DISTRICT GOPALGANJ

DISTRICT HEALTH AND ACTION PLAN 2010-2011

GOVERNMENT OF BIHAR

DISTRICT HEALTH SOCIETY,
GOPALGANJ

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Acknowledgement

With the commitment to bridge the gaps within the public health care delivery system, formulation of District Health Action Plan has been attempted. For initiating the actions in the direction of betterment of health care a coordinated district health action plan has been envisioned by collaborating different departments that are directly or indirectly related to determinates of health, like water, hygiene, sanitation, nutrition etc. Thus this assignment is a shared effort of departments of health and family welfare, ICDS, PRI, Water and Sanitation and Education to sketch a concerned action plan.

The development of DHAP for Gopalganj of Bihar entailed a series of Consultative Meetings with stakeholders at various levels: collection of secondary data from various departments, analysis of the data collected and presentation of the situation in the concerned district at a District Level workshop. The District level Workshop was organized to identify district specific strategies based on which the DHAP has been prepared.

We would also like to knowledge much needed co - operation extended by DPM (District Programme Manager), DAM (District Accounts Manager), District Nodal M & E Officer of the district for his/her assistance and support since the inception of the project. Involvement of CMO played vital role throughtout the exercise enabling a smooth conduct of consultations at block and district level

Finally, We show appreciation to all who remained associated with the team for accomplishment of the task and brought fruition to this effort.

Thanks,

Kuldip Narayan, I.A.S.
District Magistrate-cum-Chairman,
District Health Society, Gopalganj.

About the Profile

Under the umberella of National Rural Health Mission (NRHM), this District Health Action Plan (DHAP) of the District Gopalganj has been prepared. In this action plan the study and the situational analysis proceeds to make recommendations towards an excellent policy on human resource management. The Action Plan emphasis on organizational motivation and capacity building aspects.

It recommends on how with limited human and material resources we can be optimally utilized and get maximum benefits for achieving the health objectives with a behalf for betterment of rural people especially women and childrens.

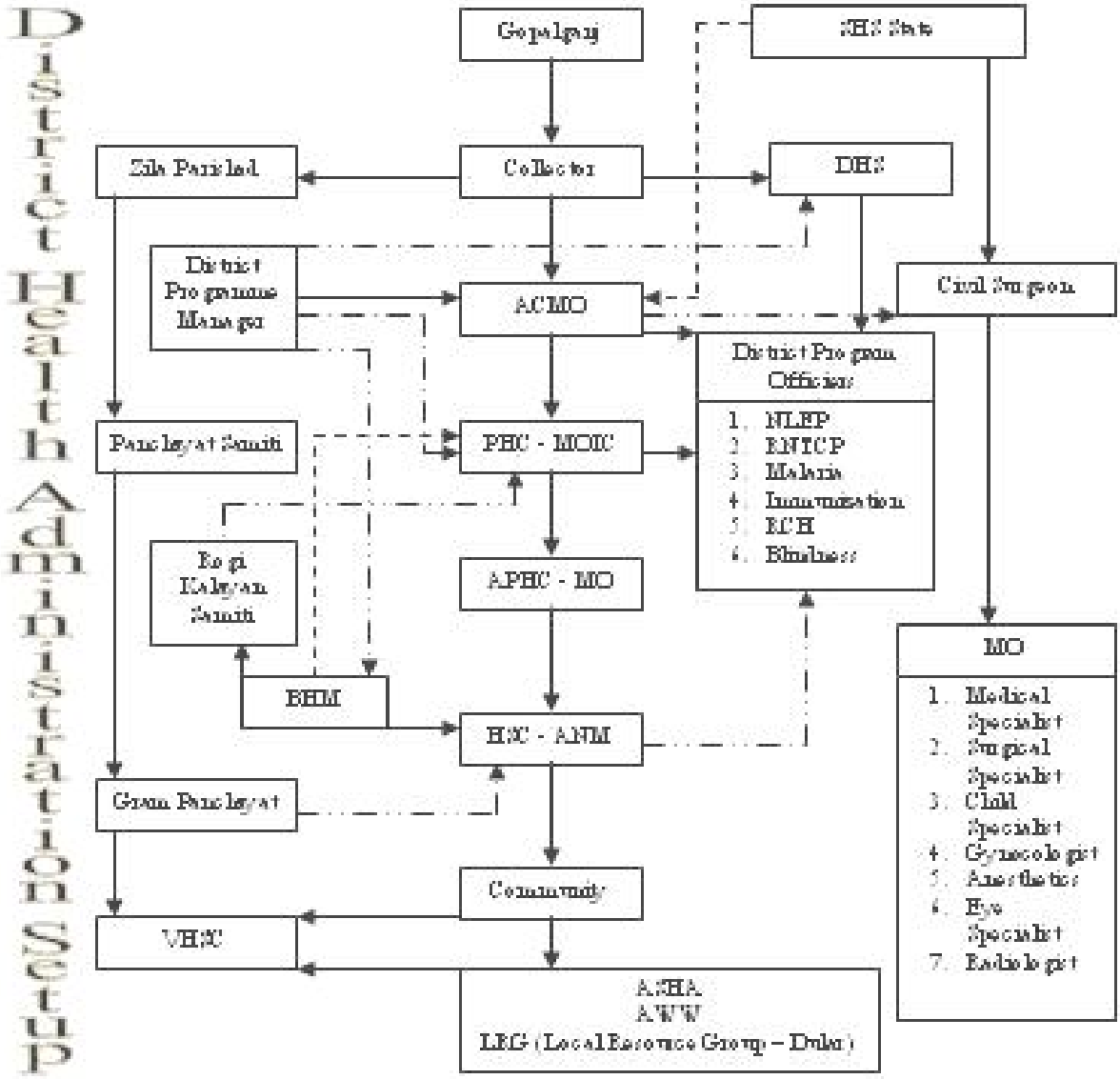
The information related to data and others used in this District Health Action Plan is authentic and correct to the best of my knowledge as this has been provided by the concerned Medical Officers and Block Health Mangers due to their excellent effort we may be able to make the District Health Action Plan of Gopalganj District.

I hope that this District Health Action Plan will fulfill the objective of National Rural Health Mission(N.R.H.M.)

Thanks,

(Dr. Sudhir Kumar Mahto)
Civil Surgeon-cum-Member Secratary
Gopalganj

Chapter – 1 (Administrative Setup)



Chapter 2

District Profile

Introduction

Gopalganj District comes into existence on 2nd October'1973. Earlier it was a part of old Saran District and has closed linked with the history of parent's district. Earlier it was a Sub – Division of Saran District.

The District of Gopalganj is located on the West – North corner of the Bihar Satate. Between 83.54° - 85.56° latitude and 26.12° - 26.39° North Attitude. It is bounded on East by Champaran and river Gandak on the South by Siwan District and on the North West Deoria District of Uttar Pradesh. The river Gandak supported by tributaries like Jharahi, Khanwa, Daha, Dhanahi etc give a big status of river. Due to this land of District is fertile and alluvial because of this river the District is good in cultivation and irrigation. The river imparts prosperity to the people to play and important role in making the District significant and unique. River Gandak by depositing the top quality of soil bringing from the Nepal, place and important role in the economy of the District.

Historical Background:-

Historians establish on the basis of analysis of evidences that this place was under the king of Videh during Vaidic age. During the Aryan period a schedule tribe Vaman King Chero roled the place. The rulers of that time were found of making temple and other religious supports. It is one of the reasons that there are so many temples and others religious places are within the reason. Some significant temples and religious supports within the district are Durga's temple of Thawe, fort of Manjha, Vaman Gandey Pond of Dighwa Dubauli, Fort of King Malkhan of Sirisia, Kuchaykot etc.

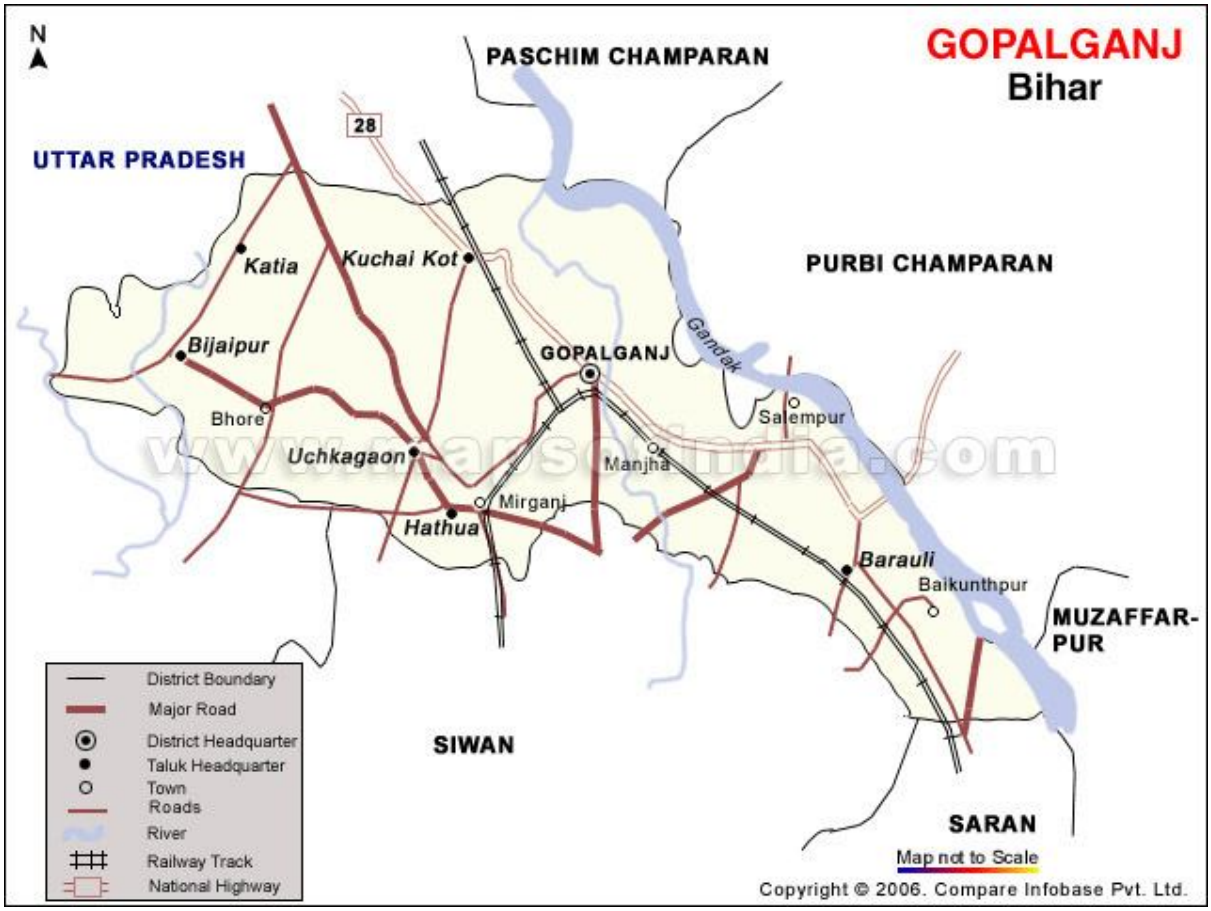
People of Gopalganj where always in the lime light either it be the struggle for freedom. Including J. P. movement and movements for women education and movement against non payment of tax and prohibition of 1930. Under the leadership of Babu Ganga Vishnu Rai and Babu Sunder Lal of Bankatta. In 1935 Pandit Bhopal Pandey gave his life for the freedom of the country.

