DISTRICT HEALTH ACTION PLAN

2010-2011

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 National Rural Health Mission (2005-12) was launched in **April 2005** by GOI. It seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure and Bihar is one of the EAG states.

The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections .The commitment to bridge the gaps in the public health care delivery system, has led to the formulation of District Health Action Plan 2010-11. Last year , because of time constraint , the plan is prepared at district level without incorporating the issues related to block and village level But for the F.Y of 2010-11 the bottom to top approach followed and that's why the planning process include village level/Sub center level planning On the basis of plans generated from these villages, block level health plan were prepared and on the basis of 16 blocks level plans the District Health Action Plan has been prepared .

In the preparation of DHAP the views of the 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.

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 and Block Health Managers, Accountants and HSC level ANM played a vital role throughout the whole exercise of preparing the District Health Action Plan .

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.

Above all we would like to appreciate the initiatives and support of all specially the whole team of PHRN Bihar and Sri Mani Bhushan Jha , Health Manager , Sadar Hospital , Katihar , for their whole hearted support through out the process of planning , preparation and finalization of the District Health Action Plan .

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Katihar

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.

In order to make NRHM fully accountable and responsive, the District Health Action Plan (DHAP) 2010-11 has been prepared. This District Health Action Plan is one of the key instruments to achieve NRHM goals. This plan is based on basic health needs of the District

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 analyzed 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 public/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.

The development of District Health Action Plan for Katihar Block 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 various meetings held under the chairmanship of Nodal Officers, MOICs and other officials at various level .

As a first step towards planning process, identification of performance gaps in comparison with the last year plan was attempted by carrying out a situational analysis. It indicates that the last year proposed most plan of actions/activities are not implemented in the district till date because of this non-performance , the expenditure of the district is less than 30% , it is the matter of great concern and should be addressed promptly so that the Missions objectives are accomplished and the poor people of district have not been deprived with their health needs. I have great believe that the gaps of the last year should be accomplish in the forth coming months and it is possible only , when all the persons concern has given their 100 percent efforts towards the accomplishment of the objectives . At last but not the least the district of Katihar is a flood prone and Kala-azar prone district , so I am hopeful that this action plan incorporated the activities that encountered the above problems .

District Magistrate cum Chairperson
District Health Society, Katihar

III. 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

IV. The Planning Process

1. FORMATION OF DISTRICT PLANNING TEAM

District Planning Team was constituted Civil Surgeon cum Chief Medical Officer , ACMO , DPM, Block Health Managers and District Programme Officers like DIO,DMO, DTO, DLO etc.

1.1 SUB CENTER LEVEL PLANNING PROCESS

In each block, all the Health cub centers were selected for this process. Situation analysis of the HSC has been done in the prescribed format that has been provided by the SHSB, Patna . Apart from it at every block , five villages were selected for 30 cluster survey . The villages were selected in such a way as to give holistic view of different sectors of block. . The 30 cluster survey was carried out in these Eighty villages from Sixteen blocks of the district.
In this survey at the village level women's health issues, differential health seeking behaviour , child health and immunization status were of prime focus. They were also asked about different ways of demand generation for health.

1.2 BLOCK LEVEL PLANNING PROCESS

On the basis of plans generated from these HSCs /villages, block level health plan were prepared. Facility survey was done for each facility available in the vicinity of block-. Block level workshops were organized to discuss proposed plans. Situation analysis helped them in finalizing their plan.

The people during the group discussions opined that frontline functionaries of different departments viz; water & sanitation, ICDS/WCD, ANMs, teachers, and field workers of NGOs could work together to help reducing risk factors from other determinants of health and make the health services available to them.

1.3 DISTRICT LEVEL PLANNING PROCESS AND AGGREGATION OF BLOCK HEALTH PLAN

The details for NRHM planning were collected from both Quantitative & Qualitative sources. The data was collected through facility survey, household survey and access to secondary data sources, compiled service statistics and also other published studies. The data collected were both of the primary & secondary type.

Sources Of Secondary Data:

The data related to various national Health Programmes were collected from following Sources.

RCH: The RCH data was collected from DLHS –3 reports. The comparative figures of the state were taken from RCH II programme document of the state and socio economic survey reports..

