARI and diarrhea and Immunization to prevent morbidity and mortality due to vaccine preventable diseases; E food and micronutrient supplementation programmes aimed at improving the nutritional status; Improved access to immunization, health care and nutrition programmes have resulted in substantial decline in IMR over the last five decades. However it is a matter of concern that the decline in prenatal and neonatal mortality has been very slow.

The major killers of children are – acute respiratory infections, dehydration due to diarrhea, measles and neonatal tetanus and in some areas malaria. The high prevalence of malnutrition contributes to over 50% of child deaths. In India, a significant proportion of child deaths (over 40% of under-five Mortality and 64% of infant mortality) take place in the neonatal period. Apart from infections, other causes like asphyxia, hypothermia and pre-maturity are responsible for neonatal mortality. About one-third of the newborns have a birth weight less than 2500 gram (low-birth weight). A significant proportion of mortality occurs in low-birth weight babies

Goal- To bring down the Infant Mortality Rate (IMR) from the present level of 60 per thousand live births to less than 30 per thousand live births by 2010.

Objectives	Constraints	Strategies	Activities	Indicator
To increase % of colostrums feeding from 13.8% to 100% within 1 hr of birth	Myths and misconception about the colostrums & breast feeding	BCC activities by ASHA/ MAMTA and ANM for colostrums feeding .	BCC activities will be taken up for Changing behavior and Practices about Importance of breast feeding amongst the community at the time of delivery.	No. of BCC activities taken up for promotion of breast feeding

To increase exclusive breastfeeding among 0-6 month children from 14.8% to 100%	Myths and misconception about the breast feeding	Communication campaign will be designed to improve awareness about advantages of breastfeeding and exclusive breastfeeding for 6 months.	One to one meeting by ASHA/ LHV/AWW worker with mother for promoting Breast feeding Dissemination of information about importance of breast feeding during VH&N Days	No. of BCC meeting held % increase in breast feeding
			Dissemination of information about importance of breast feeding during Mahila Mandal meeting at AWC.	No of women provided the information regarding the breast feeding
To increase complimentary feeding among 6 month of children from 85% to 100%	Lack of knowledge about the importance of complimentary feeding Myths & misconception about the complementary feeding	6 days integrated training program for ANMs and MOs on importance of counseling mothers about breastfeeding, new born care, management of diarrhea and ARI.	Identification of Master trainer Training of trainer on breast feeding ,complimentary feeding Training of trainee on breast feeding , complimentary feeding	No. of Master trainer identified No. of TOT on breast feeding No. of health personnel trained on breast feeding
Providing Essential New Born Care at	Lack of training of Health	Capacity building of Health personnel on New born care	Training of Medical Officers on new born care	No. of MOs trained on NBC

Facility level	personnel on New born care		Training of Staff Nurses and ANMs on new born care	No. of Staff nurses and ANM trained on NBC
			Training to skill birth attendants on new born care especially on danger signs	No. of SBA trained on NBC on danger signs
	Lack of Infrastructure and necessary guidelines at health facilities for new born care	Procurement of logistics and dissemination to health facilities	Supply of essential drugs and supplies on neonatal care	No. of drugs supplied on NNC
			Supply of equipments like neo natal respirator at PHC level onwards	No. of PHCs have respirator and others equipment like incubator
			Adaptation of Training manual for neo natal care	No. of Health facilities adopted the Manual for NNC
			Identification of training sites	No. of Training sites identified
			Provision of service guidelines for neo natal care	No. of Health facilities adopted guidelines for Neo Natal care
			Supply & display of IEC materials on neonatal care	No. IEC materials displayed
Providing Essential New Born Care at	Lack of Knowledge about the neo	Capacity building of community as well as health	Training of AWWs/ ASHA /ANMs/LHVs on neo natal care	No. of AWW/ANMs/LHVs/A

Community Level	natal care	personnel on neo natal care	Training on Identifying danger signs of hypothermia, hypoxia and sepsis to ASHA, AWW .	SHA trained on NNC
			Training of community based /volunteers on the community based interventions	No. of Volunteers trained
			Educating the community about danger signs	No. of people educated
		Dissemination of information regarding home based neo natal care	Make Community Aware about home base neonatal care and need for timely referral of sick neonates and also for post neonatal interventions	Decrease in IMR
			BCC for promoting newborn care, exclusive breastfeeding and complementary feeding, immunization, polio eradication etc	No. of BCC activities taken up for hoe based NNC
			IEC/ Community mobilization for IMNCI	No. of IEC activities taken up for IMNCI
			Advocating exclusive breast feeding	No. of advocacy meeting held

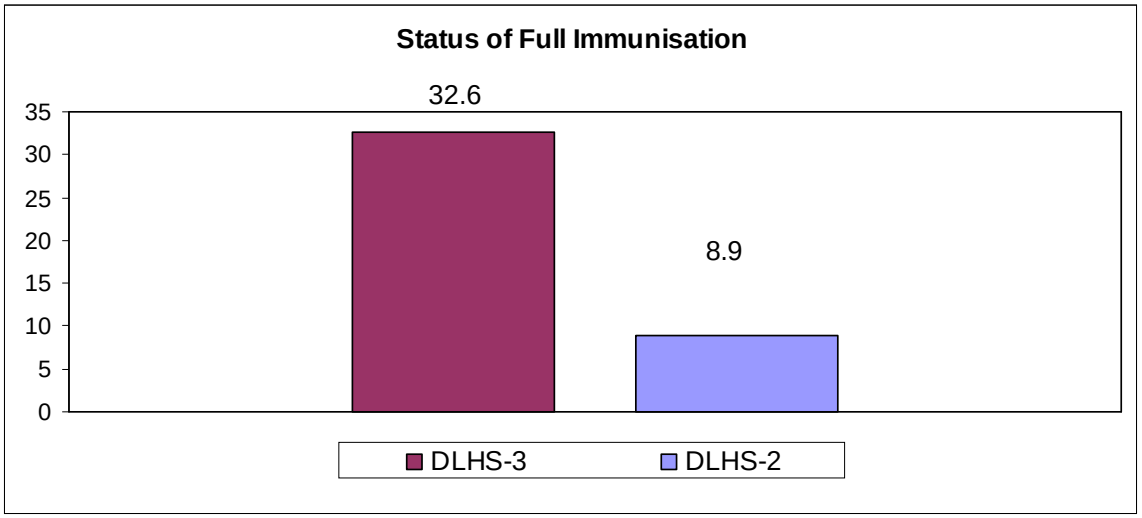
Providing critical New born care at FRU level.	Lack of facility in terms of equipment , Human resources at FRUs for New Born care	Upgrading FRUs & Capacity building of Health personnel on New Born Care	All the FRU and PHC in a phase manner will be strengthened both in terms of increasing the technical skills of the health personnel, as well as supplying adequate drugs, equipments and logistics to meet the health and care needs of the children.	No. of FRU/PHCs strengthened
			Training of Pediatrician	No. of Pediatrician trained
			Support for Pediatrician on call basis	No. of Pediatrician empanelled for on call basis
			Supply of need based equipment and instrument (Baby warmer, neonatal respirator etc.)	No. of equipment purchased and distributed to health facilities
			Supply of need based drugs, medicines and supplies	No.of PHCs have need based medicine dupply
			ANM will be encouraged to make conscious effort during their outreach immunization programs at least once to make it convenient to reach out to the sick children and refer the needy.	No. of Sick children refer by ANM during their out reach sessions
			Key stakeholders will also be sensitized on the risk symptoms & timely referrals	No. of Key stake holders sensitized

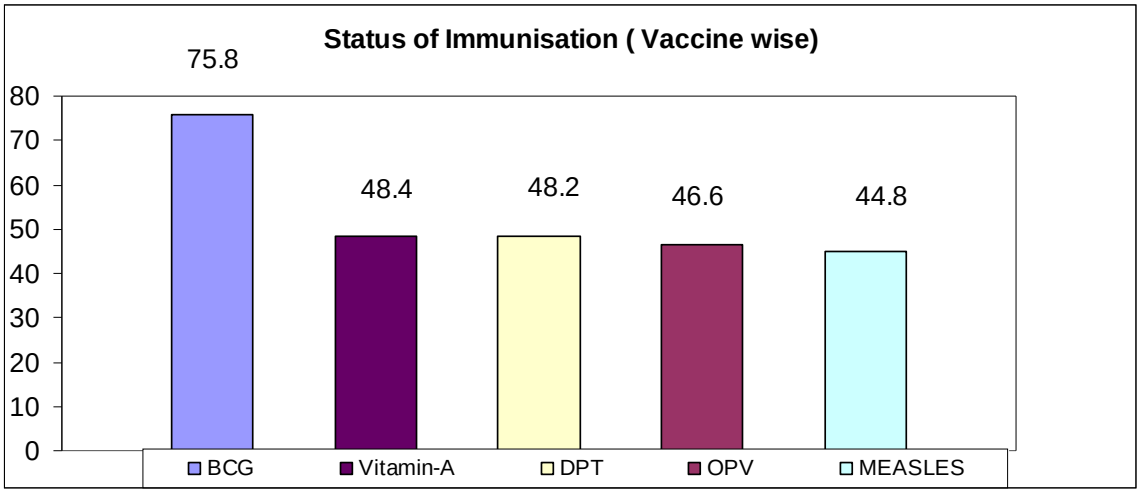
			Link up with private practitioners especially in tribal and urban slum areas to provide services to the children.	No. of Private practitioners empanelled
			Advocacy among community members on the need to be alert for addressing timely health needs of the sick child. IEC and BCC activities will be accordingly developed.	No. of advocacy meeting held for community members
Management of Diarohea and ARIs		To increase ORS distribution from 32.6 % to 75%	Supply ORS packets & Cotrimoxazole tablets through AWWs	No. of ORS packets and cotrimoxazole tablets distributed.
			Referral of sick child to higher level of care by ASHA Divas initiative	No. of referral made by ASHA
		To increase treatment of diarrohoea from 80.9% to 100% within two weeks	Promoting home available oral dehydration fluids	Decrease in IMR
		To increase treatment of ARI/Fever in the last two weeks from 75.9% to 100%	Training of AWWs and FHW on recognizing danger signs	No. of AWWs/FHW trained on recognizing danger signs
			Referral of sick child to FRUs	No. of sick child referred to FRUs
		Implementing IMNCI in District to Manage sick Neo Nates and children in Phased Manner	First round of Training of trainer was organized in the year 2008.	

			Training of Health staff will be start from Month of April 2009.	No. of Health personnel trained on IMNCI
			After conclusion of all the training this will be implemented in phased manner in district.	

A.2.1 IMMUNISATION

To Strenghten/accelarate the Immunisation programme the GOB launches **MUSKAN EK ABHIYAN** programme in the year 2007 . And this programme has a very positive impact on immunisation . The rate of full immunisation goes up significanlty from 8.9% (DLHS-2) to 32.6 % (DLHS-3) . But when we compare this progress to State and National level we find that we are far behind and we have to do lot of hard work to achieve 100% full immunisation .





Drop out rate between BCG & Measles

Generally the gaps between BCG and measles were up to 5% but according to the above chart (Dlhs-3) it raises up to 31 %. It's a very high and the matter of great concern. The reason behind it is

- The beneficiaries of BCG were migrate to other places.
- Poor service delivery
- unavailability of vaccines
- myths and misconception of community about the immunization
- Hard to reach immunization sites

It is necessary to break the gap between BCG and Measles. So we will look in matter in deep and try to provide all the children BCG vaccine as well as Measles including all vaccine in between like DPT, OPV etc.