People of Gopalganj are indebted to the freedom fighters to who gave there lives for motherland. During Mahabharat age this region was under the King Bhuri Sarwa. During 13th Century and 16th Century the place was ruled by Sultan of Bengal Gayasuddin Abbas and Babar.

Geographical Features :-

Location: -

Gopalganj District lies between 26.12° to 26.39° north latitude and attitude 83.45° to 85.55° east longitude. Head Quarter is Gopalganj town within Gopalganj Nagar Panchayat.



Area: -

The physical (geographical) area of the Gopalganj District approximates about 2033 sqr. Km. Total physical area can roughly be put in two categories i.e. Normal Area and Lowly Area (food infected area) parts of the six blocks like Gopalganj, Kuchaykot, Manjha, Sidhwalia, Barauli and Baikunthpur are flood affected areas. These areas remain under water in the rainy season. But so far as cultivation and agriculture is concern these areas called stock of food grains. Rest of the parts is normal area with full greenery and cultivable land.

Climate:-

Climate of Gopalganj is the same as rest of Bihar and can be demarcated a normal climate.

Summer season	–	March to June.
Rainy Season	-	July to October.
Winter Season	-	November to February.
Spring Season	-	February to March.

Temperature:-

Gopalganj falls within the zone of normal temperature. Normally temperature of the district varies between 10°c. - 30°c. in Winter and 30°c. - 40°c. in Summer.

Rain Fall:-

Gopalganj is situated in the region of good rain fall. Manson touches the district normally in the second half of June and showers the district up to September. Good rain falls are the main reason for development of agriculture and vegetation. The average rain fall in the district is 1009 mm.

Soil:-

Soil found in the district mainly Clay Soil, Sandy Soil and Alluvial Soil Gangatic Soil. For agriculture and vegetation. This type of Soil is useful and important.

Fauna:-

Animals widely found in the district are Cows, Buffaloes, Horses, Sheep, Goats and Pigs. These animals play an important role in the life of farmers.

Some small wild animals like Nil Gay, Rabbits, Sahil, Jackals, Fox and Peacock are in the area within the district. Some times Deers, Elephants and Leopards and also seen within the district.

Irrigation:-

Planned irrigational facilities within the district are not sufficient. There are mainly two sources of irrigation systems. One is Gandak Canal and others is government tube well. Gandak Canal has two Divisions one is the Saran Canal Division Gopalganj and second is the Saran Canal Division Bhorey. The total net irrigated areas is 98,352.64 hqr these two irrigational systems coverless than 45% of the total cultivable land area of district. Farmers depend either upon Manson or private irrigational system i.e. Hand pump, Boring, Lift irrigation. Local waters storage or on Ponds for irrigation of there fields.

Flora:-

Gopalganj falls under greenbelt areas. Roughly all types of trees and plants are found in the district namely Babbul, Neem, Shisham, Mango, Sagwan, Katahal, Sal, Shakhuwa, Peepal, Bargad etc.

Unfortunately the people of Gopalganj due to lake of awareness are cutting trees without carrying for its bad impacts. Awareness about the ecological balance must be spread amount the general people specially the children.

Crops:-

All types of food grains and crops are found in this region as Wheat, Paddy, Grams, Arahar, Maize, Sarso, Tishi, Potato, Sugar Cane etc. But Wheat, Paddy and Maize are the main crop of the district Gopalganj is also known for production of Green Vegetables, Fish, Sugar Cane, Milk and Milk products.

Education:-

There are 835 Primary, 323 Middle and 51 High Schools. One Teachers Training College, One Government Polytecnic, One Homeopathic College, One ITI, Mirganj, One Sainik School, Hathuwa, One Central School, 4 Cons College etc. are situated in the district.

Devi Durga of Thawe:-

Durga Mandir of Thawe is an important temple of Maa Durga situated at the Gopalganj – Siwan main road at Thawe Block. It is very famous temple people came from all parts of the districts and out side to pray the Goddess to full fitment of there dreams.

Festivals:-

All festivals like Durga – Pooja, Deepawali, Janamashtami, Kali Pooja, Sarswati Pooja, Nag Panchemi, Chhath Pooja, Shiv Ratri, Id, Bakarid, and Mohharam are celebrated with great religious enthusiasm spirit and harmony.

Health:-

The District has 1 District Hospital, 3 Referral Hospital, 8 Primary Health Centers and 23 Additional Primary Health Centers to center the basic health needs for the district. Some times district is face drought like condition. The irrigational facilities are not sufficient. This causes the farmers to face the drought like condition.

Weakness of the District:-

The District is suffering from major two setbacks. 1 – Flood. Time and again the district faces flood form river Gandak that destroy standing Crops and human lives and cattle lives. Half of the blocks face flood during the rainy season. Partly or wholly. This cause threat to the recourses of the district. All though there is a

Jamindari Bandh and protective Ring Bandh on the bank of river Gandak but the condition of the Bandh is worst the District has to face a lot of problem to protect the Bandh. These Bandhs are repaired time and again.

GOPALGANJ AT A GALANCE

Area :-	2033
Population (Census 2001)	
Total :-	2152638
Males :-	1075710
Females :-	1076928
Rural Population	
Total :-	2022048
Males :-	1016485
Females :-	1005563
Urban Population	
Total :-	130590
Males :-	67646
Females :-	62944

Population of shedule castes :-	267250
Density of Pooulation :-	1059
Sex Ratio :-	1001

Basic Data	India	Bihar	Gopalganj
Population :-	1026443540	82998509	2152638
Density :-	324	880	1059

Social – Economic			
Sex – Ratio	933	919	100%
Literacy Total (%)	65.38	47.53	47.51
Male (%)	75.85	60.32	63
Female (%)	54.16	33.57	32.2

Literacy Rate	
Total :-	47.50%
Males :-	63%
Females :-	32.20%

Vilages	
Total :-	1566
Inhabited :-	1397
Uninhabited :-	169

Panchayats :-	235
Sub - Divisions :-	2
Blocks :-	14
Revenue Circle :-	14
Halkas :-	101
Police Stations :-	18
Police Outposts :-	4
Town :-	4
Nagar Parishad (Gopalganj)	1
Nagar Panchayat (Barauli, Mirganj & Kateya)	3
M.P. Constituency :-	1
M.L.A. Constituency :-	6

Health	
District Hospitals :-	1
Referral Hospitals :-	3
Primary Health Centre :-	14
Additional Primary Health Centre :-	22
Health Sub Centre :-	186
Gramin Ausadhalay :-	9
Blood Bank :-	1
AIDS Control Society :-	2
Trained Nurses :-	300
Trained Doctors :-	80

Chapter-3

Situational Analysis

In the present situational analysis of the blocks of district Gopalganj the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from census 2001, report of District Health Society & Health Office, Gopalganj and various websites as well as other sources. These indicators help in pointing to the health scenario in Gopalganj 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 Gopalganj district with respect to Bihar and India as a whole.

Table 3.1: Health Indicators

Indicator	Gopalganj	Bihar	India
CBR#	36	29.9	25.0
CDR#	8.80	7.7	8.1
IMR#	53	60	63.0

Internal MIS data

1.1 Availability of facilities and location of facilities

As per existing norms one HSC is planned for every 5000 population and for tribal areas the 3000 population, one APHC for every 30,000 population and for tribal area 20,000 population one PHC for every 1, 20,000 population.

The number of gap is in the number of sectors without HSCs, without APHC, we have major gap in PHC where in practice the norm followed is one PHC per administrative block. There is noPHC in the Bihar. 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

It is required to prepare block level maps showing all villages with location of existing HSCs and APHC and its service area in all blocks as well as demarcating various sections and sectors according to population norms fixed for areas with tribal, primitive population and non tribal populations. Based on this to search out ideal locations for HSCs and APHC as and compare this to where they are currently. The location of proposed HSCs and APHC are effectively done by based on GIS. So apart from constructing the requisite number of new sub - centers we also need to either construct buildings for these 186 old HSCs and 249 new HSCs or we can take over the existing building from where they are functioning from and upgrade and equip them sub-centre requirements. The district and block level team has discussed and finalized the location of the new sub centers with the help of community, local administration and health service providers with the help of GIS map.

To ensure one progress of any district, it is important to ensure that its people are healthy and have round the clock easy access to adequate health infrastructure. 23 APHC and 186 HSCs are functioning in the district. The block wise details are as follows:

Table 3.2: Block wise health infrastructure details of Gopalganj district

Blocks	Population covered	PHC Existing (In No.)	APHC Existing (In No.)	HSCs Existing (In No.)
Baikunthpur	177196	1	1	18
Barauli	177116	1	2	18
Bhorey	148890	1	4	15
Kateya	96742	1	1	8
Kuchaikote	277714	1	3	22
Manjha	172233	1	2	10
Panchdevri	83826	1	1	5
Phulwaria	109650	1	2	14
Sadar	130955	1	1	16
Sidhwalia	113914	1	1	7
Hathuwa	130955	1	2	15
Thawe	96826	1	0	7
Uchkagaun	129043	1	2	16
Vijaipur	115723	1	0	13
Total	**1960783**	**14**	**22**	**184**

Table 3.3: Proposed Infrastructure as per IPHS norms

Blocks	Population covered	PHC		APHC		HSCs	
		Existing (In No.)	Proposed (In No.)	Existing (In No.)	Proposed (In No.)	Existing (In No.)	Proposed (In No.)
Baikunthpur	177196	1	0	1	5	18	20
Barauli	177116	1	0	2	4	18	20
Bhorey	148890	1	0	4	1	15	15
Kateya	96742	1	0	1	2	8	11
Kuchaikote	277714	1	0	3	6	22	39
Manjha	172233	1	0	2	4	10	25
Panchdevri	83826	1	0	1	1	5	13
Phulwaria	109650	1	0	2	2	14	12
Sadar	130955	1	0	1	3	16	14
Sidhwalia	113914	1	0	1	3	7	16
Hathuwa	130955	1	0	2	2	15	26
Thawe	96826	1	0	0	3	7	12
Uchkagaun	129043	1	0	2	2	16	13
Vijaipur	115723	1	0	0	4	13	13
Total	**1960783**	**14**	**0**	**22**	**42**	**184**	**249**