RNTCP: The data was collected from the monthly reports of TB department.

NLEP: The data was collected from leprosy department.

NVBDCP: The data was collected from the reports of malaria department.

NBCP: The data on blindness was collected from Blindness Control Society of Katihar district.

IDSP: The data was collected from the weekly reports that the department sends to the state.

Demographic, Socio-economic & vital rates: The data was collected from NFHS-II, DLHS , SRS , Department of Health and Family Welfare , Statistical Branch etc.

Techniques of Primary Data Collection:

Focused Group Discussion and Field Visit: The focused group discussion with Block Medical Officers and Block Health Managers were carried out from all the blocks. Field visits were made along with the village health information survey form and information was collected and filled in by the ANMs and cross -checked by the Block Health Managers of the respective blocks.

On the basis of block health plan from Sixteen (16) blocks of the district, district health action plan was made. A detailed situational analysis of the district helped in identifying problems pertaining to the district. Data collected were also compared with the evaluated data from DLHS- 3 report . These findings and the suggested goals and strategy, for the coming year were put before the participants and discussed in District level workshop.

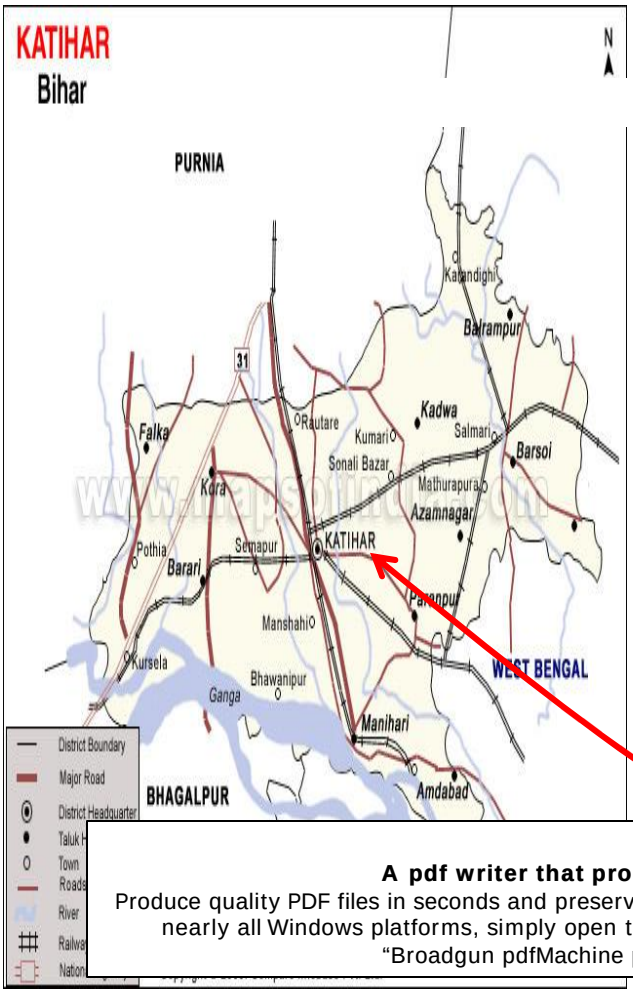
This NRHM action plan is the compilation of the planned activities to be carried out at all level of care. The activities for a year is divided into four quarters and distributed accordingly. The first quarter of the year will start from the month of April. This plan is based on the past performance of the district. The budget is planned based on the past expenditure and the requirements for the future in the District.

The planning team, which comprised of C.S Cum Chief Medical Officer, ACMO, DPM, Health Managers, and other Programme Officers, planned the various activities for