Goal - To reduce the mortality of children from vaccine prevented diseases

Objective	Constraints	Strategies	Activity	Indicator

To Increase in percentage of fully protected children in 12-23 months as per national immunization schedule to 32.6 % to 75 %	Human resource shortage at all levels	Appointment of Staff	Publication of vaccancies	No. of Staff Selected
			Selection of staff	
			Hired retired ANMs for holding immunisation sessions in remote areas	No. of ANMs hired
	Shortage of vaccines & cold chain equipments	Streamline the procurement and supply chain of vaccines	Ensure availability of vaccines and regular immunization services/equipments in PHCs and FRUs	No. of PHCs have all the vaccines through out the year
			Fund for Local Annual Maintenance contract for Cold Chain equipment	AMC for Cold Chain equipment
	Inconsistent delivery of Vaccines & syringes to district	Emergency Vaccine/Syringes procurement fund at PHC level	Procure at least three months stock of all the vaccines at PHC level	No. of PHCs have all the vaccines and syringes through out the year
	Poor monitoring	Involvement of CDPO& Health Managers for Monitoring	Necessary guideline for Involvement of Health Managers for Monitoring	Preparation and adoption of guidelines
			Constitution of District task force for monitoring	No. of session sites monitored by DTF
	Far away immunization sites		Proper Transportation facility for Courier	No. of Courier have Transportatio

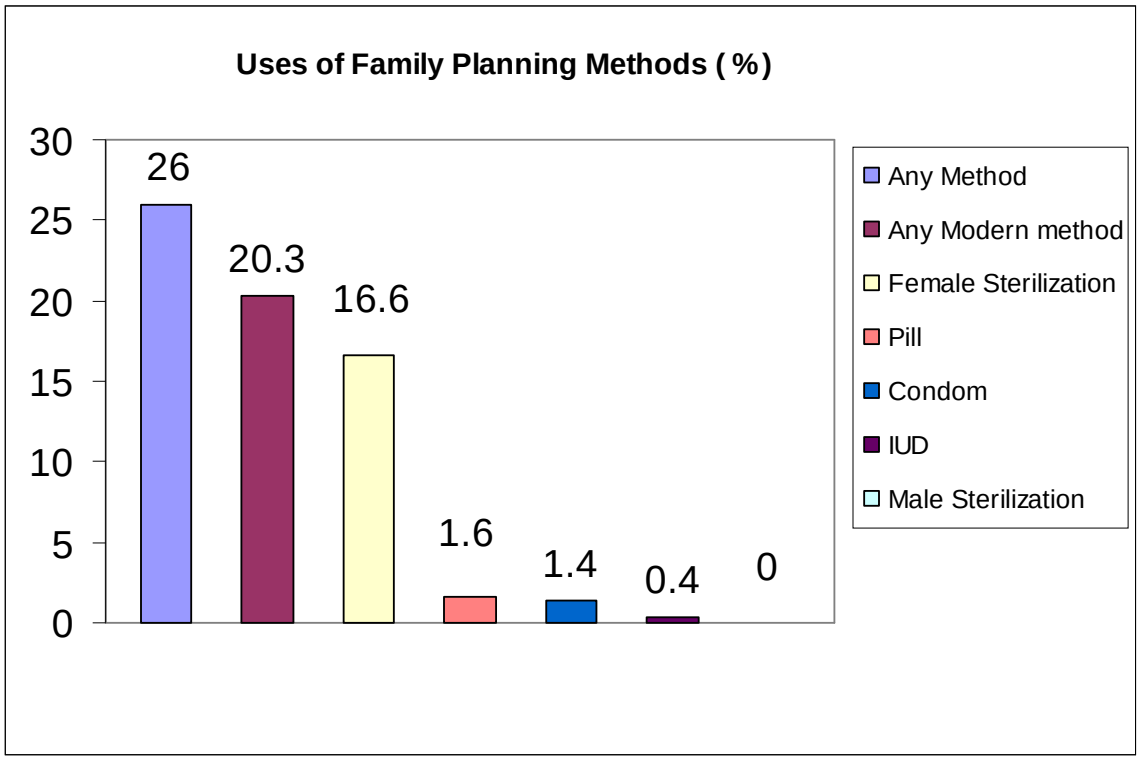
			Increase in mobility support for Vaccine Courier from Rs. 50 to Rs.100	n facility
	Myths and misconception about the immunization	BCC for awareness generation program on need for immunization	One to one meeting by ASHA/AWW with parents of the child	No. of one to one meeting held by the ASHA
			Involvement of opinion leader, religious leader and PRIs	No. of BCC meetings organized with opinion leaders/religi ous leaders
			Advertisement through local cable channels	No. of Advertisemen t on Air
			Wall writing , street play , Hoardings	No. of wall writing and street plays conducted
To strengthen the Muskan Ek Abhiyan Program	Inconsistent Payment of incentive money to ASHA/AWW/ANM	Consistent payment of incenttive money to ASHA/AWW/ANM	Responsibility of incentive payment should be given to BHM/BAM	Decrease in Back log of payments
			Provision for Incentive money for less than 80% Coverage for ANM , ASHA, AWW for their moral boost up.	Rate of immunization goes up
To Strengthen immunization in Urban areas	Inadequate health infrastructure in urban areas	Establishment of Urban Health center/Programme	Establishing immunisation sites on rent	No. of immunization sites established on rent
	Poor Coordination		Recruitment of human resources on contract for urban health center	No. of Staff recruited on contract for UHC
		PPP with Pvt. Clinics/NGO Hospital	Identification & selection of Pvt.clinics/ NGO hospital for immunisation.	No. of Pvt. Clinics / NGO hospital identified & empanelled

			Incentive for Pvt. Clinics/NGO hospital for fully immunized children	

A.3 Family Planning

The availability of family planning does more than enable women and men to limit family size. It safeguards individual health and rights, preserves our planet's resources, and improves the quality of life for individual women, their partners, and their children. In all the blocks of Katihar district the achievement with respect to target in case of Family Planning is not quite satisfactory.

The sterilisation services are largely limited to district and Referal hospitals. There is unmet need exits in the state for limiting the family, which is around 10 %. To increase access to sterilisation services, it is planned that at least one facility in each of the 16 blocks will be developed for regular sterilisation services. This facility will provide complete range of family planning services like conventional vasectomy, traditional tubectomy, laparoscopic sterilisation, non scalpel vasectomy and safe abortion services along with IUD, Oral pills Emergency contraception pills, and non clinical contraceptives. These services will be made available on all days as per the clients need.



Goal - To stabilize district population by reducing Total Fertility Rate (TFR) from 3.5 to 3.0 by 2010 , In order to achieve this, reduce current unmet need for FP by 75%.

Objective	Constraints	Strategies	Activity	Indicator
To reduce Unmet Need for Spacing	Poor performances by the out reach Blocks.	Develop at least one facility in each block to provide all FP services including terminal methods on a regular basis.	All 24 x 7 PHCs provide regular clinical contraceptive services including IUD insertions	No.of PHCs providing all F.P services
			Skill upgradation of ANMs in IUD insertion.	No. of ANM trained in IUD insertion
			Organizing IUD camps at Block level	No. of IUD Camps organized
				No. of acceptor.
			Training of service providers on Minilap , NSV & Laproscopic	No.of Mos Trained on Minilap , NSV & Laproscopic
			Organising seminars/workshop on sterlisation services	No. of seminars/workshops organised
			Upgrading facilities for sterlisation services	No.of PHCs/FRUs upgraded for sterlisation services.
		Promotion & accessibility to spacing methods & emergency contraceptive	Need based supplies of drugs , equipment and instruments	No. of PHCs have regular supply of drugs, equipment and instruments
	Unavailability of surgeon at PHCs	Increase the availability of services through	Accrediation of private providers for providing sterilization Services at their facility.	No.of Pvt. Hospital/Clinics/Nursing home NGOs accrediated

		Public-Private Partnerships	Compensation for sterilization done in Pvt. Accredited Hospitals	
			Accrediation of private providers for providing sterilization Services in camp mode	No. of Camps organised by accrediated facility
To reduce unmet Need for Terminal Methods	Poor Accessibility of operation camps		PHCs / Referal / District Hospital to provide fixed day female sterilization services.	No. of operation camps organised for female
			Compensation for female sterilization Acceptance	Amount distributed to the acceptor
				Increase in female sterlisation
	Poor PNC visits		Monitoring and supportive of ANM/LHV / AHSA to ensure that follow up services are being provided	Increase in NSV cases
To Increase NSV cases 0 % to 20 % (DLHS-3)	Poor male participation.	Increase male involvement in the use of contraceptive and motivate them for NSV	Organizing Fixed day NSV camp.	No. of NSV Camps organized
				No. of cases of male sterilization
			Compensation for NSV Acceptance	Amount distributed to the acceptor
				Increase in NSV cases
	Poor IEC on NSV	Area wise BCC / IEC on NSV	Involvement of opinion leader, religious leader and PRIs for BCC	No.of meetings conducted with/by opinion leader , Religious leader and PRIs

			One to one meeting with eligible couple by ASHA/LHV	No. of one to one meeting conducted by AHSA/LHV
To ensure quality of services	Lack of knowledge on **standards & quality assurance of sterilisation services**	**Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services**	Printing of Manuals Distribution of manuals to each & every surgeon and members of QAC Displaying the information regarding quality of sterlisation services through hoardings	No. of Manuals printed No. of manuals distributed to MOs and QAC members No. of hoardings established
Monitoring & evaluation of Services		Monitor quality of services & utilization	Quarterly visit of accrediated facility by QAC.	No. of Visits made by District Quality Assurance Committee
			Quarterly visit of District Hospital/Ref. Hospital and PHCs for monitoring of quality of services provided	No. of District Hospital/Ref. Hospital and PHCs monitored by the QAC

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAM

B.1 Revised National T.B Control Programme

Tuberculosis (TB) is a communicable disease caused by Mycobacterium Tuberculosis, which spreads from a diseased person to a healthy one. Germs of TB spread through air when untreated patients cough or sneeze. TB mainly affects the lungs; but it can also affect other parts of the body (Brain, Bones, Glands, etc.).

Tuberculosis (TB) remains a major public health problem in India. Every year approximately 18 lakh people develop TB and about 4 lakh die from it. India accounts for one fifth of global incidence of TB and tops the list of 22 high TB burden countries. Unless sustained and appropriate action is taken, approximately 20 lakh people in India are estimated to die of TB in next five years.
TB kills more adults in India than any other infectious disease.

In India, EVERY DAY:

- More than 40,000 people become newly infected with the tubercle bacilli
- More than 5000 develop TB disease
- More than 1000 people die of TB (i.e. 1 death every 1½ minutes)

The best way to diagnose lung TB is by examining the sputum under a Binocular Microscope. Germs of TB can be seen with a Binocular Microscope.

Despite the existence of a National Tuberculosis Control Programme since 1962, the desired results had not been achieved. On the recommendations of an expert committee, a revised strategy to control TB was pilot tested in 1993 in a population of 2.35 million, which was then increased in phased manner

The Revised National Tuberculosis Control Programme (RNTCP) aims to stop the spread of TB by curing patients. The key of this strategy is to cure TB through Directly Observed Treatment at a time and place convenient to the patient.

A full-fledged programme was started in 1997 and rapidly expanded in a phase manner with excellent results.

By March 2004 , Katihar district has been covered under RNTCP

The RNTCP is an application in India of the WHO-recommended Directly Observed Treatment, Short Course (DOTS) the most effective strategy to control TB.

Role of the District TB Control Society/District TB Centre

The TB programme will provide orientation, training, technical assistance, quality assurance of laboratory services, and supervision and monitoring of activities. It will also refer tuberculosis patients with serious complications who require hospitalization.

First time Katihar district is under Target zone after RNTCP launched. The cure rate is increased upto 85 %. That is due to good performance of all the TUs. They maintain the track records of High Detection and High cure rate upto 85 %.

Katihar District maintained the NSP case detection rate through out the years and improved it cure rate. The percent of positive cases detection is increased and also the cure rate has improved .

At every 500000 Population there is a provision to establish one Tuberculosis unit

There are 04 Tuberculosis unit in the district

1. Manihari
2. Barari
3. Barsoi
4. Korha

At every 100000 Population there is a provision to establish one Designated Microscopy Unit .
There are 24 Sanctioned Designated Microscopy Unit in Katihar , out of 24 DMC only 16 are functional, 8 DMCs are non-functional due to lack of Microscopist/Microscope and Lab technician

Deliberations at grassroots level (village and block level) gave an idea about perceptions and level of awareness/ stigma attached to tuberculosis. Within the community, tuberculosis is recognized as a contagious disease. Due to prevailing beliefs associated with the disease it is socially stigmatized. Because of fear of segregation from the community, individuals hide the disease thereby resulting in delayed treatment. According to the members of the community, socio-economic deprivation, unhygienic living conditions and excessive smoking are factors contributing to the occurrence of infection. TB is suspected when cough persists for more than three weeks. No home treatment is practiced for curing TB. Knowledge about DOTS is low.