Table3.4 : PHC level Infrastructure details

PHC/ Block PHC	Building		Building Condition	Power Supply (in hrs)	Gen set	Water Supply	Telephone	Sanitation (Toilet / Bath)		No. of Beds	Waste Management
	Govt.	Rented						Patient	Staff		
Baikunthpur	1	0	Good	24	1	1	1	1	1	6	1
Barauli	1	0	Good	24	1	1	1	1	1	6	1
Bhorey	1	0	Good	24	1	1	1	1	1	6	1
Kateya	1	0	Good	24	1	1	1	1	1	6	1
Kuchaikote	1	0	Good	24	1	1	1	1	1	6	1
Manjha	1	0	Good	24	1	1	1	1	1	6	1
Panchdevri	1	0	Good	24	1	1	1	1	1	6	1
Phulwaria	1	0	Good	24	1	1	1	1	1	6	1
Sadar	1	0	Good	24	1	1	1	1	1	6	1
Sidhwalia	1	0	Good	24	1	1	1	1	1	6	1
Hathuwa	1	0	Good	24	1	1	1	1	1	6	1
Thawe	1	0	Good	24	1	1	1	1	1	6	1
Uchkagaun	1	0	Good	24	1	1	1	1	1	6	1
Vijaipur	1	0	Bad	24	1	1	1	1	1	6	1
Total	14	0			14	14	14	14	14		14

1◎ implies availability 0◎ implies unavailability

Further, the current health infrastructure is supported by district hospital and Sub – Divisional Hospital. The total number of PHC will be Fourteen. 14 PHC are having vehicle services with ambulances. (Table 3.5)

Table 3.5: PHC level Vehicle details

Sl.No.	PHC/ Block	Type of Vehicle	No.	Condition
Baikunthpur	Baikunthpur	Ambulance	1	Good
Barauli	Barauli	Ambulance	1	Good
Bhorey	Bhorey	Ambulance	1	Good
Kateya	Kateya	Ambulance	1	Good
Kuchaikote	Kuchaikote	Ambulance	1	Good
Manjha	Manjha	Ambulance	1	Good
Panchdevri	Panchdevri	Ambulance	1	Good
Phulwaria	Phulwaria	Ambulance	1	Good
Sadar	Sadar	Ambulance	1	Good
Sidhwalia	Sidhwalia	Ambulance	1	Good
Hathuwa	Hathuwa	Ambulance	1	Good
Thawe	Thawe	Ambulance	1	Good
Uchkagaun	Uchkagaun	Ambulance	1	Good
Vijaipur	Vijaipur	Ambulance	1	Good

The gaps in accommodation are huge. APHC do not have the required number of quarters for Doctors as well as nurses (Table annexed). Whatever the existing quarters are there, they are in a very sorry state. There is acute shortage of quarters for Paramedics and other staff at all the APHC. In the campus residential accommodation for all staff is required not just for few is very necessary if we really want to have our PHC 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 PHC.

As far as 22 APHC are concerned, Out of 22 APHC all are functioning with facilities in damaged building (Table annexed). They are either functioning in the sub-centre building. Almost 05 APHC are functioning in government buildings, but building condition is very poor. All APHC are devoid of electricity, lacking of water supply because Hand pumps are not functioning properly. There are no residential facilities for staff.

Out of 186 existing Health Sub-Centre, 30 HSCs are running in Government building, 156 HSCs are running in rented building. Almost all the Government buildings are in poor conditions and immediately renovation / new constructions are required. As per population norms and geographical conditions 249 new more sub-

centers are required to provide better health facility to the community. The total number of new buildings is required 405 others are renovated i.e. 30 HSCs.

Manpower Availability and Gaps in Manpower

Sl. No.	Cadre	Sanctioned	In position	Vaccant
1	Madical Officer	101	52	49
2	Contractual Doctors	69	41	28
3	'A' Grade nurse	18	7	11
4	Contractual 'A' Grade nurse	46	13	33
5	LHV	21	7	14
6	A.N.M.	266	250	16
7	Contractual A.N.M.	186	48	138
8	Sanatary Inspector	11	3	8
9	Pharmacists	39	4	35
10	Health Educator	22	11	11
11	Dresser	43	10	33
12	Lab Tech	34	8	26
13	B.H.W.	54	39	15
14	F.P. Worker	30	25	5
15	Health Worker	30	3	27
16	Block Extension Educator	10	1	9
17	Public Health Nurse	5	1	4
18	Radiographer	5	3	2
19	O.T. Assistant	5	0	5
20	Opth. Assistant	3	1	2
21	Statician	2	1	1
22	Medical Officer (Lep)	1	0	1
23	Medical Social Worker (Lep)	3	3	0
24	N.M.A. (Lep)	22	12	10
25	Health Visitor	4	3	1
26	B.C>G. Technician	6	0	6
27	Computer	10	8	2
28	Clerk	69	67	2
29	4th Grade	205	139	66
30	ASHA	2040	2034	6

3.3 Infrastructure: Current Status and Gap

3.3.1 Infrastructure facilities at PHC

Gopalganj District has 14 PHC. All the PHC function from their own building. The source of water for all PHC is overhead tank.

All the facilities have electricity in all parts of the hospital. 14 PHC have Operation Theatres. Fourteen PHC have a separate aseptic labour room. PHC have adequately equipped laboratories; while generator is available in 14 PHC. Telephone facility is available in all PHC. All PHC have ambulance on the road.

None of the facility has OPD facilities for RTI /STI. OPD facility for gynecology/obstetric is not available.

There are facilities for privacy in all PHC, for sterilizing instruments is available in 14 PHC while facility for counseling is available in none of the facilities. There is no blood bank available in the district.

Quarters for MOs & Paramedical staff in all PHC are inadequate and required immediate renovation. Accommodation facilities for relatives or attendants of patients are not available in any PHC. Personal Computers are not available in any PHC except District Head Quarter.

Specific staff training of medical officer in PHC

The post of obstetrician/ gynecologist is not filled in any PHC. The post of RTI/STI specialist is not filled in any of the facilities. The post of PHN is not filled in any of the facilities, while the posts of laboratory technician, pharmacist and staff nurse are filled and available in all PHC. The post of Health Assistant (Female) is filled and available in all PHC. There is no training on sterilization, MTP, RTI / STI, New born care since last 5 years in any PHC.

3.3.2 Availability of specific facilities in Primary Health Centres

There are no facilities of toilet, water supply electricity, laboratory, vehicle, labour room in any APHC. Because, Bihar has Primary Health Centre, Additional Primary Health Centre and Health Sub Centre. But other state has PHC, PHC and HSC. In NRHM period Bihar Government has notified PHC has to be converted into PHC, APHC converted into PHC. That's why; PHC is not according to IPHS norms.

3.3.3 Availability of specific facilities in Sub-centre

Of the Sub-centres surveyed in Gopalganj district, only 30 HSCs function from government buildings, 156 are running in rented building. The total buildings are required 186 and 30 existing HSCs are required to renovate. 80% of then have at least well as the source of water, There is no facilities of electricity, toilet facility and quarters for the health worker. The ANMs is present in all SCs, but there is no any means of transportation. 10% of the SCs have health worker (male). There is no training on IUD insertion, CDD / ORT, UIP, CSSM, RCH and ARI.

3.3.4 Availability of specific facilities in District Hospital

There is one Hospital in Sadar Hospital in Gopalganj district. The Hospital functions from a pakka structure. The source of water is at least Tube well and; the district

hospital has electricity supply and has generator or a telephone. The hospital has toilet facility and a vehicle in working condition. There are facilities like laboratory and X-ray machine. There are separate indoor or outdoor departments in the Hospital. Beds, pillows, bed sheets, delivery table and examination table are available as per norms. There is an independent 1 District Hospital (DH), 1 Sub-Divisional Hospital, 14 Primary Health Centre (PHC) and 23 APHC in the district. The all facilities cover the entire ablout 21 lakhs population of the district.

Physical Infrastructure

a. Hospital Building

The DH has a compound wall fencing all around. The DH has its own building. The other facilities also operate from their own buildings.

b. Source of Water Supply

The source of water supply for the DH is Bore well/Hand Pump/ Tube Well. This is also the case with the other facilities surveyed, which have piped water, Overhead tank and pump are available at the DHs. Water supply and associated facilities are not adequate in all these facilities.

c. Electricity

Electricity is available in all parts in the facilities. The electricity supply to the DH is continuous. All the facilities have regular electricity supply. The generators available at both the DHs and 14 PHC are in working condition. It was reported that the capacity of the generators is sufficient as per the requirement at all these facilities.

d. Disposal of waste

DH is connected to the municipal sewage. The other facilities surveyed do not have any sewage facility. The waste is not segregated as infectious/ non-infectious at any of the facilities. There is waste treatment plants in District Hospital compound, The biological wastes are buried in a pit & two incinerator are also in most of the facilities surveyed.

e. Staff Quarters

It was found that quarters for both Doctors/MO and other staff are available but not sufficient. PHC of Gopalganj has quarters for the doctors-in-charge. None of the facilities have staff quarters for gynecologists, /obstetricians, pediatrician, RMOs and anesthesiologists.

f. OPD Services

OPD facilities are available in the DH. OPD facilities are found to be good in the DH. It is observed that OPD services for gynecology /obstetric and RTI / STI are available in the DH. OPD services are available in all PHC. OPD services for RTI/STI is available in the DH and Sub-Divisional hospital.

g. Availability of Beds

The information about total number of in-patient wards is available in the DH while the total numbers of beds are 60 but it will upgrade into 500 bedded. All PHC have the number of beds being 6 respectively.

h. Man power and In-service Training

In the DH, all the sanctioned posts of doctor in charge, gynecologist and obstetrician, pediatrician, pathologist, and anesthesiologist are not filled and available. There is no gynecologist and obstetrician in any PHC.

3.4 Rationalisation Equipment – Gap, Procurement & Utilisation

It is also quintessential that equipments assessment is done to ascertain gaps. Smaller low cost equipment that is frequently replaceable must be dealt with as for consumables. Larger equipment, which is costlier and requires training to make operational needs to be purchased and deployed only as part of block and district level plans linked to service quality deliverables. This would ensure that there is no mismatch between equipment purchase and infrastructure, between equipment and skilled manpower available, between equipment and related consumables supply and that the purchase of equipment is linked to quality improvements in the package of services offered at this level.

Purchase can have the same policy of pre-qualification and price negotiation at the state level with districts then placing orders. The same empowered body which implements drug and supplies procurement and distribution may undertake all equipment purchase. Further such a body would ensure that adequate arrangements are made for maintenance and such arrangements are renewed.

Attention may be given to closing the gaps regarding water supply and power supply and to ensuring that separate toilets for staff as well as bating facilities for men and women are also in place in each of the PHC and PHC structures. Inadequately recognized priority areas are waste disposal systems, drainage and sewerage all of which needs to be put into place in all APHC and PHC.