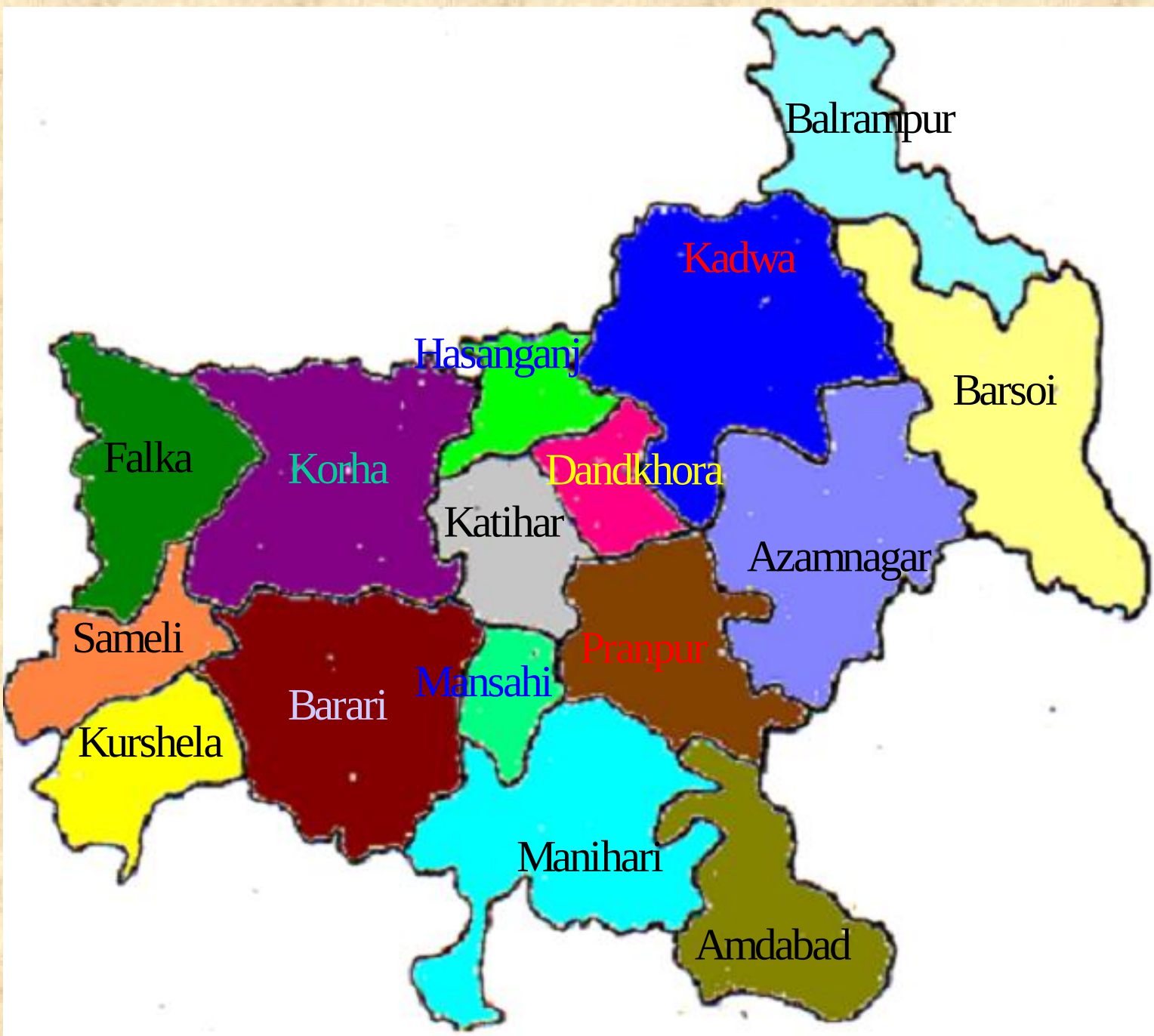
various programmes. The respective National Health Programme Officers were involved to finalize the activities for the National Health Programmes.
For the preparation of the action plan past performance records were used as secondary data. This NRHM Action Plan is the result of the brainstorming done by the personnel involved in the process.
The District Collector, DDC and Civil Surgeon cum Chief Medical Officer of the district, reviewed this plan and suggested actions to be taken for next years.