The preventives suggested for TB were to reduce smoking, have a nutritious diet and ensure protection from cold.

Most of the respondents spoke of the need for information dissemination about modes of transmission and prevention that could be adopted at village level. AWW, ASHA, ANM, Panchayat Members and community groups have been earmarked for this role of information dissemination.

GOAL-

To achieve and maintain the cure rate of atleast 85% among newly detected infectious (New sputum smear positive cases)

To achieve and maintain detection of at least 70% such cases in the population.

S. No.	Priority areas	Activity planned under each priority area
1	To achieve and maintain more than 85% cure rate and 90% conversion rate	1) Intensified field supervision
		2) To have a regular monthly meeting with PHI MOs and PHI staff for strictly implementation of DOTs strategy and RNTCP guidelines
		3) To have a in time necessary corrective measure to reduce death,defaulter, and failure rate
		4) Intensive supervision and timely initial home visit and providing basic health education for regular and complete treatment along with follow-up sputum examination as per schedule
		5) Providing training and refresher training to PHI staff and DOTS providers.
2	To achieve and maintain case detection rate more than 70%	(1) To have all efforts to increase reference rate more than 2-3% out of new adult O.P.D. to DMC for early diagnosis and prompt treatment
		(2) To have all efforts that all TB suspects go for 3 sputum examination and all Cat III patient have sputum re-examination.
		(3) To involve more Private Practitioner and social workers for referral of TB suspect to DMCs
		(4) To involve more and more NGOs and Public leading persons to increase reference of TB suspects to nearby DMCs
		(5) Strength IEC activity for create awareness about sign and symptoms of TB and importance of sputum examination and where to go for diagnosis
3	IEC activity	(1) To increase awareness at community level to know about the sign, symptoms, diagnosis and DMCs, treatment and DOT centres where all facilities are available free.
		(2) To have more and more Patient Provider, Community leader and group meeting.
		(3) IEC material displayed at public places
4	Maintains of contractual staff under RNTCP	(1) As and post lies vacant , will be fulfilled by available waiting list or by fresh recruitment
5	Training of newly recruited health staff	(1) Arrange training session at district or state level as per RNTCP guideline by making schedule as early as possible.

6	Strengthening the nvolvement of NGOs and PPs	(1) Involve more and more NGOs and PPs and encourage them to sign the scheme of RNTCP and provide them training, material and feedback.
		2) Continous medical education and meeting with IMA.
7.	Strengthening DTC/DMC/DMU	1. Maintenance and new construction of building
		2. Lab Construction.

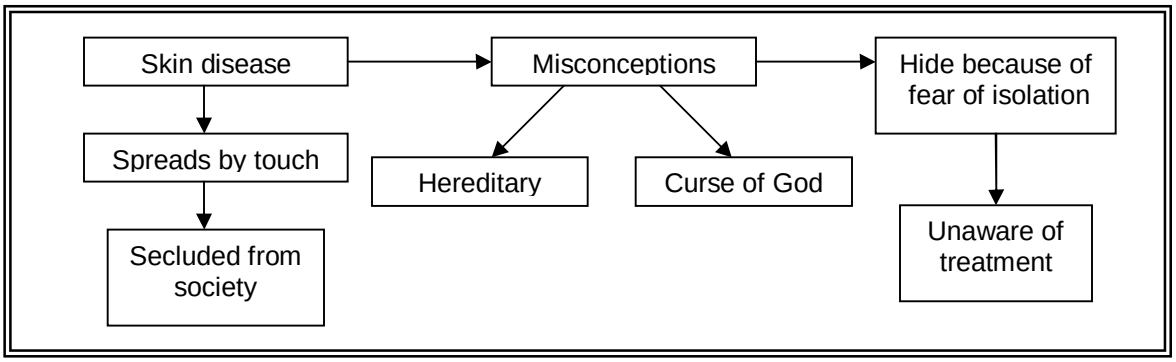
NATIONAL LEPROSY ERADICATION PROGRAMME

B.2 National Leprosy Elimination Programme

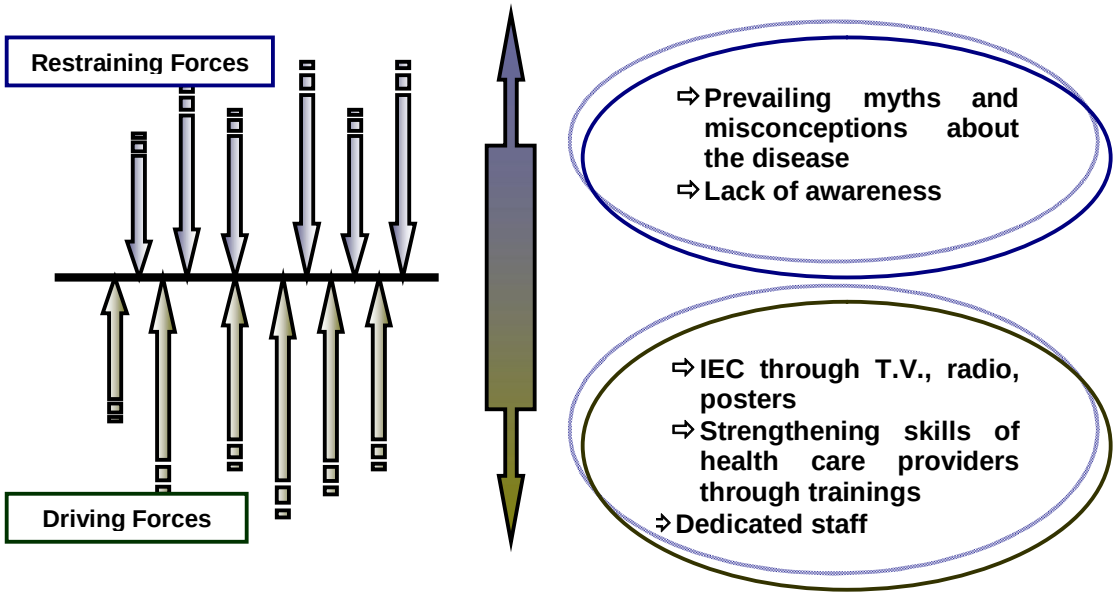
Leprosy is a chronic infectious disease caused by M. Leprae, an acid-fast, rod shaped bacillus. The disease mainly affects the skin, the peripheral nerves, mucosa of the upper respiratory tract and also the eyes, apart from some other structures. Leprosy has afflicted humanity since time immemorial. It once affected every continent and it has left behind a terrifying history and human memory of mutilation, rejection and exclusion from society.

The Govt. of India started the National Leprosy Elimination Programme in 1983 and Multi-Drug Therapy (MDT) was introduced in a phased manner district by district. The Prevalence Rate of leprosy (PR) was 21.1 in the year March-1985 which has come down to 0.89 by June-2006. World Bank assisted National Leprosy Elimination Programme (NLEP) phase-2 has been initiated since 2001.The goal of NLEP phase-2 was to eliminate leprosy by March-2005 by reducing the prevalence rate of leprosy to below 1 per 10,000 populations. The strategy of the 2nd phase of NLEP was to detect leprosy patients from high endemic districts and urban slums through Special Action Plan for Elimination of Leprosy (SAPEL).

According to the community, leprosy is a hereditary skin disease. It is believed to be curse of God. The patient is secluded from society. Initially individuals hide the symptoms because of fear of isolation from the society. There is a general notion that the disease spreads by touch. Very few are aware that the disease is curable or have heard about MDT. Prevailing erroneous beliefs and lack of awareness have been identified as the main factors which hinder the progression of the eradication programme. (Table (iv) annexed in annexure-II).



The main restraining and driving forces for leprosy are set out below:



To lower the burden of leprosy and to eliminate it from the list of public health problems the programme (NLEP) aims at providing quality leprosy services through the general health care system. To strengthen the programme more effectively following strategies have been suggested.

PRIORITY AREAS:

- Regular programme review with special reference to high and medium priority blocks and PHCs
- Strategic plan for High Priority Blocks
- Supervision & monitoring of NLEP indicators monthly by all BHOs
- Active surveillance at regular interval
- Strengthening the already existing Integration of NLEP with GHS
- Strengthening of supervision at all levels by DLO & District Nucleus MOs every month
- Coordination support service for general health care staff from district technical support team
- Detailed plan for IEC with focus on high endemic and urban areas
- Coordination with local IMA / NGOs

- Monthly review of elimination activities by DLO
- POD camps in all Blocks (Taluka)/PHCs
- Capacity building of General Health Care Staff
- Urban Leprosy Control planning and implementation in urban area with multiple service providers
- Optimal utilization of allotted funds for allocated activities under the programme
- Staff orientation to calculate, interpret and use essential NLEP indicators
- Training to all newly appointed Medical Officers/Health supervisors/MPHW (M&F) / ICDS worker
- Refresher modules for all functionaries trained earlier
- Guidelines on NLEP counseling to be available at all Health Centres. Review in monthly meetings at PHC for field staff and at District Level for PHC Medical Officers
- A comprehensive IEC communication strategy for NLEP has been developed indicating suitable methods and media for high, medium and low endemic blocks
- Streamline MDT Stock Management & Supply
- Focus on adequate availability of MDT at each level viz. District, PHCs, Govt. and Non Govt. Hospitals.
- Regular monitoring of MDT stock
- Avoidance of overstocking & expiry of MDTs
- Avoidance of shortage & effect on service delivery
- Quality of storage
- Careful validation of 25 % of the newly detected cases and regular review of registers
- Regular follow up of cases under treatment with proper counseling.
- Top priority to urban area leprosy elimination activities.
- Implementation of Simplified Information System
- Availability of SIS Guidelines at all health facilities.
- Complete and timely reporting as per SIS.

Work Plan for NLEP

To achieve the programme objectives, certain strategies and intervention approaches are planned on the basis of suggestions obtained during consultative meetings.

Strategy 1: Increase awareness among the community about the disease

Leprosy is known to be one of the most socially stigmatized diseases because of little knowledge on causes and cure. Thus increasing awareness about the disease among the members of the community is the foremost strategic intervention. By improved BCC patients can be motivated to self report at the onset of suggestive symptoms. Further promotion of IEC activities can help reducing the social stigma.

Strategy 2: Involvement of Panchayat for motivation to patients

Involvement of the Panchayat can be the paramount force for motivating patients to seek treatment and eradicating misconceptions attached to the disease. By orientation of health committees and community leaders, influential members or Panchayat members can be educated on the issue.

Strategy 3: BCC plan to mitigate stigma

For increasing treatment responsiveness and eradicating fallacious beliefs associated with the disease there is need for behaviour change in the community. This can be achieved by assessing the area-specific need for BCC and development of BCC materials for effective implementation.

Strategy 4: Reinforcement of service delivery

For ensuring effective service delivery there should be provision of quality diagnosis and treatment. Intense and continuous monitoring for regular supply of drugs can strengthen the service delivery mechanism. In addition, by means of counseling it is necessary to ensure that treatment is completed.

Objective	Strategies	Activity
	BCC to motivate patients having suggestive symptoms to go for self reporting	Using ASHA and AWW to disseminate information during VH&N day
Increase awareness among the community about the disease	IEC activities to reduce the social stigma	Interpersonal communication by health workers
		IPC Training (4 batch of 40 each)
	Involving Village committee as link agencies	Orientation of village Health & Sanitation committee
To develop BCC plan to mitigate stigma	Involvement of Panchayat for motivation to patients	Orientation of community leaders on village & health committees
		Development of BCC material
		Development of IEC material
To provide the quality treatment	Quality diagnosis and treatment	Quality diagnosis and treatment indicators to be finalized
	Intense monitoring for regular supply of drugs	Intense monitoring during sub centre days
	Appropriate counseling of patients to prevent deformities	Monitoring indicators will be developed to ensure counseling is effective

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

B.3 National Vector Borne Disease Control Programme

The NVBDCP was initiated in the year 2003-2004. It is an umbrella programme for prevention and control of vector borne diseases including Malaria, Filaria, Kala-azar and Dengue. Under the programme comprehensive and multi sectoral public health activities are implemented. Districts teams should review incidence and prevalence data available for these diseases in the district through surveillance activities and plan as per national strategy adapted to address local needs. Vector borne diseases like Malaria, Kala-azar , Dengue and Japanese encephalitis are outbreak prone diseases and therefore during formulation of the district health plan, epidemic response mechanism should also be outlined.