Major equipments like X-ray machines, ECG, Hemoglobinometers, surgical equipments, Boyle's apparatus are not available in any PHC. Auto clave, instrument sterilizers, microscopes, stethoscopes, BP apparatus, weighing machine, infant weighing machine, oxygen cylinders, ambu bags, emergency lamps, Deep freezers, ILR etc. are available but condition of most of the instruments are not up to the mark (Table annexed). All of them have the minimum necessary hospital furniture for the running of PHC. But the main problem is that they do not have any proper maintenance by the staff. There are many instruments like the Ambu bags which are not very costly and can be replaced in a short notice. They were out because of

irregular maintenance. X-Ray machines are also installed at Sub-Divisional Hospital and PHC Kuchaikote.

At the PHC level 100% of the APHC are having BP apparatus, weighing machines, Hemoglobinometers, sterilizers, IV stands, scissors, and delivery tables. None of the APHC are having the X-ray machines, binocular, blood cell calculator and emergency light.

All the PHC should be provided with Blood Transfusion and other Hematological investigation and ECG facilities for complete, improved as well as ideal PHC. Regular servicing of the instruments needs to be done to make the PHC function at its optimum level. Training needs to be provided to the staffs regarding how to use computers and equipments that are being provided to the PHC. Most of the staff does not know how to use them nor do they want to know. So these instruments provided never come out of the boxes and get destroyed with out even being used once.

At PHC level, there should be a provision for X-ray, laboratory and also transportation facilities like ambulance, jeeps, etc. PHC staff also needs to be trained how to use the instruments and what are they for. Even if they have the instruments, as they do not know what are they called or for what purpose they are used when generally asked they say they do not have the equipments

Contractual appointment of technicians for maintenance of major/minor equipments is proposed.

3.5 Training Need Assessment /Human resource development/ Capacity Building

Though regular trainings are provided under various national programmes to doctors, paramedical staff especially lab techs and MPWs, the quality of trainings are not Upto the level expected. So far the block level trainings are concerned, these are largely done like meetings and the lower level trainings go to even poorer results. Skilled team for training is another issue. This leads largely to logistics gaps and also affects the training quality and transmission sustenance. Thus the major focus should be training logistics and personnel.

There is an ANM Training Centre located in the Hathuwa which imparts 18 months of trainings to ANMs. Though most of the ANMs & LHVs have been covered under these trainings but some feedback trainings also needs to done so that they retain what they have been taught.

The following additional trainings for various levels need to be imparted in 2009–10.

- Skilled birth attendant training for ANM, LHV and Grade “A” Nurse etc.

The capacity of participants needs to be further built up by exposure visits to model health institutions of other states as well. Apart from all the above mentioned trainings the staff at all levels should be constantly updated about the latest technology and developments. All the staff should be given regular training on how to use computers and instruments that are being regularly provided to them by the centre so that the dream of having completely functioning PHC, APHC, HSCs for 24 hours a day and 7 days a week comes true.

The goal of the training policy shall be attainment of a specified quality of care for a given facility. The same is applied for para-medicals as well as for medical officers. To achieve this goal we recommend an in-service training package with following features:

Multi-skilling for Paramedical

Training Roster: A roster of all MPWs and health supervisors should be maintained at the block and district level just for this purpose denoting last training attended topics and number of days of training in each.

Syllabus: The syllabus for it should be built up to include:

- Changes in health programme guidelines of national health programmes- best address through two day sensitization programmes, whenever such a change is made.
- Renewal of core area of their work – RCH programme for MPWs and national programmes for male workers.
- Multi skilling training in which female workers learn more about national programmes and about basic laboratory skills and male workers learn about RCH and adequate levels of basic laboratory skills.
- Adequate training for first contact curative care.
- A modified IEC training programme capability with focus on interpersonal and community mobilization skills along with better understanding of a multicultural and ethnically diverse society.

On-the job Training : The supervisors should be held responsible for on the job training of the health workers and periodic evaluation of knowledge and skill of health workers be used to ensure that they perform this task adequately, as they should be accountable for this in their juniors. The medical officers must be equipped to evaluate the supervisors on training in most areas and in some areas like basic laboratory services they should be capable of providing in-service training.

Integrate Training Funds: All training funds from various programmes are deployed n such a way that even as the objective of that grant is realized, the training goals the state has set itself is also advanced within that same space.

Training Cell: A training cell for in-service MOs, MPWs and supervisors training have constituted in the Institute of Public Health (IPH) that is constantly doing training needs assessment, training material development, master trainer training of district training centers, supervision of training rosters and training evaluation.

Trainings for Medical Officers

Continuing Medical Education: We recommend a continuing medical education scheme for medical doctors to upgrade their knowledge and skills. A continuing medical education scheme should be pursued as a very useful intervention strategy in health care delivery system.

Minimum Skill-Mix for PHC: Having defined a minimum package of services at the PHC as essential to meet public health goals one needs to a put in place a road map by which the desirable skill mix needed for delivering such a package of service would become a reality. We make the following suggestions in this regard.

- Decide on what skill mix is needed in each PHC and what the gaps are. The focus is on emergency obstetric care but the skill mix approach need not be confined to this alone.

- Draw up a schedule for providing short term trainings so that existing medical officers and specialists fill up the gaps with acquired basic skill sets other than in areas which their primary specialization. Thus a surgeon may also learn to do caesarean section or ENT and ophthalmic work, or a physician may learn paediatric functions and so on.

- Where gaps still remain one may use public private partnership to fill up the gaps.

Though regular trainings are provided under various national programmes to doctors, paramedical staff especially lab techs and MPWs, the quality of trainings are not Up to the level expected. So far the block level trainings are concerned, these are largely done like meetings and the lower level trainings go to even poorer results. Skilled team for training is another issue. This leads largely to logistics gaps and also affects the training quality and transmission sustenance. Thus the major focus should be training logistics and personnel.

There is an ANM Training Centre located in the Sub-Divisional Hospital Campus, Hathuwa which imparts 18 Months of trainings to ANMs.

3.6 Health Services:

There are 186 subcentres, 22 APHC and 14 PHC spread in the 14 blocks of Gopalganj. The OPD situation, bed occupancy and hospital management related

issues are not in a very good condition if compared to the potential and capacity of institutions. The quality of public health services has been described in concerned sections and here the analysis of the clinical services.

- APHC have yet to start function on a 24 hour basis though roasters in this view have been prepared in all facilities.
- ANMs availability in the headquarters still is an issue.
- Though contractual appointments are given, the no. of doctors is not adequate.
- Neonatal care is also a problem area needs improvement. Equipments and nursery facility provided to improve this also needs to be properly installed and used in almost all those facilities.
- The management of severe and acute malnutrition is not at all taking place.
- Supervisors are neither in sufficient number nor trained enough for supervising the work of the ANMs.
- In many places post of sector supervisors are vacant and needs to be fulfilled
- ANMs are not provided with stationery by the district.
- Supervisors also complaint that they are not provided any stationery from the block headquarters and they are purchasing stationery on their own expenses.
- There is no system of checklist to get the actual data from ANMs for reporting.
- The complete system of monitoring the current status of the health needs to be redefined.
- The geographical constraint is the main constraint in reaching 100% immunization.
- The distance between most of the tolas is greater compared to those villages in the plain areas.
- ANM/MPWs are overburdened with work due to the shortage of staff which needs attention from the district authorities.
- Most of the ANMs either travel by cycle or they merely walk due to hilly areas.
- There is less coordination among ANM / MPWs, and AWWs.
- There is a greater gap of man power, infrastructure and equipment's at subcentre level due to which Subcentres are not functioning with quality services.
- Continuing out of pocket expenditure by ANM on stationary and travel with lack of adequate arrangements for facilitating mobility also effects the proper functioning of the subcentres.
- Continuing gaps in the cold chain maintenance and supply of disposables needed to improve quality in immunization.

Creating Conducive environment: Service condition

(Transfer, promotion; financial burdens; Personal Security Accommodation for staff)- The lack of a transparent fair system of transfer is easily one of the greatest

causes of workforce dissatisfaction and demoralization. Some staff spends their lifetimes working in remote areas seeking and never getting a transfer whereas others perceived to be able to personally and unfairly influence decision making get plum postings throughout their careers. This makes less staff willing to serve in rural areas and when they are so posted do their task with such a deep-rooted sense of frustration and anger that the quality of the work suffers. The problems of doctors not willing to serve in rural areas should be seen only in this context and should not even be raised against the medical profession unless a basic transfer policy has been put in place.

Promotions need to be regular and timely and fair. There have been almost no promotions for the last three years in this state. This has led to situation of deep dissatisfaction that runs through the entire department. It has also meant that all positions of authority starting from the top most and preceding through the CHMOs up to the BMOs are held in an adhoc and arbitrary manner. Further the opportunities for an active career plan for a talented doctor or one who is able to work is able to work hard and perform more are absent. Considerable possibilities for non-medical and even non-service incentives that can be given to a doctor have bee left unexplored. For paramedical staff too the lack of any possibility of a promotion let alone a career acts as a great demotivation from taking any initiative. These are all remediable aspects that need to be urgently attended to.

One nagging problem is the significant amount of expenditure that is being required to be spent out of pocket for staff, especially junior most staff, for what are clearly official functions. The main problems relate to travel allowance and stationary. This needs to be remedied at once, starting with stationary expenses of MPW females.

Another major problem is personal security, again a problem maximal with MPW females. Violence and sexual harassment, covert and overt affects about 10% but creates a sense of insecurity in all.

Another basic service issue is accommodation. At no level is there adequate housing for all staff. The focus has been on developing government housing for doctors first. At the PHC level there is accommodation available, especially for doctors but it is seldom adequate to house even half the staff or even half the number of doctors. At the PHC, most do not have accommodation for doctors and only about half have usable accommodation for other categories of staff. In many of these locations, availability of basic quality rental accommodation is also a problem.

Laboratory Services

Laboratory services at the sub-centre are absent. By norms four basic tests-Blood pressure, weighing of pregnant women and children, blood haemoglobin estimation and urine testing for sugar and albumen (also ESR) are expected to take place here. These above tests however do take place infrequently in APHC but even here they

are not regular. That the PHC, as per norms, has a basic laboratory which can do about 20 basic diagnostic tests has almost been forgotten within the system. Even microscope availability is low. In the last three years there has been considerable movement forward in this area and now availability may approximate 5% of APHC- still a low figure.

In PHC the laboratory is active but performs almost exclusively two tests, the blood smear examination for malarial parasites and sputum examination for AFB. The list of desirable diagnostics at the PHC level is over 40 tests. Where PHC are active the workload of these two tests are heavy (as no tests are being don at sector level) and this crowds out the possibility of doing any other laboratory investigations except the four that are to be done at the HSC level. Also as a consequence, the 'smear taking to report reaching back' time gets lengthened considerably (on an average 15 days to a month). With such delay this entire workload on the laboratory brings no additionality to health service outcomes. The blood smear examination has increasingly taken the form of a "modern" ritual denoting medical care devoid of content.

There is no major perception of the lack of laboratory services as serious lacunae – again reflecting on the weaknesses in understanding and lack of emphasis of quality issues in medical care.