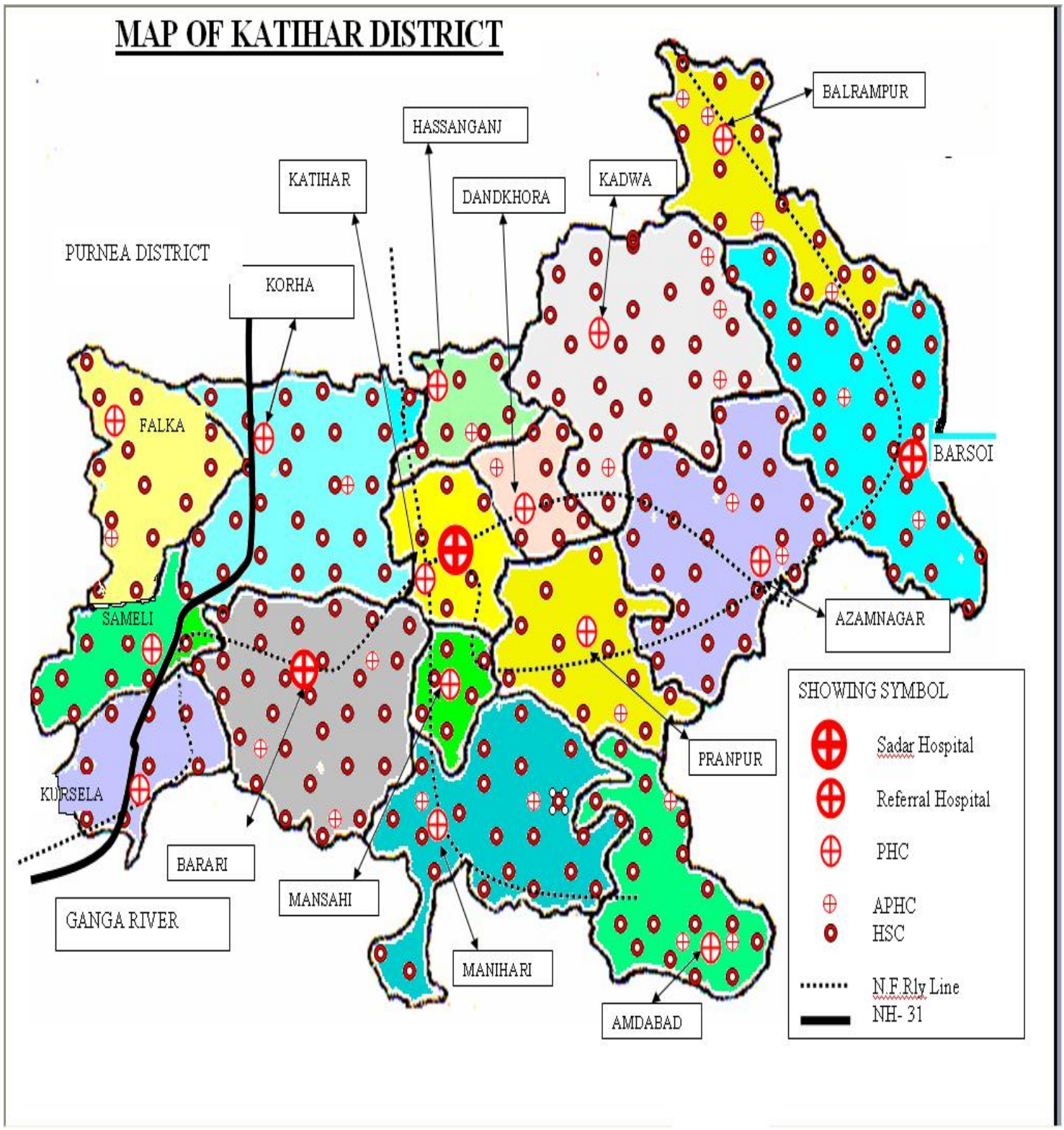
V. Profile of the District

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





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

VI . Situational Analysis-

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	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	**1**	**1**	1
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 Management
	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.

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	71	33
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	77	268
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

VII. Strengthening Infrastructure and Human Resource

Health Sub Center

Issues in Planning	Current status	Activities to be under taken	Out put to be achieved	Time frame for 2010-11
To make all the HSCs functional	Out of 257 HSC only 85 having own building & 42 are running in rented building	Running water facility by using untied funds	All the 257 HSCs have running water facility	1st and 2nd Quarter
Lack of appropriate furniture and stationery	All the HSCs have not adequate furniture	Procurement of furniture and stationery as per IPHS norms by using untied funds	All the 257 HSCs are equipped with furniture & stationery	1st and 2nd Quarter
Lack of equipments	All the HSCs have not adequate equipment as per IPHS norms	Procurement of equipment as per IPHS norms	All the HSC s equipped with prescribed equipment	1st and 2nd Quarter
Lack of Human resources	Out of 345 sanctioned post of ANM (R) 268 post are vaccant	Recruitment of ANM	All the Vaccant post of contractual ANM are filled	1st quar.
Lack of Nursing skill	All the contractual ANMs lacks the nursing skills	Training of ANMs on SBA , IMNCI, ANC & Immunisation	All the contractual ANMs are trained on these skills	1st , 2nd and 3rd quar.