The main objectives of NVBDCP are:

To reduce mortality and morbidity due to Malaria
To reduce percentage of PF cases.
To control other vector borne diseases like Kala azar , Dengue, Filaria, Chikungyniea etc.

Katihar is a Kala azar & Malaria prone district of Bihar .

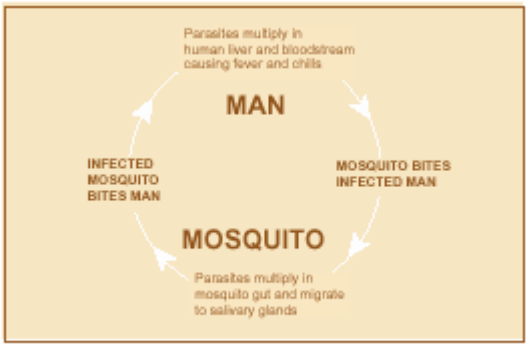
B.3.1 Malaria

Malaria is a life-threatening parasitic disease transmitted by mosquitoes. It was once thought that the disease came from fetid marshes, hence the name mal aria, (bad air). In 1880, scientists discovered the real cause of malaria a one-cell parasite called plasmodium. Later they discovered that the parasite is transmitted from person to person through the bite of a female Anopheles mosquito, which requires blood to nurture her eggs.

Today approximately 40% of the world's population mostly those living in the world's poorest countries are at risk of malaria. The disease was once more widespread but it was successfully eliminated from many countries with temperate climates during the mid 20th century. Today malaria is found throughout the tropical and sub-tropical regions of the world and causes more than 300 million acute illnesses and at least one million deaths annually.

There are four types of human malaria Plasmodium vivax, P. malariae, P. ovale and P. falciparum. P. vivax and P. falciparum are the most common and falciparum the most deadly type of malaria infection.

The malaria parasite enters the human host when an infected Anopheles mosquito takes a blood meal. Inside the human host, the parasite undergoes a series of changes as part of its complex life-cycle. Its



Man and mosquito play complementary roles in the malaria cycle.

various stages allow plasmodia to evade the immune system, infect the liver and red blood cells, and finally develop into a form that is able to infect a mosquito again when it bites an infected person. Inside the mosquito, the parasite matures until it reaches the sexual stage where it can again infect a human host when the mosquito takes her next blood meal, 10 to 14 or more days later.

Malaria symptoms appear about 9 to 14 days after the infectious mosquito bite, although this varies with different plasmodium species. Typically, malaria produces fever, headache, vomiting and other flu-like symptoms. If drugs are not available for treatment or the parasites are resistant to them, the infection can progress rapidly to become life-threatening. Malaria can kill by infecting and destroying red blood cells (anaemia) and by clogging the capillaries that carry blood to the brain (cerebral malaria) or other vital organs.

Malaria, together with HIV/AIDS and TB, is one of the major public health challenges undermining development in the poorest countries in the world.

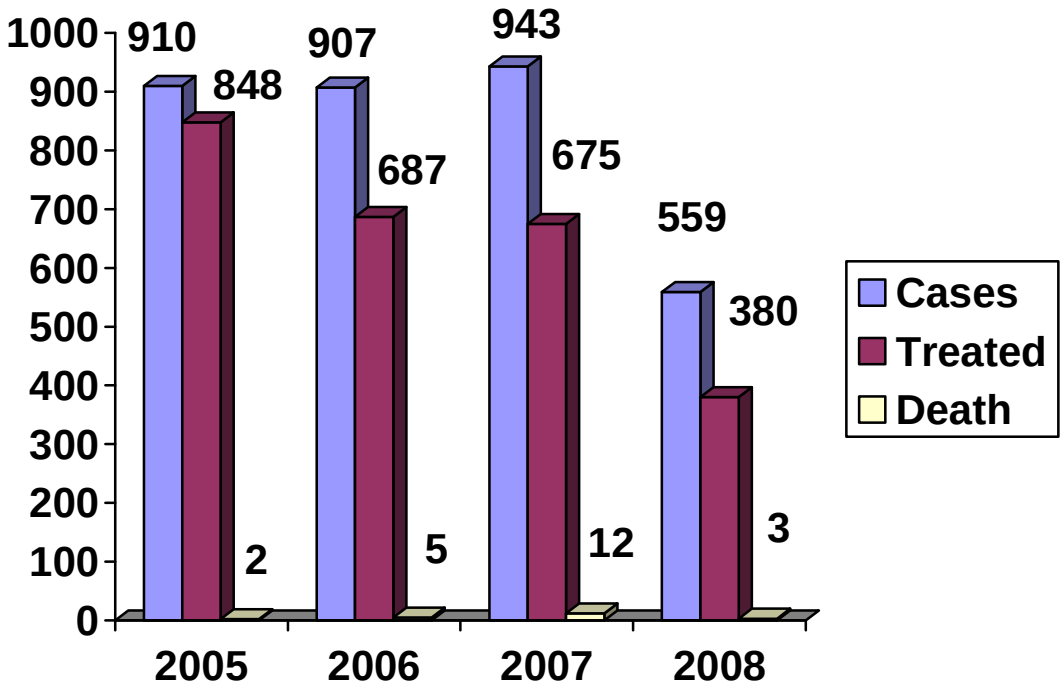
Goal- To reduce mortality and morbidity due to Malaria

Objectives	**Constraints**	**Strategies**	**Activities**
Early Case Diction and Prompt Treatment	Lack of Knowledge about malaria prone areas	Identify pockets populations at risk to have increased access to early diagnosis and prompt treatment	House to house survey by ASHA/AWW/MHW etc
	Lack of Human resources such as Malaria inspector , Lab Technician	Appointment of L.T and Malaria inspector on Contract basis	Publication of vacancies
			Recruitment & selection of H.R
	Lack of FTDs & DDC	For complete surveillance of fever cases identification and treatment, role of FTDs and DDCs are very important Establishments of FTDs and DDCs	Appointment of Malaria link workers on contract basis
			Training of Malaria link workers
			Establishment of Fever Testing depots at every 5000 Population
			Establishment of Drug distribution center at every 5000 Population.
		Follow MAP treatment policy	Strictly follow the MAP treatment guidelines for diagnosis & treatment of

			malaria cases
			Procurement of Rapid diagnosis sticks for PF cases.
			Procurement and timely supply of necessary equipments and lab reagents
			Procurement & supply of essential drugs
Strengthening institutional infrastructure	Lack of Infrastructure for District Malaria Office such as office , vehicle and store	Construction / hire building on rent for District Malaria office and store	Construction of building for District Malaria office & Store
			Hire building on rent for District Malaria office & Store
			Provision for Vehicle for DMO for better monitoring
Preventive Vector Control	**Lack of Biological control (Hatchery)**	**Establishment of hatchery at every block**	Establishment of hatchery for larvivours fishes at district level as well as at block level.
			Introduction of fishes at breeding places at least once in every six months
	Improper and poor spraying	**Indoor Residual Spray**	Timely and proper IRS in high risk area according to MAP guidelines
		To reduce man mosquito contact	To reduce man mosquito contact distribution of Impregnated Mosquito Net in high risk area.
To increase the knowledge about the sign , symptoms and treatment of Malaria	**Lack of awareness and knowledge about the malaria in masses**	Emphasize upon Behavioral Change communication and social mobilization	Awareness generation towards adopting personal prophylactic measures to control Malaria
			Awareness towards service delivery centers for treatment of Malaria
			Awareness generation towards the spray

B.3.2 Kala-Azar

Katihar is a Kala-azar prone area in the State. Studies reveals that the ST and SC community especially Mushhar community are vulnerable towards the epidemic due to their poor living conditions.



Kala-azar scenario at Katihar

Goal

To contribute to improving the health status of vulnerable groups and at-risk population living in kala-azar-endemic areas by the elimination of kala-azar so that it is no longer a public health problem.

Targets

To reduce the annual incidence of kala-azar to less than one per 10,000 population at district by 2010.

- Reduce case fatality rates
- Prevent the emergence of Kala azar / HIV / AIDS, and TB co-infections

Objectives	Constraints	Strategies	Activities
Early Case Diction and Prompt & complete Treatment	Lack of Knowledge about Kala-azar prone areas	Identify pockets populations at risk to have increased access to early diagnosis and prompt treatment	House to house survey by ASHA/AWW/MHW etc
	Lack of Human resources such as Lab Technician	Appointment of L.T on Contract basis	Publication of vacancies
			Recruitment & selection of H.R
	Lack of FTDs & DDCs	For complete surveillance of Kala-azar cases identification and treatment, role of FTDs and DDCs are very important. Use of FTDs and DDCs of Malaria for Kala-azar cases	Appointment of link workers on contract basis
			Training of link workers
			Establishment of Fever Testing depots at every 5000 Population
			Establishment of Drug distribution center at every 5000 Population.
	Lack of equipment & Drugs, reagents	**Timely diagnosis and treatment**	Strictly follow the treatment guidelines for diagnosis & treatment of Kala-azar cases
			Procurement of K-39 testing kits .
			Procurement and timely supply of necessary equipments and lab reagents
			Procurement & supply of essential drugs
Provide better living condition	**Lack of Pucca houses for vulnerable community**	Convergence to welfare and DRDA for availability of pucca houses under Indira Awas Yojna	Meeting with public representatives and PRIs
			Meeting with DDC and DRDA director
			Meeting with Block program officer (DRDA)

To make preventive measures to eradicate Kala-azar	**Improper & poor spraying of DDT**	**Indoor Residual Spray**	Timely IRS in high risk area and vulnerable area.
			Monitoring of spraying by MOIC & Block Health Managers
			Capacity building programme for sprayer for DDT spray to ensure that every corner of the house is properly spray up to height of six feet from the ground level.
		To reduce man mosquito contact	To reduce man mosquito contact by distribution of Impregnated Mosquito Net in high risk area and vulnerable community/people
	Myths and misconception about the spray	To conduct IEC/BCC activities	Awareness generation about the DDT Spray for Kala-azar
			FGD with vulnerable people about the spraying
			One to one meeting by ASHA with vulnerable households on spraying
		Emphasize upon Behavioral Change communication and social mobilization	Awareness generation towards adopting personal prophylactic measures to control Kala-azar
			Awareness towards service delivery centers for treatment of Kala-azar
			Awareness generation towards the spray

B.3.3 Filaria control Programme

The National Filaria Control Programme was launched in 1555 for the control of filariasis. Activities taken under the programme include: (i) delimitation of the problem in hitherto unsurveyed areas, and (ii) control in urban areas through recurrent anti-larval measures and anti parasite measures. Man, with micro Filaria in the blood is the main reservoir of infection. The disease is not directly transmitted from person to person, but by the bite of many species of mosquitoes which harbor infective larvae. Important vectors are species of Culex, Anopheles, Mansonia and Aedes. The incubation period varies, and micro-Filaria appears in the blood after 2-3 months in B. malayi after 6-12 months in W. bancrofti infections.