Referral Services

The current referral services have two forms. Firstly there is a fund placed at the disposal of the panchayat for use hire / pay for transport to shift needy patients to hospital. There is an understanding that this must be used for high risk and complication of child birth. Fund flow and even awareness of this provision in panchayats is low and because of other structural constraints lack of vehicle, inability to call vehicle in time etc) its utilization is very low even as the need for referral goes unanswered.

The other referral is the patient asked orally or with a slip to go seek treatment at a higher centre. This brings no advantage to patient or to the system and is perceived by patient as the referring facility having deliberately or otherwise failed to deliver its services. There no clear norms for what is to be referred and when and there are no mechanisms to monitor referral to reduce unnecessary referral and insist on necessary ones. There is no feedback of any sort. In sort there is no "referral system" in place.

Preventive services:

This being the most important aspect of disease control, a lot of stress has to be laid on it. All the staff of the MMU should be trained on the preventive strategies for the control of various diseases. MMU staff has to be identified, trained and assigned the duty of propagating this preventive aspect. Preventive strategy should be in tandem with the IEC/Advocacy being undertaken and it should be a flow of information,

starting from basic information of the disease and its treatment modalities in IEC and ending with the preventive aspect of the disease.

- Diagnostic services:
- Laboratory based
- Complete Blood Count
- Routine Urine examinations
- Urine examinations for sugar and Albumin
- Stool examinations.
- Peripheral smear for Malaria.
- Laboratory based diagnostic and surveillance procedures for Leprosy and other endemic diseases should also be made available.
- Sputum examinations should be carried out for diagnosis and monitoring of treatment under RNTCP.
- Facilities for diagnosis/ collection centre for the investigations of HIV/AIDS infection shall be made available.
- Radiological investigations (optional, to be need based and decided locally)
- A portable X-ray machine.
- Portable Ultrasonography equipment.
- Portable ECG machine (optional, to be need based and decided locally)
- Screening for breast cancer, cervical cancer (optional, to be need based and decided locally).
- Basic facilities for diagnosis ophthalmic anomalies/deficiencies (optional, to be need based and decided locally).
- Clinical services:
- Maternal health- Outreach Gynecological health care services
- ANC services
- Minimum 3 ANC check-ups.
- Prophylaxis of iron and folic acid.
- Tetanus Toxoid immunization.
- Early detection of complicated pregnancy.
- Counseling and referrals for institutional delivery.
- Child health
- Outreach pediatric health care services.
- Management of Diarrhoea and dehydration.
- Management of malnutrition.
- Monitoring of growth of under five year olds.
- Routine immunization.
- Family planning and Reproductive health services
- Clinical FP services- Cu-T, Injectables, Sterilizations (optional).
- RTI/STI management.
- Counseling on Various family planning initiatives/ methods (Natural- LAM, Safe period etc. and Modern- Condoms, Oral pills etc)
- Adolescent health issues
- Breast feeding

- First Aid and Minor Surgical procedures.
- Drug Distribution centre for various treatment modalities available under NRHM and State health initiatives.
- Specialized health care services (optional, to be need based and decided locally)
- Pediatrics / Orthopedic / Skin and STD /Ophthalmic /Psychiatric/Cardio-thoracic
- Ear Nose Throat disorders

Pharmacy services:

Referral and Transportation services

Linkages to be developed with Institutional health care providers from the public as well as private sector. MMU should also act as a means of transportation for cases requiring Institutional care.

Emergency Care Services

MMU shall be in the forefront of the support and care required during disasters/epidemics/public health emergencies/accidents etc. MMU will have a preformed action plan with duties delegated to each of the staff to cope up with such emergencies.

Telemedicine

(optional, every district should aim at establishing this facility as a part of scaling up of the outreach activities) This initiative shall help reduce the time lapse between diagnosis and treatment. To be linked with the local Medical College, where a technical hub shall be created.

Chapter 4

Chapter 4
Setting Objectives and Suggested Plan of Action

4.1 Introduction

District health action plan has been entrusted as a principal instrument for planning, implementation and monitoring of fully accountable and accessible health care mechanism. It has been envisioned through effective integration of health concerns via decentralized management incorporating determinants of health like sanitation and hygiene, safe drinking water, women and child health and other social concerns. DHAP envisages accomplishing requisite amendments in the health systems by crafting time bound goals. In the course of discussions with various stakeholder groups it has been anticipated that unmet demand for liable service provision can be achieved by adopting Intersectoral convergent approach through partnership among public as well as private sectors.

4.2 Targeted Objectives and Suggested Strategies

During consultation at district level involving a range of stakeholders from different levels, an attempt has been made to carve out certain strategies to achieve the specific objectives that are represented by different indicators. The following segment of the chapter corresponds to the identified district plan objectives demonstrating current status of the indicators along with the expected target sets that are projected for period of next two years (2010-12).

Chapter 5

Work Plan

5.1 Proposed Activities with Reference to Time Frame

To make suggested strategies and activities more accountable a model work plan has been developed. In the matrices below, proposed activities for the performance indicators have been planned year-wise to give a broad picture as to when the activity could happen. Besides, persons/departments that share the responsibility for primary activities have also been broadly demarcated.

5.1.1 Work Plan for RCH

NRHM envisage to have an substantial impact on: (*i*) reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR); (*ii*) universal access to integrated comprehensive public health services; (*iii*) child health, water, sanitation and hygiene; (*iv*) prevention and control of communicable and non-communicable diseases, including locally endemic diseases; (*v*) population stabilization, gender and demographic balance; (*vi*) revitalize local health traditions and main-stream Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health (AYUSH); (vii) promotion of healthy life styles.

Table 5.1: Work plan for RCH

	Activity	Time Frame (from 2010-11) in Percentage
	Objective	
	Universal coverage of all pregnant women with package of quality ANC services as per national guidelines	50.0
	Increase in deliveries with skilled attendance at birth including institutional deliveries	65.0
	FRUs (including DHs, PHC/APHC) made functional as defined in the National RCH- 2 PIP	45
	Activities	
	Block level microplanning to find gaps in infrastructure, manpower, skills & equipments	-
	Filling of equipment gaps	-
	Streamlining procurement and distribution mechanism for supplies at PHC and APHC.	
	Performance incentives for staff	

	RCH Camps (Minimum of 2 camps per block)	To complete
	Appointment of contractual staff (ANM, LHV and staff nurse)	To complete
	Posting of specialists at PHC	-
	Referral transport	-
	PPP for ambulance services	-
	PPP for EmOC centres	-
	24 hour delivery services at PHC and APHC	12
	Training to dais/SBAs (7 day programme)	
	Motivational workshops (1 day)	14 Blocks
	Involvement of private sector/nursing homes to improve institutional deliveries	
	IEC and BCC activities	
	Objective	
	Universal coverage of all eligible pregnant women under JSY scheme	50%
	Ensuring all eligible women covered under Janani Suraksha Yojana	50%
	Objective	
	Increase in percentage of new born babies given colostrums	
	Increase in prevalence of exclusive breast-feeding	90%
	Percentage of severely malnourished children below 6 years referred to medical institutions	15%
	Strengthen referral network	
	Orientation of AWWs, SHG women and ASHA on importance of breast feeding (1 day)	
	Workshop on provision of low cost nutritious food to AWWs, SHG women and ASHA (1 day)	
	Workshop on gender related sensitization to MOs (2 day)	
	Reorientation training to service providers	
	IEC for behaviour change of community	20%
	Unmet demand for contraception - Total - Spacing - Limiting	 1.2% 15%
	Increasing Number of government health institutions providing i) Female sterilization services ii) Male sterilization services iii) IUD insertion services	 90% 6% 15%
	Compensation on sterilization	To complete
	Organization of Cu-T insertion camp	To complete
	Organization of sterilization camps	To complete
	Multi-skill training to staff/ MOs for sterilization techniques	To complete
	Procurement of laparoscopes	To complete
	Social marketing of family planning devices	To complete
	Provision of Medical Termination of Pregnancy	To complete
	IEC for promotion of male and female sterilization	To complete
	Training to MOs on management of RTI/STI (3 day)	To complete
	Health check up and partner treatment camps	To complete
	Adequate medicine supply for RTI/STI management	To complete

	Training on adolescent counseling (to NGOs, paramedical staff, SHG women, AWWs, ASHA (3 day)	To complete
	Educational programmes in schools	
	Counseling day at block PHC/PHC	Once a month
	Honorarium to counselors	
	Establish link with private practitioners	
	Special interventions	
	PNDT campaign	1/year
	Capacity Building of Staff	
	Strengthening working capacity of ASHA	Twice in a month at PHC
	Family health camps at district level (3 day)	
	Institutional strengthening	
	Repair/renovation of HSCs	
	Construction of new HSCs	30
	Construction of new APHC	
	Construction of new PHC	
	Operationalization of mobile clinics	
	Adequacy of equipments at health centers	
	Formation of Urban Health Center	
	Establishment of Trauma center	
	Regular monitoring and evaluation at blocks and district	Ensuring in 14 Blocks

5.1.2 Work Plan for Health Infrastructure

Functional and accountable infrastructure being an essential prerequisite for an effective health delivery system a set of strategies has been neatly designed taking into consideration already existing infrastructure and the possible constraints.

Table 5.2: Work Plan for Health Infrastructure

	Activity	**Time Frame (from 2010-11)**	**Responsibility**
1	Finish training of ASHA	2040	Civil Surgeon, MOiC
2	Monitoring of working capacity of ASHA	To complete	Civil Surgeon, MOiC
3	Increase incentives for ASHA working in difficult areas	Ensuring in 14 blocks	Civil Surgeon, MOiC
4	Selection of members	HMIS formed in all PHC	Civil Surgeon, MOiC
5	Orientation of selected members	-	Civil Surgeon, MOiC
6	Guidelines for functioning of committees	-	Civil Surgeon, MOiC
7	Provide government building to existing sub centres	57	Civil Surgeon
8	Construction of new sub centres	60	Civil Surgeon
5	Filling up vacant posts for ANM and MPW at sub-	To complete	Civil Surgeon

	Activity	Time Frame (from 2010-11)	Responsibility
	centres		
10	Additional ANM at sub-centre	To complete	MOiC
11	Grant for maintenance and contingency at sub-centre level	To complete	MOiC
12	Infrastructural set-up for PHC		Civil Surgeon
13	Recruitment of specialists (gynecologist, surgeon, pediatrician and anesthetist)	-	Deputy Commissioner, Civil Surgeon
14	Contractual appointment of staff nurse and LTs		Deputy Commissioner, Civil Surgeon
15	Provision of electricity, water supply and staff quarters at APHC	6	
16	Deployment of medical doctors at PHC level	20	Civil Surgeon
17	Repair and maintenance of equipments	-	MOiC
18	Specialized management training (for BMOs, DPOs and DPM)	-	State Training Co-ordinator
15	Specialized communication training (for BEEs, NGOs & media officers)	-	State Training Co-ordinator
20	Awareness generation training for health workers, link workers, ICDS workers, SHG leaders and PRI members	-	State Training Co-ordinator
21	Multiskilling training for paramedical staff	To complete	State Training Co-ordinator
22	Refresher training course for ANMs	To complete	State Training Co-ordinator
23	Selection of members for VHSC	-	Civil Surgeon, MOiC
24	Establishment of guidelines for functioning of committee	-	Civil Surgeon, MOiC
25	Interaction between MPWs/ANMs, AWWs and ASHA	-	Civil Surgeon, MOiC
26	Development of guidelines	-	Civil Surgeon MOiC
27	Regular monitoring and reporting system for used	-	Civil Surgeon MOiC