Construction/ Rennovation of Existing HSCs and proposed 184 HSCs	Unavailability of Land only 18 HSCs have availability of land	Involvement of opinion leader, and PRIs for Community mobilization for land donations .	Land available for atleast 88 proposed HSCs in the next two years	1st and 2nd quar.
		Meeting with C.O/B.D.O in the chairmanship of District Magistrate for availability of land		
Irregular/non payment of rent of 42 rented building	No disbursement of fund by DHS	Timely disbursement of fund by DHS	Rent of all the rented HSCs have been paid on time	1st ,2nd ,3rd and 4th quar.
Irregular presence of staffs	Lack of Staff quarter at HSC level	Community mobilization/ Social audit	At least 90 % attendance secured	1st ,2nd ,3rd and 4th quar.
		Construction of Staff Quarter	All the HSCs have Staff quarter .	1st ,2nd ,3rd and 4th quar.

ADDITIONAL PRIMARY HEALTH CENTERS

Issues in Planning	Current status	Activities to be under taken	Out put to be achieved	Time frame for 2010-11
Lack of proper building and infrastructure	Out of 25 APHC only 21 having functioning	Make all the 25 APHCs functional by using untied funds	All the 25 APHCs functional.	1st and 2nd Quarter
Lack of appropriate furniture and stationery	All the APHCs have not adequate furniture	Procurement of furniture and stationery as per IPHS norms by using untied funds	All the 25 APHCs are equipped with furniture & stationery	1st and 2nd Quarter
Lack of equipments	All the APHCs have not adequate equipment as per IPHS norms	Procurement of equipment as per IPHS norms	All the APHCs equipped with prescribed equipment	1st and 2nd Quarter
Lack of Human resources	Out of 104 sanctioned post of grade A- Nurse 33 are vacant	Recruitment of grade A-nurse	All the Vacant post of contractual Grade- A nurse has been filled	1st quar.
	Out of 50 sanctioned post of ANM (regular) 15 Post are vacant	Recruitment of Regular ANM	All the 15 Vacant post of regular ANM are filled	2nd quar.

	Out of 50 sanctioned post of Medical officers 31 posts are vacant	Recruitment of Medical officers	All the 31 vacant post of Medical officers are filled	2nd quar.
Lack of Nursing skill	All the contractual Nurses lacks the nursing skills	Training of Nurses on SBA , IMNCI, ANC & Immunisation	All the contractual Nurses are trained on these skills	1st , 2nd and 3rd quar.
Construction of 34 Proposed APHCs	Unavailability of Land	Involvement of opinion leader, and PRIs for Community mobilization for land donations .	Land available for atleast 20 proposed APHCs in the next two years	1st and 2nd quar.
		Meeting with C.O/B.D.O in the chairmanship of District Magistrate for availability of land		

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.

Issues in Planning	Current status	Activities to be under taken	Out put to be achieved	Time frame for 2010-11
Up gradation of PHCs into 30 bedded CHCs by phase wise manner	All the 16 PHCs are 06 bedded	Selection of of PHCs which has been up graded into CHCs in phase wise manner	.04 PHCs has been upgraded into CHCs	3rd and 4th quar.
Lack of appropriate furniture and stationery	All the 16 PHCs have not adequate no. of furniture as per IPHS norms	Procurement of furniture and stationery as per IPHS norms	All the 16 PHCs well equipped with furniture	1st and 2nd quar.
Lack of equipments	All the 16 PHCs lacks the equipments as per IPHS norms	Procurement of equipment as per IPHS norms	All the 16 PHCs have well equipped with appropriate equipments as per IPHS norms	2nd & 3rd quar.
Lack of Human resource at PHCs level	Out of 67 sanctioned post of Contractual Specialist Doctors only 01 Specialist MO Posted	Recruitment and selection of Human resource	All the vacant post of Medical officers to be filled	1st quar. .
		Empanelling Pvt. Gynaecologists for PHCs to provide ANC/PNC services at fixed day	Increase in ANC and PNC at PHCs level	1st,2nd ,3rd, & 4th quarter
		Hiring Pediatrician for PHCs to OPD services at fixed day.	Increase in Child OPD	1st,2nd ,3rd, & 4th quarter