Constraints

- It affects mainly the economically weaker sections of communities
- Result in low priority being accorded by governments for the control of lymphatic filariasis.
- Low effectiveness of the tools used by the control programme
- The chronic nature of the disease and that

Suggestions

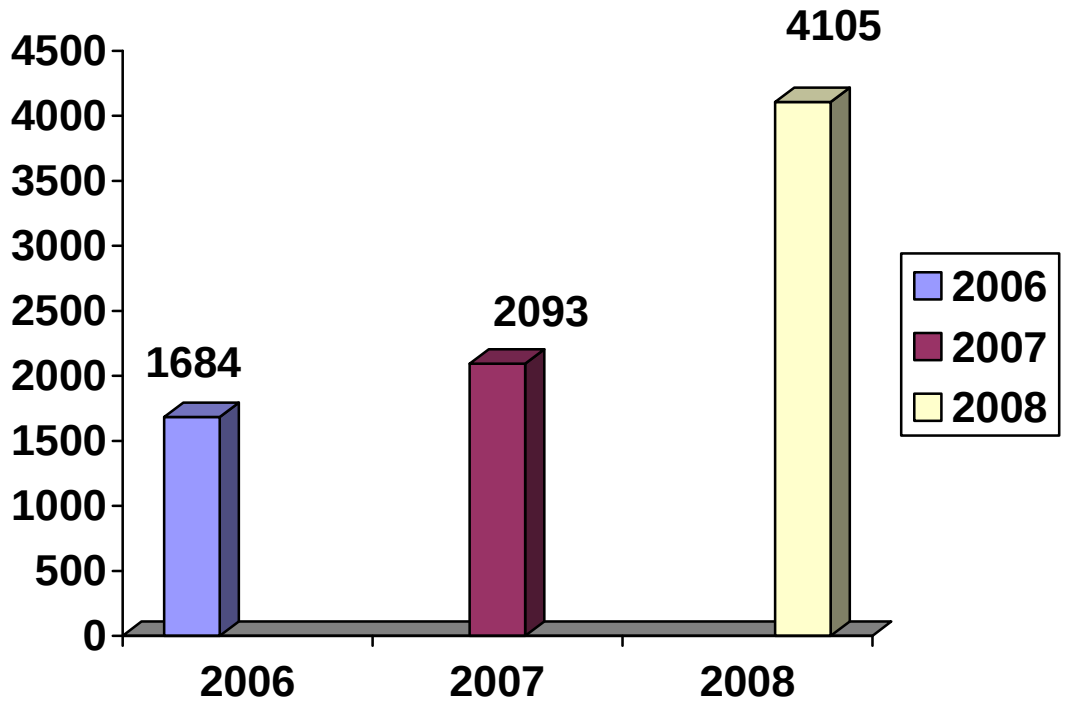
- Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.
- Continuous use of vector control measures.
- Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.
- IEC for ensuring community awareness and participation in vector control as well as personal protection measures.

NATIONAL BLINDNESS CONTROL PROGRAMME

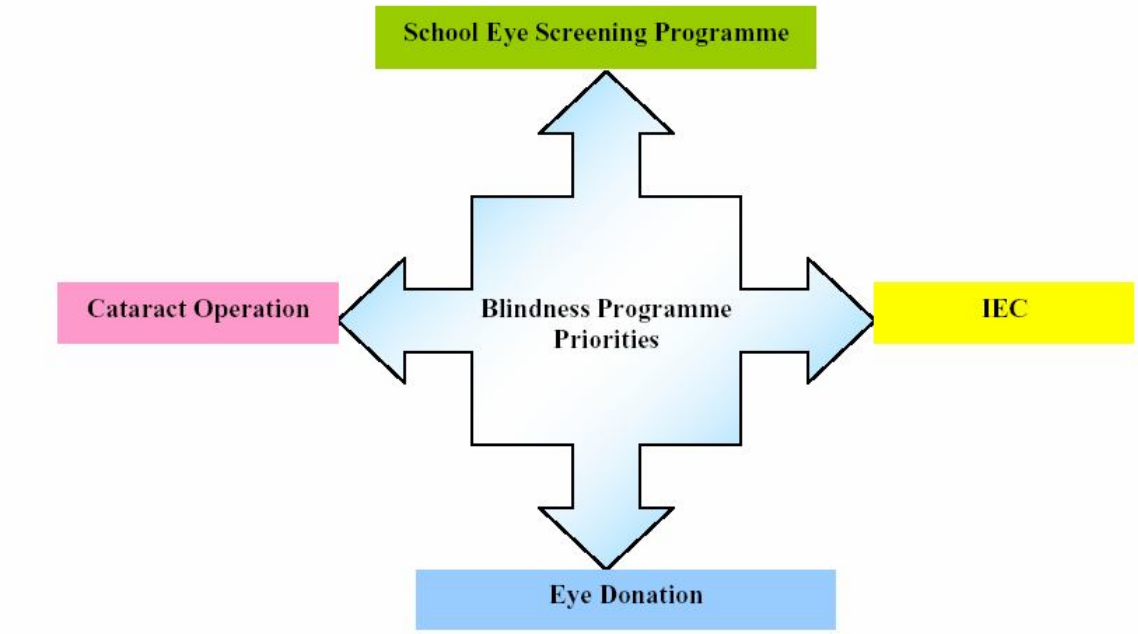
B.4 NATIONAL BLINDNESS CONTROL PROGRAMME

Blindness is a major public health problem in most developing countries where eye care facilities are still limited. Cataract is the leading cause accounting for 50% to 70 % of total blindness.
India is the first country in the world to launch blindness prevention related programme as early as 1963 i.e. National programme for trachoma control. After few changes in the names, this programme was re-designated, since 1976 as "National programme for Control of Blindness" (NPCB)

The National programme for control of blindness was launched in year 1976 with a goal for reduction in prevalence of blindness from 1.4 percent to 0.3 percent. The four-pronged strategy refers to strengthening service delivery, developing human resources for eye care, outreach activities and developing institutional capacities. All school children in the age group of 10-14 years should be screened for refractive errors. Percentage of children detected with refractive errors should be 5-7%.



Year wise no. of Cataract operation



Objectives	Constraints	Strategies	Activities
To increase cataract surgery rate	**Lack of eye surgeon & opthalmist in the district**	Strengthening service delivery	Filling vacant posts of eye specialists
			Organizing outreach camps in rural areas & extremely backward classes tola
		Target older age groups	Identification of cases
			Increase treatment acceptance
			Follow up to treated cases

To Increase the surgery rate with IOL	**Lack of equipments and drugs**	Procurement, distribution and assurance of quality equipment and drugs	Operational mobile units (procurement of ambulance, microscope etc
			Ensure adequate supply of medicines
			Continuous availability of vitamin A
	Lack of knowledge about the new technology	**In-service training programmes**	Refresher training course for eye surgeons & opthalmists for skill up gradation (new techniques)
School Eye Screening: children in the age group of 10-14 years should be screened for refractive errors	**Lack of awareness about the refractive errors**	**School health camps**	Organization of camps for identification of children with refractive errors and prohibition of free spectacles
			Training to teachers in schools
			Snellen's Vision Box for schools
		Promoting outreach activities and public awareness	Effective communication about outreach camps
			Awareness regarding eye-care
Oral Health Screening for - Community - School children		**Promotion of Vitamin A supplementation through AWW , ANM and ASHA**	Promotion of Vitamin A supplementation
			IEC campaigning about eye donation

B.5 INTEGRATED DISEASE SURVEILLANCE PROJECT

Goal

To reduce the burden of morbidity and mortality due to various diseases in the district.

Objective

- Establishing a sustainable decentralized system of disease surveillance for timely and effective public health action.
- Integrating disease surveillance activities. To avoid duplication and facilitate sharing of information across all disease control programmes so that valid data are available for appropriate health decision.

Epidemic branch deals with Communicable Diseases, i.e. Waterborne Diseases such as Cholera, Gastroenteritis, Typhoid and Infective hepatitis, Zoonotic Diseases like, Plague and Leptospirosis, Arthropod borne diseases like, Dengue fever, Kala-azar and Malaria , Air borne disease like Meningococcal Meningitis and provides health relief services in the wake of natural calamities like heavy rain, floods, draught, cyclone etc. to prevent post calamity disease outbreak. The collection and a good analysis of data analysis of this data gives us the indication when to apply what method to stop epidemic and control it.

Strategies adopted

- Operationalization of norms and standards of case detection, reporting format.
- Streamlining the MIS system- Establishing Web based & channels for data collection within the district and transmission mechanisms to state level.
- Analyzing line listing of cases and Geographical Information Systems (GIS) mapping approach Preparation of graphs & charts on the basis of reports for planning strategies during epidemic outbreak.
- Training to all the grass root level workers, MO's & CHC staff in Data Collection, and data transfer mechanisms.

B. 6 ASHA (Accredited Social Health Activist)

ASHA will take steps to **create awareness** and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services. She will counsel women on birthpreparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child. ASHA will mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government. She will work with the Village Health & Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan. She will arrange escort/accompany pregnant women & children requiring treatment/admission to the nearest pre- identified health facility i.e. Primary Health Centre/Community Health Centre/ First Referral Unit (PHC/CHC /FRU).

ASHA will provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme. She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit will be provided to each ASHA Emphasizing evidence base decentralized village and district level health planning and management is going to be accomplished through appointment of Accredited Social Health Activist (ASHA). The general norm was **'One ASHA per 1000 population'.** The criteria for selection were women preferably eighth pass and married/widowed of same village . She should be 'Bahu' of that particular village .

Selection of ASHA

Out of revised target of 2549 ASHA selection of 1866 ASHA has been selected and 1548 ASHA has been trained on first Module . Rest of selection and Training of remaining ASHA will be completed in the year 2009-2010.

District training team had received TOT in the year 2006 . They are responsible for giving training at the block level.The TOT members who received the training will train the ASHA at the block level.

The main Constraints in proper implementation of ASHA are following :

- Poor coordination between the MOIC and Mukhias on selection.

- Lack of interest in ASHA selection amongst PRIs members
- Due to excess load of work DPMU & BPMU personnel un -deliberately do not focus on the ASHA programme. That's why all the issues related to ASHA such as selection, Training , Payment of incentives etc. are untouched .

To over come to this issue , There is a great need of a District Project Manager (ASHA) , at the district level and Block ASHA Manager at each and every block, Whose are respectively responsible for all the works related to ASHA at the District level and the Block level. Except that for helping ASHA in their work there should be a Help Desk at block level and village level in each and every block and villages .

BUDGET

	Budget Head					
Slno.	**1. Maternal Health**	**Q.1**	**Q.2**	**Q.3**	**Q.4**	**Total**
1.1	Operationalise Blood Storage units in FRU	618000.00	618000.00	618000.00	618000.00	2472000.00
1.2	Organise workshops on various aspects of operationalisation of 24x7 services at the facilities @ Rs. 25,000 / year / district	0.00	25000.00	0.00	0.00	25000.00
1.3	Monitor quality of services and utilisation	7289.25	7289.25	7289.25	7289.25	29157.00
1.4	Home deliveries	40000.00	40000.00	40000.00	40000.00	160000.00
1.5	(A) Institutional deliveries (Rural) @ Rs.2000/- per delivery for 10.00 lakh deliveries	24000000.00	12000000.00	12000000.00	12000000.00	60000000.00
1.6	(B) Institutional deliveries (Urban) @ Rs.1200/- per delivery for 2.00 lakh deliveries	2757008.00	1378504.00	1378504.00	1378504.00	6892520.00
1.7	Incentive for MAMTA @ Rs. 100 per delivery	150000.00	950000.00	950000.00	950000.00	3000000.00
1.8	Accrediation of private nursing homes for conducting of Institutional delivery @Rs.1400	2000000.00	2000000.00	2000000.00	2000000.00	8000000.00
1.9	Monitor quality and utilisation of services@ 2% of total JBSY budget	124464.25	124464.25	124464.25	124464.25	497857.00
	Total Maternal Health	**29696761.50**	**17143257.50**	**17118257.50**	**17118257.50**	**81076534.00**
	2. Child Health					
	IMNCI					