	Activity	Time Frame (from 2010-11)	Responsibility
	grant		
28	Appointment of staff	-	Deputy Commissioner, Civil Surgeon
	Availability of conveyance	-	Civil Surgeon
	Adequate equipments and medicines	-	Civil Surgeon, MOiC
28	Monthly meeting conducted at sub-centre level	Once a month	MOiC
25	Meeting at PHC level to review problems related to health delivery mechanism	Once a month	MOiC
30	Organization of training as per state guidelines	-	Civil Surgeon
31	District level training of MOs for managerial skills and EmOC	-	Civil Surgeon
32	Assessment of communication needs in the context of NRHM	To complete	Civil Surgeon
33	Use of print media, folk media, T.V. and radio	To complete	Civil Surgeon
34	Financial planning for reaching of supplies at various levels	Ensuring Supply in 14 Blocks	Civil Surgeon
35	Well established supply chain	Ensuring Supply in 14 Blocks	Civil Surgeon
36	Appointment of AYUSH practitioners at PHC/PHC	-	Deputy Commissioner, Civil Surgeon
37	Integration with private doctors at village level	To complete	Civil Surgeon

5.1.3 Work Plan for Child Immunization

Table 5.3 Work plan for child immunization

	Activity	Time Frame (from 2010-11)	Resonsibility
1	Cold chain maintenance for quality assurance of vaccine	Ensuring Supply in 14 Blocks	Civil Surgeon, MOiC
2	Improving transport system	Ensuring in 14 Blocks	Civil Surgeon, MOiC
3	Monitoring mechanism for adequate supply	Ensuring in 14 Blocks	Civil Surgeon, MOiC
5	Organization of weekly immunization day at sub-	Ensuring in 14 Blocks	Civil Surgeon, MOiC

	Activity	Time Frame (from 2010-11)	Resonsibility
	center		
6	Fill-up vacant post of ANMs	-	District Magistrate and Civil Surgeon
7	Pulse polio immunization camps	-	Civil Surgeon, MOiC
8	Catchup round	-	Civil Surgeon
5	Close coordination between ANM, AWW and ASHA	Ensuring in 14 Blocks	MOiC
10	Safe injection practices (provision of disposable syringes)	Ensuring in 14 Blocks	MOiC
11	Identification of areas with low immunization coverage	Ensuring in 14 Blocks	MOiC
12	Involving AWWs, NGOs, ASHA and Panchayat on immunization day	Ensuring in 14 Blocks	MOiC
13	Orientation and awareness generation training for health workers	Ensuring in 14 Blocks	MOiC

5.1.4 Work Plan for Malaria under NVBDCP

Table 5.4: work plan for Malaria Control

	Activity	Time Frame (from 2010-11)	Responsibility
1	Use of video display, posters, pamphlets, booklets, wall painting and street plays	To complete in each block	District Malaria Officer
2	Coordination with school education	To complete in each block	District Malaria Officer
3	Fortnightly door to door surveillance by health worker	-	District Malaria Officer
4	Increase blood smear collection	-	Civil Surgeon, District Malaria Officer
5	Transportation of slides from collection point to laboratory on daily basis	-	District Malaria Officer
6	Functional laboratory at PHC/PHC level	-	Civil Surgeon
7	Blood examination center at each block	-	Civil Surgeon
8	Appointment of lab technicians	-	Civil Surgeon

	Activity	Time Frame (from 2010-11)	Responsibility
5	Insecticidal sprays at high risk areas	To complete in each block	District Malaria Officer
10	Promotion of Gambuzia culture	-	District Malaria Officer
11	Distribution of medicated mosquito nets	-	District Malaria Officer
12	Acceptance/ treatment of usage of herbal medicine	Ensuring in 14 Blocks	Civil Surgeon
13	ASHA Training	14 Blocks	District Malaria Officer

5.1.5 Work Plan for RNTCP

Table 5.5: Work plan for TB control

	Activity	Time Frame (from 2010-11)	Responsibility
1	Interpersonal communication by local health workers, NGOs and Panchayat	Ensuring in 14 Blocks	DTO, MOiC
2	Use of posters, pamphlets, wall paintings and street plays	Ensuring in 14 Blocks	DTO, MOiC
3	Increase awareness of DOTS	Dissemination on VHN day	Health Worker, ICDS, NGO, PRI, Education Department
4	Community participation	Ensuring in 14 Blocks	Health Worker, ICDS, NGO, PRI, Education Department
5	Involvement of private practitioners	Ensuring in 14 Blocks	DTO , MOiC
6	Promote case detection through sputum microscopy	Ensuring in 14 Blocks	DTO, MOiC
7	Complete treatment	Ensuring in 14 Blocks	DTO, MOiC
8	Increase accessibility to treatment	Ensuring in 14 Blocks	DTO, MOiC
5	Follow-up examination to achieve sputum conversion	Ensuring in 14 Blocks	DTO ,MOiC
10	Establishment of TB cells at block level	Ensuring in 14 Blocks	DTO ,MOiC
11	Quality assurance of sputum smear	Ensuring in 14 Blocks	DTO ,MOiC
12	Regular and uninterrupted supply of drugs	Ensuring in 14 Blocks	DTO ,MOiC
13	Systematic monitoring and	Ensuring in 14 Blocks	DTO ,MOiC

	Activity	Time Frame (from 2010-11)	Responsibility
	evaluation		
14	Appointment of field staff	Ensuring in 14 Blocks	District Magistrate, Civil Surgeon, DTO
15	Training to DOTS providers	Refresher Training	Civil Surgeon
10	Sensitization training to MOs providing treatment at block level	-	Civil Surgeon
11	ASHA Training	14 Blocks	DTO

5.1.6 Work Plan for NBCP

Table 5.6: Work plan for Blindness control

	Activity	Time Frame (from 2010-11)	Responsibility
1	Organization of eye camps in collaboration with private agencies/ institutions	Thrice at block level	ACMO, MOiC
2	Integrate eye care as a part of primary health care	-	
3	Availability and repair of necessary equipments	Ensuring in 14 Blocks	ACMO, MOiC
4	Posting of eye-surgeon at block level	-	Civil Surgeon
5	Follow-up of treated cases	Regular Monitoring at each block	ACMO, MOiC
6	Quality control mechanism	-	
7	Streamlined vitamin-A supply	Ensuring in 14 Blocks	ACMO, MOiC
8	Availability of medicines during eye camps	Strenghthen procurement & Supplies	District Blindness Control Society
5	Sensitization work Shop at block level for MOs and health workers	14 (once at each block)	District Blindness Control Society
10	Technical training of ophthalmic medical assistants at district for skill up-gradation and new techniques	-	District Blindness Control Society
11	Behaviour change of community to increase treatment acceptance	-	ACMO
12	Interpersonal	-	ACMO, MOiC

	Activity	Time Frame (from 2010-11)	Responsibility
	communication by health workers and ICDS workers		
13	Use of print media, mass media and folk media	-	ACMO, MOiC
14	ASHA Training	14 Blocks	ACMO, MOiC

5.1.7 Work Plan for NLEP

Table 5.7: Work plan for Leprosy eradication

	Activity	Time Frame (from 2010-11)	Responsibility
1	Recruitment of field staff	-	
2	Orientation training of new staff	One training programme	
3	Updating records		DLO
4	Increase case detection and referral for treatment	-	CS, DLO
5	Case validation and re-registration	-	MO I/C, DLO
6	Organization of POD camps	-	
7	Organization of Skin Disease Diagnosis, Treatment & Education Camps in remote and inaccessible areas	-	MO I/C, DLO
8	Urban leprosy awareness camps	-	CS, DLO
5	Procurement of IEC equipments	-	CS, DLO
10	Sensitization workshop for panchayat members to motivate them for community education	14 (once at each block)	
11	Proper counseling by health worker and MOs to prevent deformities	14 (once at each block)	
12	Sensitize community for self reporting	-	DLO
13	Sensitization workshop at gram Panchayat	-	DLO
	Community mobilization through interpersonal communication, print media and folk media (in local dialect)	-	DLO
14	Provide personal support and	-	DLO

	Activity	Time Frame (from 2010-11)	Responsibility
	psychological assurance		
15	ASHA Training	In 14 Blocks	DLO

5.1.8 Work Plan for FRU

Table 5.8: Work plan for FRU

	Activity	Time Frame (from 2010-11)	Responsibility
1	Operationalization of FRU (Diesel, Service Maintainace Charges, Misc and other cost)	-	RCH Officer, DS, and CS
2	Operationalise Blood Storage unit in FRU	-	RCH Officer, DS, and CS

5.1.9 Work Plan for Human Resource

Table 5.9: Work plan for Human Resource

	Activity	Time Frame (from 2010-11)	Responsibility
1	Appointment of Contractual Doctors	-	CS and DM
2	Appointment of Contractual Grade 'A' Nurse		CS and DM
3	Appointment of Contractual ANM	-	CS and DM
4	Appointment of Contractual Paramedical staffs	-	CS and DM

5.1.10 Work Plan for Untied Fund

Table 5.10: Work plan for Untied Fund

	Activity	Time Frame (from 2010-11)	Responsibility
1	Untied Fund for PHC	-	MOICs and BHM
2	Untied Fund for APHC		MOICs and BHM
3	Untied Fund for Sub-Center	-	MOICs and BHM
4	Meeting at District Level	-	CS and DPM
5	Meeting at PHC Level		MOICs and BHM

5.1.11 Work Plan for ASHA

Table 5.11: Work plan for ASHA

	Activity	Time Frame (from 2010-11)	Responsibility
1	Selection of ASHAs	-	MOIC and BHM
2	Training of ASHAs	-	MOIC and BHM
3	ASHA Divas	-	MOIC and BHM
4	Motivation of ASHAs	-	MOIC and BHM

5.1.12 Work Plan for Maternal Health

Table 5.12: Work plan for Maternal Health

	Activity	Time Frame (from 2010-11)	Responsibility
1	Operationalise 24x7 PHCs and APHCs	-	MOICs and BHM
2	RCH Outreach under served areas		MOICs and BHM
3	Institutional Deliveries(Urban and Rural)	-	CS, DS, and MOICs
4	Ceasarian Deliveries at PHC level	-	MOICs and BHM

5.1.13 Work Plan for Child Health

Table 5.13: Work plan for Child Health

	Activity	Time Frame (from 2010-11)	Responsibility
1	Development of New born child care unit (NCU)	-	DS, MOICs
2	School health Programme	-	DM, CS, DPM and DEO

5.1.14 Work Plan for Family Planning

Table 5.14: Work plan for Family Planning

	Activity	Time Frame (from 2010-11)	Responsibility
1	Dissemination of manuals on sterilization standards and quality assurance of sterilization services	-	CS, ACMO, DS, and MOICs
2	NSV Camps	-	CS, ACMO, DS, and MOICs
3	Monitor Progress quality and utilization of services	-	CS, ACMO
4	Accredition of private provider for sterilization services	-	Quality assurance committee

Chapter 6

Monitoring and Evaluation

6.1 Introduction

Monitoring and Evaluation is a key and integral part of NRHM and systems are in place at each level to ensure the monitoring for smooth progress. The Mission Steering Group (MSG) has been set up at the Center and further the Empowered Programme Committee has also been set up to monitor the progress. The various societies at the state and the district level have been merged into an Integrated Society at the state level where it is the executive arm of the State Health Mission.