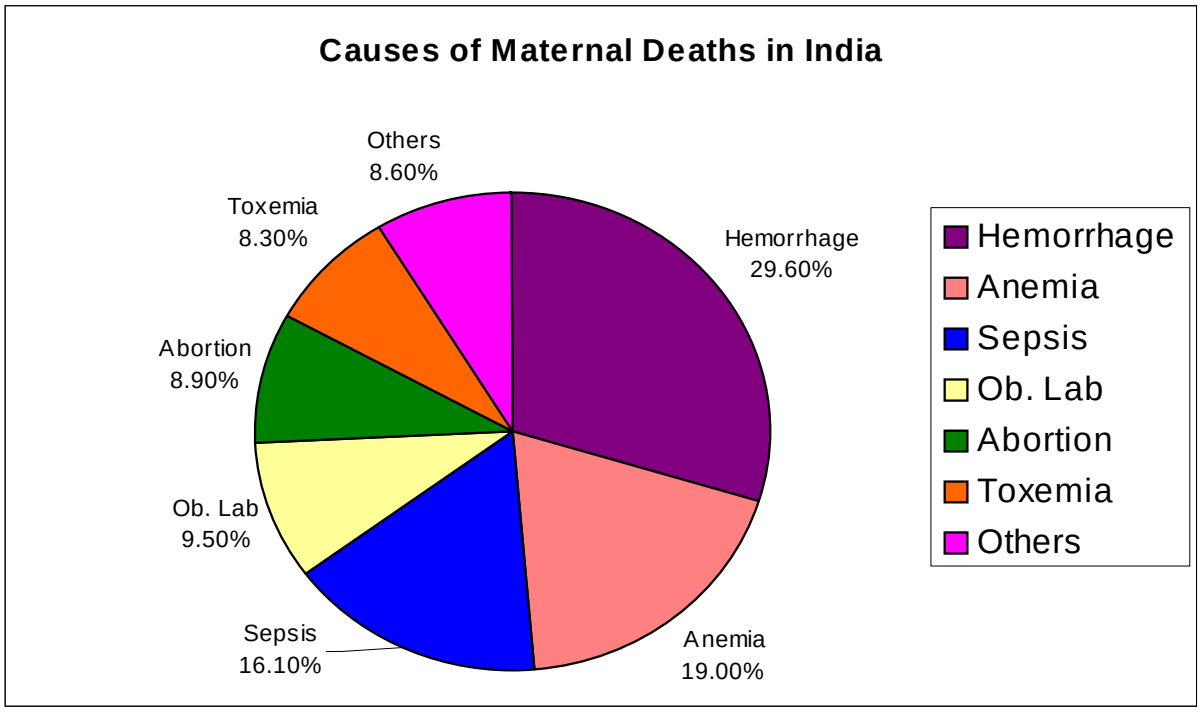
	Out of 46 sanctioned post of Pharmacists 45 post are vacant , out of 42 sanctioned post of Lab. Technician 39 are vacant .	Appointment of Pharmacists and Lab. Technician on contract basis	All the vacant post of 45 pharmacist and Lab . Tech. to be filled	2nd Quar.
Construction/ Renovation of Existing 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.	1st quar.
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 .	Every block have organize BCC/ IEC activities	1st and 2nd quarter
		Displaying all the services (Citizen's charter) provided by the PHCs at centre as well as prominent places of the villages	All the 16 PHCs displayed citizens charter	1st quarter
		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	At least 03 RKS members of every RKS has been trained	1st & 2nd quar.