2.1	**Monitor progress against plan; follow up with training, procurement, review meetings etc**	**4630.00**	**4630.00**	**4630.00**	**4630.00**	**18520.00**
2.2	**Facility Based Newborn Care/FBNC**	**1000000.00**	**1000000.00**	**1000000.00**	**1000000.00**	**4000000.00**
2.3	**Implementation of FBNC activities in districts. (Monitor progress against plan; follow up with training, procurement, etc.)**	**5016.00**	**5016.00**	**5016.00**	**5016.00**	**20064.00**
2.4	**Home Based Newborn care**	**500000.00**	**500000.00**	**500000.00**	**500000.00**	**2000000.00**
2.5	**School Health Programme (Details annexed)**	**3163993.50**	**3163993.50**	**3163993.50**	**3163993.50**	**12655974.00**
2.6	**Infant and Young Child Feeding**	**175000.00**	**175000.00**	**175000.00**	**175000.00**	**700000.00**
2.7	**Care of sick children & severe malnutrition**	**1000000.00**	**1000000.00**	**1000000.00**	**1000000.00**	**4000000.00**
2.8	**Management of Diarrhoea, ARI and Micro nutrient**	**1250000.00**	**1250000.00**	**1250000.00**	**1250000.00**	**5000000.00**
	Total Child Health	**7098639.50**	**7098639.50**	**7098639.50**	**7098639.50**	**28394558.00**
	3. Family Planning					
3.1	**Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services**	**6250.00**	**6250.00**	**6250.00**	**6250.00**	**25000.00**
3.2	**Provide female sterilisation services on fixed days at health facilities in districts (Mini Lap)**	**728935.50**	**728935.50**	**728935.50**	**728935.50**	**2915742.00**

3.3	**Organise NSV camps in districts @Rs.10,000 x 500 camps**	**0.00**	**20000.00**	**65000.00**	**65000.00**	**150000.00**
3.4	**Compensation for female sterilisation at PHC level in camp mode**	**2250000.00**	**2250000.00**	**6750000.00**	**6750000.00**	**18000000.00**
3.5	**Compensation for NSV Acceptance @50000 cases x1500**	**273375.00**	**273375.00**	**820125.00**	**820125.00**	**2187000.00**
3.6	**Accreditation of private providers to provide sterilisation services**					**0.00**
3.7	**Compensation for sterilization done in Pvt. Accredited Hospitals (1.50 lakh cases)**	**1500000.00**	**1500000.00**	**2250000.00**	**2250000.00**	**7500000.00**
3.8	**Monitor progress, quality and utilisation of services**	**3411.50**	**3411.50**	**3411.50**	**3411.50**	**13646.00**
3.9	**Spacing Methods**					**0.00**
3.10	**IUD Camps**	**73095.50**	**73095.50**	**73095.50**	**73095.50**	**292382.00**
3.11	**Organise Contraceptive Update seminars for health providers (one at state level & 38 at district level) (Anticipated Participants-50-70)**	**0.00**	**25000.00**	**0.00**	**0.00**	**25000.00**
3.12	**POL for Family Planning for 500 sub-district facilities**	**46904.25**	**46904.25**	**46904.25**	**46904.25**	**187617.00**
3.13	**Repair of Laproscopes**	**0.00**	**5831.00**	**0.00**	**0.00**	**5831.00**
	Total Family Planning	**4881971.75**	**4932802.75**	**10743721.75**	**10743721.75**	**31302218.00**

	4. Adolescent Reproductive and Sexual Health					
4.1	**Disseminate ARSH guidelines.**	**0.00**	**31250.00**	**0.00**	**0.00**	**31250.00**
4.2	**Conducting ARSH Camp in 10% of Subcentres across the state (as Village ARSH Week)**	**0.00**	**0.00**	**16062.50**	**16062.50**	**32125.00**
	Total ARSH	**0.00**	**31250.00**	**16062.50**	**16062.50**	**63375.00**
	5. Vulnerable Groups					
5.1	**Health Camps in Maha-Dalit Tola**	**300685.88**	**300685.88**	**300685.88**	**300685.88**	**1202743.50**
	Total Vulnerable Groups	**300685.88**	**300685.88**	**300685.88**	**300685.88**	**1202743.50**
	6. Innovations					
	PNDT and Sex Ratio					
6.1	**Orientation programme of PNDT activities, Workshop at State, District and Block Level (1+38+533)**	**0.00**	**141666.66**	**141666.66**	**141666.66**	**424999.98**
6.2	**Monitoring at District level and Meetings of District level Committee**	**72893.50**	**72893.50**	**72893.50**	**72893.50**	**291574.00**
6.3	**MUSKAAN**					
6.4	**Incentive for ASHA per AWW center (80000x200 per month)**	**1399556.11**	**1399556.11**	**1399556.11**	**1399556.11**	**5598224.44**
6.5	**Incentive for ANMs per AWW center (80000x150 per month)**	**996750.00**	**996750.00**	**996750.00**	**996750.00**	**3987000.00**

6.6	**Incentive to private clinics for conducting immunisation services**	**300000.00**	**300000.00**	**300000.00**	**300000.00**	**1200000.00**
	Total Innovations	**2769199.61**	**2910866.27**	**2910866.27**	**2910866.27**	**11501798.42**
	7. Infrastructure and Human Resource					
7.1	**Salary of 3106 MPWs @Rs.2950/- x 60 months (since 2005)**	**35400.00**	**0.00**	**0.00**	**0.00**	**35400.00**
7.2	**Hiring of 1000 Retired ANMs or ANMs from other states for out reach services @ Rs. 5000 / month / ANM**	**375000.00**	**375000.00**	**375000.00**	**375000.00**	**1500000.00**
7.3	**Hiring Specialists**					
7.4	**Empanelling Gynaecologists on CALL BASIS for conducting institutional deliveries, providing Essential and Emergency Obs Care at government facilities @ Rs. 1,00,000 per annum per district for 38 districts**	**0.00**	**36932.00**	**36932.00**	**36932.00**	**110796.00**
7.5	**Empanelling Gynaecologists for gynaecology OPD in under or un served areas @ Rs. 1000 / week x 52 weeks**	**0.00**	**80863.24**	**80863.24**	**80863.24**	**242589.72**
7.6	**Empanelling Gynaecologists for PHCs to provide OPD services @ Rs. 300 / week x 52 weeks**	**0.00**	**36391.49**	**36391.49**	**36391.49**	**109174.47**

7.7	**Hiring Anesthetists for facilities that have vacant Anesthetist positions @ Rs. 1000 per case x 120000**	**0.00**	**1166296.75**	**1166296.75**	**1166296.75**	**3498890.25**
7.8	**Hiring Paediatrician for facilities where there are vacant Paediatricians positions @ Rs. 35,000 / month (2 per district)**	**0.00**	**25852.91**	**25852.91**	**25852.91**	**77558.73**
7.9	**Hiring Gynaecologists for facilities that have vacant positions @ Rs. 650 per case x 75000 cases**	**0.00**	**473808.00**	**473808.00**	**473808.00**	**1421424.00**
7.10	**Store Keeper @Rs 8000/- per month**					
7.11	**Incentive for C-section(@1500/- (facility Gynec. Anesth. & paramedic)**	**52483.40**	**69977.86**	**69977.86**	**69977.86**	**262416.98**
7.12	**Facility improvement for establishing New Born Centres at 76 FRUs across the state - @ Rs. 50,000 / per FRU**	**0.00**	**22000.00**	**0.00**	**0.00**	**22000.00**
7.13	**Facility improvement for establishing New Born Centres at PHCs across the state - @ Rs. 25,000 / per PHC**	**0.00**	**62383.00**	**0.00**	**0.00**	**62383.00**
	Total Infrastructure and Human Resources	**462883.40**	**2349505.25**	**2265122.25**	**2265122.25**	**7342633.15**

	8. Training					
8.1	**Strengthening of existing SBA Training Centres**	**0.00**	**40000.00**	**0.00**	**0.00**	**40000.00**
8.2	**Training of ANMs / LHVs in SBA (Batch size of four)**	**0.00**	**393333.33**	**393333.33**	**393333.33**	**1179999.99**
8.3	**Training of nurses/ANMs in safe abortion**	**0.00**	**3498.89**	**3498.89**	**3498.89**	**10496.67**
8.4	**Training of Medical Officers in safe abortion**	**0.00**	**8504.24**	**8504.24**	**8504.24**	**25512.72**
8.5.	**TOT on IMNCI for Health and ICDS worker**	**0.00**	**137652.33**	**137652.33**	**137652.33**	**412956.99**
8.6	**IMNCI Training for Medical Officers (Physician)**	**0.00**	**130811.66**	**130811.66**	**130811.66**	**392434.98**
8.7	**IMNCI Training for all health workers**					
8.8	**IMNCI Training for ANMs / LHVs/AWWs**	**0.00**	**136232.00**	**136232.00**	**136232.00**	**408696.00**
8.9	**IMNCI Training for Anganwadi Workers**					
8.10	**Followup training(HEs,LHVs)**	**0.00**	**28185.66**	**28185.66**	**28185.66**	**84556.98**
8.11	**One Day ARSH Orientation by the MOs of 25% ANMs**	**0.00**	**3654.39**	**3654.39**	**3654.39**	**10963.17**
8.12	**One Day ARSH Orientation of PRI by the MOs of50% ANMs**	**0.00**	**4859.56**	**4859.56**	**4859.56**	**14578.68**
8.13	**Programme Management Training**					
8.14	**Training of DPMU staff @ 38 x Rs.10,000**	**0.00**	**11079.89**	**0.00**	**0.00**	**11079.89**

8.15	**Training for ASHA Help Desk to DPMs (38), Block level organisers (533) and MOICs (533), @ 1104 x 1000/-**	**0.00**	**33000.00**	**0.00**	**0.00**	**33000.00**
	Total Training	**0.00**	**930811.95**	**846732.06**	**846732.06**	**2624276.07**
	25 % raised	**0.00**	**1163514.94**	**1058415.08**	**1058415.08**	**3280345.09**
	9. BCC/IEC					
9.1	**Sensitization workshop for RKS members (3 members/RKS) (TA, Food, Resource materials, resource persons etc)**	**5000.00**	**5000.00**	**0.00**	**0.00**	**10000.00**
9.2	**District Level events(Radio, TV, AV, Human Media as per IEC strategy dissemination)**	**25000.00**	**25000.00**	**25000.00**	**25000.00**	**100000.00**
9.3	**Block level BCC interventions (Radio, kalajattha and for IEC strategy dissemination)**	**46552.50**	**46552.50**	**46552.50**	**46552.50**	**186210.00**
9.4	**Advertising of different programmes of NRHM in different types of certificates issued by BDO/CO and Block Informatics Centre established by Rural Development Department, Govt. of Bihar**	**140713.00**	**140713.00**	**140713.00**	**140713.00**	**562852.00**
9.5	**Technical support at District level**	**0.00**	**25000.00**	**0.00**	**0.00**	**25000.00**

9.6	**Media Advertisements on various health related days**	**25000.00**	**25000.00**	**25000.00**	**25000.00**	**100000.00**
9.7	**Developing Mobile Hoarding Vans and A V Van for State and District**	**0.00**	**10638.50**	**10638.50**	**0.00**	**21277.00**
9.8	**Implementation of specific interventions including innovations of BCC strategy/plans block level**	**134071.25**	**134071.25**	**134071.25**	**134071.25**	**536285.00**
9.9	**Implementation of specific interventions including innovations of BCC strategy/plans District level**	**15000.00**	**15000.00**	**15000.00**	**15000.00**	**60000.00**
9.10	**Implementing need based IEC Activities in Urban Areas (Support for Organization of need based IEC Activities in Urban Areas)**	**100000.00**	**100000.00**	**100000.00**	**100000.00**	**400000.00**
9.11	**Capacity building of frontline functionaries (ANM, ASHA) in IPC skills building**	**0.00**	**21929.66**	**21929.66**	**21929.66**	**65788.98**
9.12	**IEC for Blood Storage Units (Details annexed)**	**90789.5**	**90789.5**	**90789.5**	**90789.5**	**363158.00**
	Sub-total IEC/BCC	**582126.25**	**639694.41**	**609694.41**	**599055.91**	**2430570.98**
	25% Raised	**727657.81**	**799618.01**	**762118.01**	**748819.89**	**3038213.73**
	10. Procurement of Equipments/Instruments					
10.1	**Equipments / instruments for Safe**	**0.00**	**53629.62**	**0.00**	**0.00**	**53629.62**