Monitoring and Evaluation plan would help in providing an overview of progress that has to be addressed during monthly review meetings held at different levels of the health system. It is strongly recommended that all activities are monitored and integrated at different levels of the health system to address the specific NRHM requirements and collated into a single format. As the aim is to ultimately institutionalize quality assessment in routine monitoring, the performance evaluation mechanism will mostly rely on ongoing monthly reports, progress report concurrent and mid-term and end-line surveys.

In line with the objective set and work plan finalized, subsequent section details out the monitoring and evaluation indicators in matrix form for each programmatic area.

6.1.1 Monitoring and Evaluation Matrix for Health Infrastructure

Activity	Indicator	Means of verification
Strategy 1: Training of ASHA		
Finish training of ASHA	Number of ASHA trained	DPMU Report
Monitoring of ASHA	Monitoring mechanism in place	DPMU Report
Strategy 2: Establishment of HMS		
Selection of members	opening of bank accounts for HMS members Development and acceptance of model MOU Meetings of CPS/ HMS/ HMS	DPMU Report
Strategy 3: Functioning of HMS		
Clear guidelines for working of HMS	Guideline formulated and Number of HMS members oriented Number of orientation/ training session held	DPMU Report
Guidelines for expenditure of maintenance grant		
Orientation and training of elected HMS members		
Strategy 4: Upgradation of health institutions		
Provide government building to existing sub centres	Number of sub centres to be provisioned in government building	DPMU Report/CMO Report /Health MIS

Activity	Indicator	Means of verification
Construction of new sub centres	Number of sub centre constructed	DPMU Report/CMO Report /Health MIS
Filling up vacant posts for ANM and MPW at sub-centres	Number of ANM and MPW recruited	Health MIS/DPMU Report
Additional ANM at sub-centre	Number of additional ANM recruited at sub centre	Health MIS/DPMU Report
Grant for maintenance and contingency at sub-centre level	Grants for maintenance and contingency level provided at sub-centre level	Health MIS/DPMU Report
Infrastructural set-up for PHC	Number of PHC Strengthened	
Recruitment of specialists (gynecologist, surgeon, pediatrician and anesthetist)	Number of specialists recruited (gynecologist, surgeon, pediatrician and anesthetist)	
Contractual appointment of staff nurse and LTs	Number of LTs appointed on contractual basis	
Provision of electricity, water supply and staff quarters at APHC	Number of APHC wherein provision of electricity, water supply and staff quarters are made	
Strategy 3: Human resource development		
Specialized management training (for BMOs, DPOs and DPM)	Number of management training programme organized for BMOs, DPOs and DPM	Health MIS/Training Plan
Specialized communication training (for BEEs, NGOs & media officers)	Number of training programme organized for BEEs, NGOs & media officers	
Awareness generation training for health workers, link workers, ICDS workers, SHG leaders and PRI members	Number of awareness generation training organized for health workers, link workers, ICDS workers, SHG leaders and PRI members	
Multiskilling training for paramedical staff	Number of paramedical staff trained	
Refresher training course for ANMs	Number of refresher training course for ANMs	
Strategy 5: Constitution of Village Health and Sanitation Committees		
Guidelines for VHSC	Number of HMS members oriented	DPMU Report
Strategy 5: Integration with ASHA programme		
Interaction between MPWs/ANMs, AWWs and ASHA	Number of meetings held between MPWs/ANMs, AWWs and ASHA	Health MIS/MOs Report
Strategy 6: Directions for use of maintenance grant at each level		
Development of guidelines	Guidelines developed and formed	CMO office Report
Regular monitoring and reporting system for used grant	Regular monitoring and reporting system in place	
Strategy 7: Organization of community meeting		
Monthly meeting conducted at sub-centre level	Number of monthly meeting organized a sub centre level	DPMU/Block MOs Report
Meeting at PHC level to review problems related to health delivery mechanism	Meetings organized at the PHC level	
Strategy 8: Formulation of district training plan		
Recognition of need of trainings	Training need identified	DPMU Report/CMO

Activity	Indicator	Means of verification
Organization of trainings as per state guidelines	Number of training organized	Report /Health MIS
Refresher training of paramedics on minor ailments	Number of paramedics trained	
Training of MOs for managerial skills, EmOC	Number of MO's, ANM identified	
Training of ANMs for ANC, DOTS		
Strategy 5: Formulation of district BCC plan		
Assessment of communication needs in the context of NRHM	Assessment of communication needs	DPMU Report/CMO Report /Health MIS
Strategy10: Streamlined procurement and logistic supply plan		
Financial planning for reaching of supplies at various levels	Financial Plan at each level in place	DPMU Report
Well established supply chain	Establishment of supply chain	
Strategy 11: Coordination with private practitioners/ institutions		
Appointment of AYUSH practitioners at PHC/PHC	Number of AYUSH physicians relocated and appointed	DPMU Report
Integration with private doctors/ISMP at village level	Number of private practitioners involved	DPMU Report

6.1.2 Monitoring and Evaluation Matrix for Immunisation

Activity	Indicator	Means of verification
Strategy1: Streamlining cold chain system		
Cold chain maintenance for quality assurance of vaccine	Institution wherein cold chain is established and streamlined	Logistic Plan/MIS
Strategy 2: Logistics of vaccine and disposable supply		
Improving transport system	Transportation system improved	CMO office Report/ Nodal officers Report
Monitoring mechanism for adequate supply	Monitoring mechanism in place	CMO office Report/ Nodal officers Report
Strategy 3: Strengthening service delivery		
Organization of weekly immunization day at sub-center	Number of weekly immunization day at sub-center	Monthly Progress Report/Health MIS
Fill-up vacant post of ANMs	Number of ANMs recruited on contractual basis	Monthly Progress Report/Health MIS
Pulse polio immunization camps	Number of pulse polio immunization camp organised	Monthly Progress Report/Health MIS
Catchup round	Number of catch up round organised	Monthly Progress Report/Health MIS
Close coordination between ANM, AWW and ASHA	Cordination meeting organized and grievance addressed between ANM, AWW and ASHA	Block MO's Report
Strategy 4: IEC for behaviour change of community		
Identification of areas with low immunization coverage	Number of low immunization coverage area	DPMU Report/Health MIS
Involving AWWs, NGOs, ASHA and panchayat on immunization day	Number of AWWs, NGOs, ASHA and panchayat involved on immunization day	

Activity	Indicator	Means of verification
Orientation and awareness generation training for health workers	Number of orientation and awareness generation training for health workers	

6.1.3 Monitoring and Evaluation Matrix for Vector Borne Disease Programme

Activity	Indicator	Means of verification
Strategy1: IEC activities		
Use of video display, posters, pamphlets, booklets, wall painting and street plays	Number of video display, posters ,pamphlets and street plays organised	Health MIS/Communication Plan
Coordination with school education	Number of school involved as part of school education	
Strategy 2: Increased surveillance		
Fortnightly door to door surveillance by health worker	Number of door to door surveillance programme organized by health worker	
Strategy 3: Early diagnosis and prompt treatment		
Increase blood smear collection	Percentage increase in blood smear collection	Health MIS/Nodal officers Report
Transportation of slides from collection point to laboratory on daily basis	Percentage increase in slides transported from collection point to laboratory on daily basis	
Strategy 4: Strengthening laboratory facilities		
Functional laboratory at PHC/PHC level	Number of functional laboratory at PHC/PHC level	Health MIS/Nodal officers Report
Blood examination center at each block	Blood examination centre established	
Appointment of lab technicians	Number of lab technicians appointed	
Strategy 5: Preventive measures to reduce chances of outbreak		
Insecticidal sprays at high risk areas	Proportion of high risk areas having insecticidal sprays	Malaria Programme Plan Report
Distribution of medicated mosquito nets	Number of medicated mosquito nets distributed	
Strategy 6: Integration with ISM practitioners		
Acceptance/ treatment of usage of herbal medicine	Proportion of members accepting herbal medicine	Health Survey

6.1.4 Monitoring and Evaluation Matrix for NTCP

Activity	Indicator	Means of verification
Strategy 1: Sensitization of community through IEC activities		
Use of posters, pamphlets, wall paintings and street plays	Number of posters, pamphlets, wall paintings and street plays conducted/displayed	Health MIS
Increase awareness of DOTS	Proportion of community members aware of DOTS	Survey Report

Activity	Indicator	Means of verification
Strategy 2: Increasing referral from grass root to health institutions		
Community participation	Proportion of community members involved	Health Survey
Involvement of private practitioners	Number of private practioners involved	Health MIS
Strategy 3: Treatment strengthening		
Complete treatment	Number of cases completed treatment	RNTCP Report/MIS
Follow-up examination to achieve sputum conversion	Number of cases followed up	
Strategy 4: Infrastructural strengthening		
Establishment of TB cells at block level	TB cells established at block level	RNTCP Report/ Health MIS/Logistic Plan
Regular and uninterrupted supply of drugs	Number of days drug was stocked out	
Systematic monitoring and evaluation	Monitoring and evaluation plan finalized	
Appointment of field staff	Number of field staff appointed	
Training to DOTS providers	Number of DOTS provider trained	
Sensitization training to MOs providing treatment at block level	Number of training session organised at the block level	

6.1.5 Monitoring and Evaluation Matrix for Blindness Control Programme

Activity	Indicator	Means of verification
Strategy 1: Outreach activities		
Organization of eye camps in collaboration with private agencies/ institutions	Number of eye camp organized in collaboration with private agencies/ institutions	BCP Report/Health MIS
Strategy 2: Strengthening service delivery		
Posting of eye-surgeon at block level	Number of eye surgeon recruited	CMO Office Report/DPMU/Health MIS
Follow-up of treated cases	Number of cases followed up	
Integrate eye care as a part of primary health care	Institutions who integrated eye care as a part of primary health care	
Availability and repair of necessary equipments	Number of equipments repaired	
Strategy 3: Adequate drug/vaccine supply		
Streamlined vitamin-A supply	No of days Vitamin A has been out of stock	Health MIS/Logistic plan Report
Availability of medicines during eye camps	Number/Type of Medicine being supplied at eye camp	
Strategy 4: Capacity building of human resources		
Sensitization Workshop at block level for MOs and health workers	Number of sensitization work organized at block level for MOs and health workers	Health MIS/DPMU Report
Technical training of ophthalmic medical assistants at district for skill up-gradation and new techniques	Number of ophthalmic medical assistants at district trained for skill up-gradation and new techniques	
Strategy 5: IEC for public awareness on eye care		