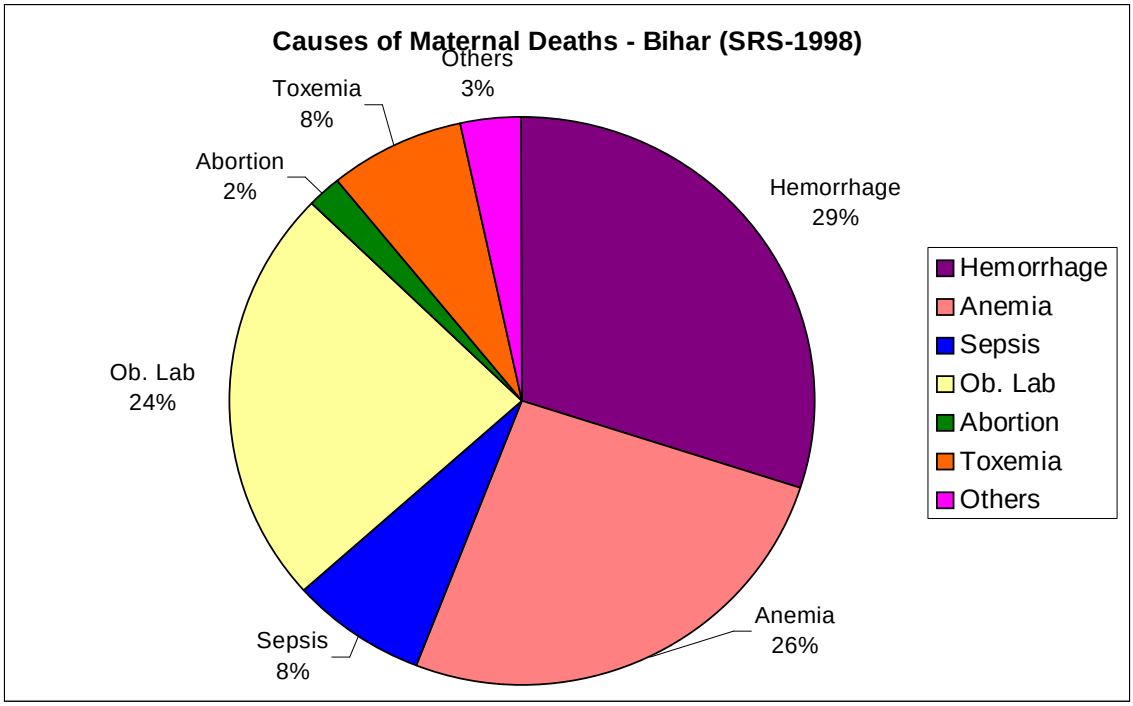
REPRODUCTIVE AND CHILD HEALTH

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





Goals

: Reduce MMR from present level 312 (SRS 2007-08) to less than 100

Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
1. To improve coverage of 03 antenatal care to 32.5 % to 75 by 2011.	Only 32.5 % of women receive 03 ANC during their pregnancy period . .	Awareness generation about importance of ANC at Community level	• Increase in ANC • Increase in reported cases of pregnancy	1st and 2nd quar.
Lack of awareness about importance of ANC		Social mobilization to create demand in the community for ANC clinics		
		Use of local resources in terms of ASHA , AWC to track the pregnancy inform the ANMs	Increase in reported cases of pregnancy	1st and 2nd quar
No ANC at HSC level	HSC have not provided the ANC services	Organising Regular ANC clinics at Health Centers level	50 % of the HSC organize regular weekly ANC clinics	1st ,2nd ,3rd & 4th quar.