	Abortion					
10.2	**Equipments / instruments for Blood Storage Facility / Bank at facilities**	**0.00**	**32895.00**	**0.00**	**0.00**	**32895.00**
10.3	**Procurement of Minilap sets for 500 FP centres**	**0.00**	**48000.00**	**0.00**	**0.00**	**48000.00**
10.4	**Equipments / instruments, reagents for STI / RTI services @ Rs. 1 Lac per district per year**	**25000.00**	**25000.00**	**25000.00**	**25000.00**	**100000.00**
10.5	**Labour room equipment procurement**	**0.00**	**1338167.33**	**1338167.33**	**1338167.33**	**4014501.99**
10.6	**ICU Equipment procurement**	**0.00**	**0.00**	**1203703.50**	**1203703.50**	**2407407.00**
10.7	**Equipments / instruments for ANC at Health facilities (other than Sub Centre) @ Rs. 50,000/ district / year**	**0.00**	**25000.00**	**25000.00**	**0.00**	**50000.00**
10.8	**Equipments / instruments for ANC at Health facilities for Sub Centre @ Rs. 5,000/ Sub centre / year**	**0.00**	**428333.33**	**428333.33**	**428333.33**	**1284999.99**
10.9	**Procurement of 18 NSV kits per district @ Rs. 1100 / kit x 380**	**0.00**	**11000.00**	**0.00**	**0.00**	**11000.00**
10.10	**IUD insertion kit**	**0.00**	**15000.00**	**0.00**	**0.00**	**15000.00**
	Total Procurement of Equipments	**25000.00**	**1977025.28**	**3020204.16**	**2995204.16**	**8017433.60**
	11. Programme Management					

11.1	**Contractual Staff for DPMSU recruited and in position**	**168000.00**	**168000.00**	**168000.00**	**168000.00**	**672000.00**
11.2	**.Provision of equipment/furniture and mobility support for DPMU staff @ 12 months x 38 districts x Rs.85340/-**	**256019.50**	**256019.50**	**256019.50**	**256019.50**	**1024078.00**
11.3	**Appointment of CA**	**60000.00**	**60000.00**	**60000.00**	**60000.00**	**240000.00**
	Total Programme Management	**484019.50**	**484019.50**	**484019.50**	**484019.50**	**1936078.00**
		46446818.95	**39191184.88**	**45778112.39**	**45739814.27**	**177155930.48**

Sl. No.	**Budget Head**					
	12 .RNTCP	**Q.1**	**Q.2**	**Q.3**	**Q.4**	**Total**
12.1	**Civil Work**	**75000**	**75000**	**0**	**0**	**150000.00**
12.2	**Lab. construction**	**0**	**300000**	**300000**	**0**	**600000.00**
12.3	**Contrac. Service**	**500000.00**	**500000.00**	**500000.00**	**500000.00**	**2000000.00**
12.4	**IEC/BCC**	**100000.00**	**100000.00**	**100000.00**	**100000.00**	**400000.00**
12.5	**Training of Health personnel**	**75000.00**	**75000.00**	**50000.00**	**50000.00**	**250000.00**
12.6	**Vehicle Hiring**	**100000.00**	**100000.00**	**100000.00**	**100000.00**	**400000.00**
12.7	**Procurement of Vehicle**	**50000.00**	**50000.00**	**0.00**	**0.00**	**100000.00**
12.8	**Procurement of equipment**	**45000.00**	**45000.00**	**0.00**	**0.00**	**90000.00**
12.9	**Printing**	**150000.00**	**100000.00**	**100000.00**	**100000.00**	**450000.00**

12.10	Vehicle Maintenance	60000.00	60000.00	60000.00	70000.00	250000.00
12.11	Maintenance of equipment	25000.00	25000.00	0.00	0.00	50000.00
12.12	Honorarium to contractual staff	150000.00	150000.00	150000.00	150000.00	600000.00
12.13	Co-ordination with NGO/PVt. Practioner	400000.00	400000.00	400000.00	400000.00	1600000.00
12.14	Misc.	125000.00	125000.00	125000.00	125000.00	500000.00
	Total of RNTCP	1855000.00	2105000.00	1885000.00	1595000.00	7440000.00
	13 .National Leprosy elimination Programme					
13.1	Drivers honorarium	13500	13500	13500	13500	54000.00
13.2	Audit fee @ Rs. 500/Month	1500	1500	1500	1500	6000.00
13.3	Honorarium for accountant for account works @400/pm	1200	1200	1200	1200	4800.00
13.4	DLS (leprosy) for rent telephone, electricity etc. Rs. 18000/Pm	4500	4500	4500	4500	18000.00
13.5	Photo copy and stationery	3500.00	3500.00	3500.00	3500.00	14000.00
13.6	Hiring of Vehicle/ POL/ maintenance	18750	18750	18750	18750	75000.00
13.7	Supportive medicine	12500	12500	0	0	25000.00
13.8	Regeants & Laboratory equipments	6000	6000	0	0	12000
13.9	Patients welfare	6000	0	0	0	6000
13.10	Organisation of School quiz @ 10 Quiz/blocks	16250	16250	16250	16250	65000
13.11	Meeting with PRI Members @ Rs. 4000 / Block	16000	16000	16000	16000	64000
13.12	Organisation of Health Melas	5000.00	0.00	0.00	0.00	5000
13.14	Training of New Mos on Leprosy	0.00	27300.00	0.00	0.00	27300.00
13.15	Reorientation training of Mos	0.00	27300.00	0.00	0.00	27300.00

13.16	**Training of ASHA @ Rs. 3200 Per batch . Per batch of 40 ASHA 20 batch**	**0.00**	**32000.00**	**32000.00**	**0.00**	**64000.00**
13.17	**Aids & Appliances**	**12500.00**	**0.00**	**0.00**	**0.00**	**12500.00**
13.18	**Urban leprosy control Programme**	**15000.00**	**30000.00**	**15000.00**	**15000.00**	**75000.00**
	Total of NLEP	**132200.00**	**210300.00**	**122200.00**	**90200.00**	**554900.00**
	14. National Vector Borne Disease Control Programme					
	Kala-azar					
14.1	**Wages for SFW @ Rs. 113 per SFW for 60 days**	**210180.00**	**0.00**	**210180.00**	**0.00**	**420360.00**
14.2	**Wages for FW @ Rs. 92 per SFW for 60 days**	**1065780.00**	**0.00**	**0.00**	**1065780.00**	**2131560.00**
14.3	**Office expenses**	**2325.00**	**2325.00**	**2325.00**	**2325.00**	**9300.00**
14.4	**Construction of office for DMO**	**950000.00**	**0.00**	**0.00**	**0.00**	**950000.00**
14.5	**Construction of Hatchery at block @ Rs. 50000.00 / Hatchery for 16 blocks**	**200000.00**	**400000.00**	**200000.00**	**0.00**	**800000.00**
14.6	**Contigency**	**2325.00**	**2325.00**	**2325.00**	**2325.00**	**9300.00**
14.7	**Transportation of DDT (District to PHC)**	**4000.00**	**6000.00**	**6000.00**	**2000.00**	**18000.00**
14.8	**Transportation of DDT (PHC to Village)**	**1500.00**	**4000.00**	**2000.00**	**1500.00**	**9000.00**
14.9	**Repair of spray equipments**	**3000.00**	**0.00**	**3200.00**	**0.00**	**6200.00**
14.10	**Purchase of Spray equipments**	**16000.00**	**0.00**	**8800.00**	**0.00**	**24800.00**
14.11	**Mobility support for DMO**	**27150.00**	**0.00**	**27150.00**	**0.00**	**54300.00**

14.12	**Mobility support for MO (PHC)**	**13500.00**	**0.00**	**13650.00**	**0.00**	**27150.00**
14.15	**Daily Allowance for supervision of Spray**	**10800.00**	**0.00**	**0.00**	**7200.00**	**18000.00**
14.16	**I.E.C**	**10800.00**	**0.00**	**0.00**	**7200.00**	**18000.00**
14.18	**Incentive to ASHA for Complete treatment of Kala-azar cases**	**16250.00**	**16250.00**	**16250.00**	**16250.00**	**65000.00**
14.19	**Loss of Wages for Kala-Azar patients during their treatment period for 30 days @ Rs. 50 Per day**	**243750.00**	**243750.00**	**243750.00**	**243750.00**	**975000.00**
14.20	**Strengthing of PHC for Kala-azar Patients 10 bed per PHC/DH/Ref. Hos. @ rs. 1000 with mattress**	**18000.00**	**162000.00**	**0.00**	**0.00**	**180000.00**
14.21	**Mobility support for DMO @ Rs. 10000.00 / PM for 8 months**	**20000.00**	**20000.00**	**20000.00**	**20000.00**	**80000.00**
14.22	**Mobility support for Malaria Inspector Purchase of 02 Motorcycle @ Rs. 50000.00 each**	**100000.00**	**0.00**	**0.00**	**0.00**	**100000.00**
14.23	**POL for Motor cycle @ 30 liter per months @ Rs. 50 /lit. for 12 months**	**9000.00**	**9000.00**	**9000.00**	**9000.00**	**36000.00**
14.24	**Emphoteracin storage in District @ Rs. 500 per month for 12 months**	**1500.00**	**1500.00**	**3000.00**	**0.00**	**6000.00**
14.25	**Treatment card for Kala-azar patients @ Rs. 2.50 / treatment card**	**3250.00**	**0.00**	**0.00**	**0.00**	**3250.00**
14.26	**Register for line listing for listing of loss fo wages for kala-azar patients 02 register for per effec. PHCs@ Rs. 50 / Register**	**900.00**	**0.00**	**0.00**	**0.00**	**900.00**

14.27	Hiring of ware house for storage of DDT @ Rs. 5000 per month for 12 months	15000.00	15000.00	15000.00	15000.00	60000.00
14.28	Kala-azar forthnight programme @ Rs. 4000/ PHC	18000.00	18000.00	18000.00	18000.00	72000.00
14.29	Monthly emoulments of KTS-6 @ Rs. 10000.00 /PM for 12 months	180000.00	180000.00	180000.00	180000.00	720000.00
14.30	Procurement of impregnated bed nets	250000.00	500000.00	250000.00	0.00	1000000.00
	14.1 Filaria					
14.1.1	District Coordination meeting 02 meeting @ 7500.00	7500.00	0.00	7500.00	0.00	15000.00
14.1.2	IEC on Filaria elimination	20000.00	10000.00	10000.00	0.00	40000.00
14.1.3	Training for MO	55000.00	0.00	0.00	0.00	55000.00
14.1.4	Training for Para medical staff	40000.00	0.00	0.00	0.00	40000.00
14.1.5	Night Blood survey	16698.00	0.00	0.00	0.00	16698.00
14.1.6	POL for mobility support	8000.00	9000.00	8000.00	8000.00	33000.00
14.1.7	Training of Drug distributor @ Rs. 92 each	192740.00	192740.00	192740.00	192740.00	770960.00
14.1.8	Honorarium to DD @ Rs. 92/pm	192740.00	192740.00	192740.00	192740.00	770960.00
14.1.9	Training of Supervisor	47347.00	47347.00	0.00	0.00	94694.00
14.1.10	Honorarium for Supervisor	23673.50	23673.50	23673.50	23673.50	94694.00
	Total of NVDCP	**3996708.50**	**2055650.50**	**1665283.50**	**2007483.50**	**9725126.00**
	15. National Blindness control Programme					
15.1	Grant in Aid for cataract operation	750000.00	750000.00	750000.00	750000.00	3000000.00