Activity	Indicator	Means of verification
Behaviour change of community to increase treatment acceptance	Number of community members who showed positive behavioral change	DPMU/Communication deptt. report
Interpersonal communication by health workers and ICDS workers	Proportion of community members contacted health workers and ICDS workers	

6.1.6 Monitoring and Evaluation Matrix for NLEP

Activity	Indicator	Means of verification
Strategy1: Surveillance for case detection		
Recruitment of field staff	Number of field staff recruited	LCP Nodal officers Report/Health MIS
Orientation training of new staff	Number of new staff oriented	
Updating records	Proportion of records updated	
Strategy 2: Strengthen service delivery		
Increase case detection and referral for treatment	Number of cases detected and referred	LCP Nodal officers Report/Health MIS
Case validation and re-registration	Number of cases validated and re-registered	
Organization of POD camps	Number of POD camps organized	
Organization of Skin Disease Diagnosis, Treatment & Education Camps in remote and inaccessible areas	Number of Skin Disease Diagnosis, Treatment & Education Camps in remote and inaccessible areas	
Urban leprosy awareness camps	Number of Urban leprosy awareness camps organised	
Strategy 3: Collaboration with PRI		
Sensitization Workshop for panchayat members to motivate them for community education	Number of Workshop organized for panchayat members to motivate them for community education	Health MIS
Strategy 4: Prevention of disability and rehabilitation		
Proper counseling by health worker and MOs to prevent deformities	Proportion of cases counseled by health worker and MOs	Block MOs Report
Sensitize community for self reporting	Proportion of community members sensitized	Health MIS
Strategy 5: IEC to mitigate stigma		
Sensitization Workshop at gram panchayat	Number of Workshop organized at gram panchayat level	Health MIS/ ICP Report/Communication division
Community mobilization through interpersonal communication, print media and folk media (in local dialect)	Reach of IEC activity i.e. interpersonal communication, print media and folk media (in local dialect)	

Chapter 7
Budget

Chapter 4
Setting Objectives and Suggested Plan of Action

4.1 Introduction

District health action plan has been entrusted as a principal instrument for planning, implementation and monitoring of fully accountable and accessible health care mechanism. It has been envisioned through effective integration of health concerns via decentralized management incorporating determinants of health like sanitation and hygiene, safe drinking water, women and child health and other social concerns. DHAP envisages accomplishing requisite amendments in the health systems by crafting time bound goals. In the course of discussions with various stakeholder groups it has been anticipated that unmet demand for liable service provision can be achieved by adopting Intersectoral convergent approach through partnership among public as well as private sectors.

4.2 Targeted Objectives and Suggested Strategies

During consultation at district level involving a range of stakeholders from different levels, an attempt has been made to carve out certain strategies to achieve the specific objectives that are represented by different indicators. The following segment of the chapter corresponds to the identified district plan objectives demonstrating current status of the indicators along with the expected target sets that are projected for period of next two years (2010-12).

Structured approaches for State/ District/ Block PIP planning

National Rural Health Mission

Strategy & Activity Plan with budget

Name of the State/ UT:

Sr. NO		Activities	Component Code (only at state level)	Output 2012	Activity Plan										Budget Plan							
					2009-2010 FY				20010-2011 FY						2009-2010FY					2010-2011FY		
					Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	{X x (A)} = B Budget Planned	(< Budget received B or C or > than planned)	Budget utilised {Y x (A)} = D	{(B~D) under or over-utilised Budget =E	Budget Planned (including spill over amount {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	R
											Q1	Q2	Q3	Q4								
B																						
B.1	Decentrlisation																					
	B.1.11	ASHA Support system at State level																				
	B.1.12	ASHA Support System at District Level			1	1	0		1		1	1	1	1	36000	36000	0	36000	0	288000	NRHM	
	B.1.13	ASHA Support System at Block Level			14	0	14		14		14	14	14	14	192857.1	2700000	675000	0	675000	2100000	NRHM	
	B.1.14	ASHA Support System at Village Level														182571	45643	0	182571	3661200	NRHM	
	B.1.15	ASHA Trainings																				
	B.1.16	Replenishment														918800	0	0	918800	1627200	NRHM	2034 ASHAs @800
	B.1.17	Emergency Services of ASHA																				
	B.1.18	Motivation of ASHA							2034						725	2573750	643438	0	2573750	1474650	NRHM	
	B.1.19	Capacity Building /Academic Support programme																				
	B.1.2	ASHA Divas													75	3302000	825500	1088200	2213800	2806920	NRHM	Calculated for 203
	B.1.21	Untied Fund for Health Sub Center, Additional Primary Health Center and Primary Health Center			223	140	83		223						10000-HSC,25000-PHC,APHC	2808000	1404000	650000	2158000	4943000	NRHM	
	B.1.22	Village Health and Sanitation Committee			1386	1386	0		1386						10000	13865000	13865000	0	13865000	1386000	NRHM	
	B.1.23	Rogi Kalyan Samiti			16	16	0		16							2700000	2100000	462002	2237998	4937998		
B.2		Infrastrure Strengthening																				
	B.2.1	Construction of HSCs (315 No.)			8	0	8		20						950000	7600000	7600000	0	7600000	19000000	NRHM	
	B.2.2	Construction of PHCS																				
	B.2.3	Up gradation of CHCs as per IPHS standards			4	0	0		4						4000000	16000000	4000000	0	4000000	12000000	NRHM	
	B.2.4	Infrastructure and service improvement as per IPHS in 48 (DH & SDH) hospitals for accreditation or ISO : 9000 certification																				
	B.2.5	Upgradation of ANM Training Schools			1	0	1		1						2500000	2500000	500000	0	2500000	2500000	NRHM	
	B.2.6	Annual Maintenance Grant			16	16	0		16						2700000	2700000	675000	166550	2533450	5233450	NRHM	
B.3		TOTAL INFRASTRUCTURE strengthening																				
	B.3	Contractual Manpower																				
	B.3.1 A	Incentive for PHC doctors & staffs														640613	160153	0	640613	0	NRHM	
	B.3.1 B	Salaries for contractual Staff Nurses														11613884	2903471	2495321	9118563	29118563	NRHM	
	B.3.1.C	Contract Salaries for ANMs																				
	B.3.1. D	Mobile facility for all health functionaries														2026266	0	0	2026266	700000	NRHM	
	3.2	Block Management Unit			14	14	0		14							7604758	1901189	2120000	5484758	14234758	NRHM	for 14PHC @Rs 62
B.4		PPP Initiativs																				
	B.4.1	102-Ambulance service (state-806400) @537600 X 6 Distrrict																				
	B.4.2	1911- Doctor on Call & Samadhan																				
	B.4.3	Addl. PHC management by NGOs																				
	B.4.5	SHRC																				
	B.4.6	Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP)														2348300	0	0	2348300	2348300	NRHM	
	B.4.7	Dialysis unit in various Government Hospitals of Bihar																				
	B.4.8	Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar																				
	B.4.9	Providing Telemedicine Services in Government Health Facilities																				
	B.4.1	Outsourcing of Pathology and Radiology Services from PHCs to DHs																		5000000	NRHM	
	B.4.11	Operationalising MMU														4212000	0	0	4212000	4212000	NRHM	
	B.4.14	Monitoring and Evaluation (State , District & Block Data														1530000	382500	376422	1153578	2683578	NRHM	
	B.4.15	Generic Drug Shop																				
	B.4.16	Centre																				
	B.4.17	Hospital Maintenance																				
	B.4.18	Providing Ward Management Services in Government Hospitals																				

District wise and Head wise allocation of budget for Routine I

SL No.	Name of District	District Profile used for calculation of Budget: P.W.	ANM	Alternate Vaccinator	Number of immunisation Site	AWC	ASHA	HSC	APHC	BPHC	Reffral + SDH	District Hospital /Metarnity Hospital	WIC + WIF	Slums	Under served Areas
1	Gopalganj	93400	281		281	2158	2022	186	23	14	4	1		42	15
1	Qtr I														
2	Qtr II														
3	Qtr III														
4	Qtr IV														

SL No.	Name of District	Mobility Support: Mobility support to District Officials Rs. 50000 per district (38) .	Mobility Support: Mobility support for supervision at state level @ Rs. 100000 per year.	Cold chain maintenance: Cold chain maintenance for AMC @ Rs. 2000 per machine per year for 2200 machine (DF+ILR) and 10 WIC and 3 WIF @ Rs. 10000 per year and maintenance of vaccine vans @Rs.25000 per van for 47 vans. * 22,00,000 for AMC given at State level to one agency for repair of existing ILR & DF has been deducted from Rs. 50,00,000 alloted and the remaining 28,00,000 is divided for WIC/WIF maintainance of Vaccine vans as per approved rates. the final remaining amount of 1430000 could be utilised for Minor Repair for district and regional Cold chain stores among the districts. @ Rs 30000 appox per Cold chain stores for minor repairs			Focus on slum & underserved areas in urban areas: for 3565 slums and 14385 underserved areas @ Rs. 350 per month per slum for one session * Slums @10000 population (Each AWC in a slum has 1500 population therefore 7 slums =10000 population	Focus on slum & underserved areas in urban areas: Alternate vaccinators honorarium (details in separate sheet)	Mobilization of children through ASHA or other mobilizers: @ Rs. 150 per month per worker for 80000 sessions per month for remaining 5 months as the State has budget the same under Muskan in RCH PIP. The state has projected this for month incase the same is not extended beyond Oct.09	Alternative vaccine delivery in hard to reach areas: Alternative vaccine delivery in hard to reach areas in 4500 session per month @ Rs. 100 per session	Alternative vaccine delivery in hard to reach areas: Alternative Vaccine Deliery in other areas @ Rs. 50 per session for session 17000 ANMs for 104 days.	Compute: Computer Assistants support for State level @ Rs. 12000 per person per
1	Gopalganj	50000			25000	38788	239400	67200	1516500	18000	1443200	
1	Qtr I	12500			10000	10000	59850	16800	379125	4500	360800	
2	Qtr II	12500			3250	10000	59850	16800	379125	4500	360800	
3	Qtr III	12500			7000	10000	59850	16800	379125	4500	360800	
4	Qtr IV	12500			4750	8788	59850	16800	379125	4500	360800	

District	H-t-Teams	Transit Teams	Mobile Teams	Mela Teams	OneMan Teams	Total Teams	No. of Supervisor	No. of Sub-Depot	No. o De Veh
GOPALGANJ	7216	728	40	180	160	8324	2494	665	
Qtr I									
Qtr II									
Qtr III									
Qtr IV									