15.2	Grant in Aid for School eye screening	25000.00	25000.00	25000.00	25000.00	100000.00
	Total of NBCP	**775000.00**	**775000.00**	**775000.00**	**775000.00**	**3100000.00**
	16. IDD					
16.1	Training on IDD	17000.00	0.00	0.00	0.00	17000.00
16.2	Awareness campaign on IDD	2000.00	2000.00	4500.00	0.00	8500.00
16.3	Awareness campaign on IDD in school	4000.00	4000.00	9000.00	0.00	17000.00
16.4	Activities at AWC & Communities	2000.00	2000.00	4500.00	0.00	8500.00
16.5	IEC Material	7397.00	0.00	0.00	0.00	7397.00
	Total of IDD	**32397.00**	**8000.00**	**18000.00**	**0.00**	**58397.00**
	17. Integrated Disease Surveillance Project					
17.1	Grant in Aid for IDSP	143628.00	143629.00	143628.00	143628.00	574513.00
	Total of IDSP	**143628.00**	**143629.00**	**143628.00**	**143628.00**	**574513.00**
18. NRHM Additionalities						
	ASHA					
18.1	Honorarium to ASHA Project Manager @ Rs. 20000.00 PM for 12 Months	60000	60000	60000	60000	240000.00
18.2	Honorarium to Data Assistant @ Rs. 8000/PM for 12 Months	24000	24000	24000	24000	96000.00
18.3	T.A/D.A & stationery , telephone , Fax etc. @ Rs. 3000.00 PM for 12 Months	9000.00	9000.00	9000.00	9000.00	36000.00
18.4	ASHA Help Desk @ Rs. 1000/PM for 12 Months at District level	3000.00	3000.00	3000.00	3000.00	12000.00

18.5	**Honorarium to ASHA Block Manager @ Rs. 12000.00 PM for 12 Months**	**576000.00**	**576000.00**	**576000.00**	**576000.00**	**2304000.00**
18.6	**Refreshment cost of Monthly meeting for ASHA @ Rs 20/ASHA for 12 months**	**152940.00**	**152940.00**	**152940.00**	**152940.00**	**611760.00**
18.7	**Monitoring cost of ASHA programme**	**32802.00**	**32802.00**	**32802.00**	**32802.00**	**131208.00**
18.8	**ASHA Training**	**3641428.50**	**3641428.50**	**0.00**	**0.00**	**7282857.00**
18.9	**ASHA Drug Kit & Replishment**	**367400.00**	**367400.00**	**0.00**	**0.00**	**734800.00**
18.10	**Motivation of ASHA - Two Saree & one umbrella to each ASHA @ 725/ASHA**	**924012.50**	**924012.50**	**0.00**	**0.00**	**1848025.00**
18.11	**ASHA Divas @ Rs. 75 Per ASHA/PM**	**573525.00**	**573525.00**	**573525.00**	**573525.00**	**2294100.00**
18.12	**Award for best performance to ASHA**	**96000.00**	**96000.00**	**96000.00**	**96000.00**	**384000.00**
18.13	**Identity Card @ Rs. 20 per ASHA**	**50980.00**	**0.00**	**0.00**	**0.00**	**50980.00**
	Total of ASHA	**6511088.00**	**6460108.00**	**1527267.00**	**1527267.00**	**16025730.00**
19. Institutional Strengthening						
19.1	**Sub-centre rent and contingencies @ Rs.500/- x 60 months**	**393750.00**	**393750.00**	**393750.00**	**393750.00**	**1575000.00**
19.2	**Creating 38 Additional SBA training centres @ Rs.15000 x 38 districts**	**0.00**	**18750.00**	**0.00**	**0.00**	**18750.00**
19.3	**Untied fund for Health Sub Center @ Rs. 10000.00 / SHC**	**3595000.00**	**0.00**	**0.00**	**0.00**	**3595000.00**

19.4	**Untied fund for Village Health & Sanitation Committee@ Rs. 10000.00Per VHSC**	**15520000.00**	**0.00**	**0.00**	**0.00**	**15520000.00**
19.5	**Grant in Aid for Rogi Kalyan Samiti @ Rs. 500000.00 for DH & Rs. 100000.00 for Per PHC**	**2100000.00**	**0.00**	**0.00**	**0.00**	**2100000.00**
19.6	**Construction of Health Sub Center @ Rs. 9.50 Lakhs per HSC**	**9500000.00**	**37050000.00**	**37050000.00**	**0.00**	**83600000.00**
19.7	**Construction of Residential quarter for APHC**	**2400000.00**	**4800000.00**	**4800000.00**	**0.00**	**12000000.00**
19.8	**Upgradation of HSC**	**0.00**	**6000000.00**	**6000000.00**	**0.00**	**12000000.00**
19.9	**Upgradation of ANM School**	**1500000.00**	**1500000.00**	**0.00**	**0.00**	**3000000**
19.10	**Annual maintenance grant for District Hospital @ Rs. 500000.00**	**500000.00**	**0.00**	**0.00**	**0.00**	**500000.00**
19.11	**Annual maintenance grant for RH and PHC @ Rs. 100000.00**	**1900000.00**	**0.00**	**0.00**	**0.00**	**1900000.00**
19.12	**Incentive for PHC doctors & staff for better performance in implementing programme**	**0.00**	**117260.79**	**117260.79**	**0.00**	**234521.58**
19.13	**Honorarium for Contractual Grade-A Nurses@ Rs. 7500.00 pm for 12 months**	**2340000.00**	**2340000.00**	**2340000.00**	**2340000.00**	**9360000.00**
19.14	**Honorarium for Contractual ANM @ Rs. 6000.00 pm for 12 months**	**4356000.00**	**4356000.00**	**4356000.00**	**4356000.00**	**17424000.00**
19.15	**Mobile facility for all health functionaries**	**444000.00**	**444000.00**	**444000.00**	**444000.00**	**1776000.00**
19.16	**Cost of Block Programme Management unit**	**2130000.00**	**2130000.00**	**2130000.00**	**2130000.00**	**8520000.00**

19.17	Waste management	144000.00	144000.00	144000.00	144000.00	576000.00
19.18	Operationilising Mobile Medical Unit	0.00	1404000.00	1404000.00	1404000.00	4212000.00
19.19	Monitoring & evaluation of Data Center	480000.00	480000.00	480000.00	480000.00	1920000.00
19.20	Delivery Kit for ANM & ASHA at HSC level	1340230.00	0.00	0.00	0.00	1340230.00
19.21	SBA Drug Kit to ANM/Nurses	0.00	100327.50	100327.50	0.00	200655.00
19.22	Availability of Sanitary Napkin	25000.00	0.00	0.00	0.00	25000.00
19.23	Procurement of Beds for PHCs & DH	0.00	340000.00	255000.00	255000.00	850000.00
19.24	Mainstreaming of AYUSH	1710000.00	1710000.00	1710000.00	1710000.00	6840000.00
19.25	Cost of IFA for Pregnant & Lactative mother	0.00	349072.00	349072.00	0.00	698144.00
19.26	Cost of IFA for 1-5 years Children	0.00	596604.00	596604.00	0.00	1193208.00
19.27	Cost of IFA to Adolscents girl	0.00	547299.00	547299.00	0.00	1094598.00
19.28	Reimbursement for existing cold chain room at District	100000.00	150000.00	50000.00	0.00	300000.00
19.29	Earthing and wiring of cold chain room	100000.00	100000.00	0.00	0.00	200000.00
19.30	Pol for Generator for Cold Chain maintenace	145787.00	145787.00	145787.00	145787.00	583148.00
19.31	Preparation of Health Action Plan	0.00	0.00	50000.00	0.00	50000.00
	Total	**50723767.00**	**65216850.29**	**63463100.29**	**13802537.00**	**193206254.58**
20. Pulse Polio & Routine Immunisation						

20.1	**Cost of organisation of Pulse Polio Round**	**7951752.00**	**5301168.00**	**5301168.00**	**7951752.00**	**26505840.00**
20.2	**Mobility Support for DIO**	**12500.00**	**12500.00**	**12500.00**	**12500.00**	**50000.00**
20.3	**Annual Maintenance contract for Cold Chain repairing**	**16000.00**	**16000.00**	**16000.00**	**16000.00**	**64000.00**
20.4	**Annual Maintenance contract for Vaccine Van repairing**	**25000.00**	**0.00**	**0.00**	**0.00**	**25000.00**
20.5	**Strengthening of R.I sessions at Urban & slum area**	**250000.00**	**150000.00**	**200000.00**	**164400.00**	**764400.00**
20.6	**Honorarium of Alternate Vaccinator**	**50250.00**	**50250.00**	**50250.00**	**50250.00**	**201000.00**
20.7	**Incentive for ASHA for Community Mobilisation**	**407625.00**	**407625.00**	**407625.00**	**407625.00**	**1630500.00**
20.8	**Alternate Vaccine delivery at hard to reach area @ Rs. 100 per session**	**46200.00**	**46200.00**	**46200.00**	**46200.00**	**184800.00**
20.9	**Alternate Vaccine delivery in other areas @ Rs.50 per sessions**	**567400.00**	**567400.00**	**567400.00**	**567400.00**	**2269600.00**
20.10	**Data operator for DIO office @ Rs. 8000 per month for 12 month**	**24000.00**	**24000.00**	**24000.00**	**24000.00**	**96000.00**
20.11	**Printing of immunisation card , tally sheet & monitoring form**	**0.00**	**296235.50**	**296235.50**	**0.00**	**592471.00**
20.12	**Cost of Quarterly review meeting at district level @ Rs. 8000.00 per meeting**	**8000.00**	**8000.00**	**8000.00**	**8000.00**	**32000.00**
20.13	**Cost of Quarterly review meeting at Block level**	**163050.00**	**163050.00**	**163050.00**	**163050.00**	**652200.00**
20.14	**2 Days district level orientation on R.I for ANM/LHV/MPW/Nurse/ Midwife and other health personnel**	**29425.00**	**29425.00**	**29425.00**	**29425.00**	**117700.00**
20.15	**One day cold chain handler training**	**21400.00**	**0.00**	**0.00**	**0.00**	**21400.00**

20.16	**one day Training of Data operator**	**16100.00**	**0.00**	**0.00**	**0.00**	**16100.00**
20.17	**To preparation of Microplan at sub centre level @ Rs. 100 per sub centre**	**46900.00**	**0.00**	**0.00**	**0.00**	**46900.00**
20.18	**For consolidation of Micro-plan at Block level**	**18000.00**	**0.00**	**0.00**	**0.00**	**18000.00**
20.19	**POL for Vaccine delivery from state to district and district to PHC**	**25000.00**	**35000.00**	**20000.00**	**20000.00**	**100000.00**
20.20	**Maintenance of Computer & Internet facility for RIMS @ Rs. 400 /Pm**	**1200.00**	**1200.00**	**1200.00**	**1200.00**	**4800.00**
20.21	**Cloured plastic bags for ANM**	**5628.00**	**5628.00**	**5628.00**	**5628.00**	**22512.00**
20.22	**Bleach solution for PHC**	**8000.00**	**0.00**	**0.00**	**0.00**	**8000.00**
20.23	**Twin Bucket @ Rs. 400 per PHC**	**6400.00**	**0.00**	**0.00**	**0.00**	**6400.00**
20.24	**Ticklers bags for R.I card counter foil@ Rs. 250 per bags per AWC for 2215 AWC**	**36550.00**	**0.00**	**0.00**	**0.00**	**36550.00**
20.25	**Honorarium for contractual ANM as a alternate vacinator for Break Period of one month @ Rs. 1400 / ANM for 144 ANM**	**201600.00**	**0.00**	**0.00**	**0.00**	**201600.00**
	Total of R.I & Pulse polio	**9937980.00**	**7113681.50**	**7148681.50**	**9467430.00**	**33667773.00**
	25 % Raised	**12422475.00**	**8892101.88**	**8935851.88**	**11834287.50**	**42084716.25**
	Total Budget	**123039082.45**	**125057824.55**	**124313443.06**	**77515217.27**	**449925567.31**

SUMMARY OF BUDGET

Slno.	Budget Head	Amount
1	Maternal Health	81076534.00
2	Child Health	28394558.00
3	Family Planning	31302218.00
4	ARSH	63375.00
5	Vulnerable group programme	1202743.50
6	Innovation	11501798.42
7	Infrastructure & Human Resource	7342633.15
8	Training	3280345.09
9	BCC/IEC	3038213.73
10	Procurement of equipments	8017433.60
11	Programme Management	1936078.00
12	RNTCP	7440000.00
13	NLEP	554900.00
14	NVBDCP	9725126.00
15	NBCP	3100000.00
16	IDD	58397.00
17	IDSP	574513.00
18	ASHA	16025730.00
19	Institutional strengthing	193206254.58
20	Routine Immunisation & Pulse polio	42084716.25
	Total	**449925567.32**