To provide out reach maternal care		Organizing ANC clinic sessions in remote areas through mobile health units.	25 % cases of MMU OPD should be ANC	1st ,2nd ,3rd & 4th quar
Lack of Human Resources	All the 16 post contractual Gynaecogists are vacant	Empanelling Gynaecologists for gynaecology OPD in under or un served areas	Increase in ANC cases upto 75 %	1st ,2nd ,3rd & 4th quar
Lack of service delivery system	ANMs are not trained in SBA	Training of ANM & Grade-A on ANC and SBA	100 % ANM & Grade-A trained in ANC and SBA	1st ,2nd ,3rd & 4th quar
	Apathy behaviour of health personnel towards the beneficiary	BCC and counselling sessions for service providers	User friendly environment	1st quar.
To strengthen PHC s for providing maternal care	Lack of staff and specialist MOs	Empanelling Gynaecologists for gynaecology OPD in PHC.	Increase in ANC cases at PHCs upto 50 %	1st ,2nd ,3rd & 4th quar
Providing the ANC services at their door steps	No VHND at AWC	Organizing Monthly Village Health and Nutrition Days in each Aaganwadi Centres	100 % coverage of VHND at AWC .	1st ,2nd ,3rd & 4th quar
To increase the institutional deliveries to 12.4% to 75 % by 2011	Only 12.4 % of deliveries are institutional deliveries	Make all the existing 25 APHCs functional for 24*7 Delivery services	All the 25 APHCs are functional and providing delivery services	1st quar.
Lack of infrastructure /Facility at APHC and PHCs	All the 16 post contractual Gynaecogists are vacant 268 post of ANM are Vacant and 33 post of grade –A nurse are vaccant	. Recruitment and availability of Staff nurses & ANM to all PHCs/APHCs.	100% of vacant post of contractual manpower should be filled	1st quarter and 2nd quarter
		Hiring retired ANM for ANC and institutional deliveries	300 retired ANM are recruited	

Lack of Maternal health care center at urban area	Except District Hospital katihar , there is no urban health center	Construction of urban health center for every 10000 population	4 urban health centers constructed	2nd and 3rd quarter
Lack of equipments in labour room	All the 16 PHCs including D.H lack the labour room equipments as per IPHS norms	Procurement of Labour room equipment as per IPHS norms.	All the 17 health facilities equipped with labour room equipment	1st and 2nd quarter
Lack of drugs at labour room	As per IPHS norms there are acute shortage of drugs at labour room	Strengthen the Procurement and supply of drugs policies at district level	All the 17 health facilities have adequate amount of drugs in labour rooms	1st and 2nd quarter.
Strengthen FRUs and PHCs for CEmOC services	At Katihar ,Govt. health facilities have not at all any infrastructure at all in terms tackle CEmOC	Ensuring adequate and safe blood supplies by strengthening existing blood banks /storage or opening new blood banks/storage in the district.	Operationalisation of 02 blood storage units at FRUs	1st and 2nd quarter.
Lack of Human resources to tackle CEmOC		Empanelling Gynecologists and anesthetic on CALL BASIS for conducting institutional deliveries, providing Essential and Emergency Obs Care at government facilities	10 Gynecologists and 10 anesthetic will be empanelled	1st and 2nd quarter.
Poor monitoring of services		Monitoring & evaluation by MOs and Block Health Managers	Improved quality of services	1st , 2nd 3rd & 4th quar.

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

Objective - To increase coverage of post partum care to 15.3 % to 60%.by 2011

Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
Low % of PNC	At Katihar 93 % 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	60 % PNC coverage	1st and 2nd quarter
		Availability of bed and other facilities for the mother and neonates	100 % bed availability	1st and 2nd quarter
		Recruitment of MAMTA for PNC & Neo Natal care at every PHCs/ Referal Hospital.	No. of MAMTA recruited	1st quarter.
Lack of follow up of cases		Follow-up Monitoring and follow up of cases by ASHA/LHV and ANM during their home visits especially for post natal care (PNC) using IMNCI protocols and visit neonates and mothers within three days and six weeks of delivery.	50 % of delivery cases follow up by ASHA / LHV	All the 4 quar.

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.

Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
Lack of MTP services at health facilities	At present MTP services provided at D.H only	Ensure availability of MTPs in all FRU and PHCs	MTPs services provided in all the 17 health facilities	1st quarter
Lack of training about the MTP technique	5 % of ANMs trained on MTP	Capacity building of Health personnel on MTP	50 % of ANM trained on MTPs	1st and 2nd quarter
Lack of equipments	MTPs equipment available at only D.H	Procurement of essential equipment such as Vacuum extractor & Manual Vacuum aspirator	Availability of MTPs equipment in all 17 health facilities.	1st quarter
Lack of knowledge about the legal status of MTP	Only 10 % people have the knowledge about the laglity of MTPs	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 .	50 % of the population aware about the legality of MTPs services	Through out the year
		Establishment of hoarding at prominent places displaying the information regarding the legal status of MTP	17 hoarding established	1st and 2nd quarter

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

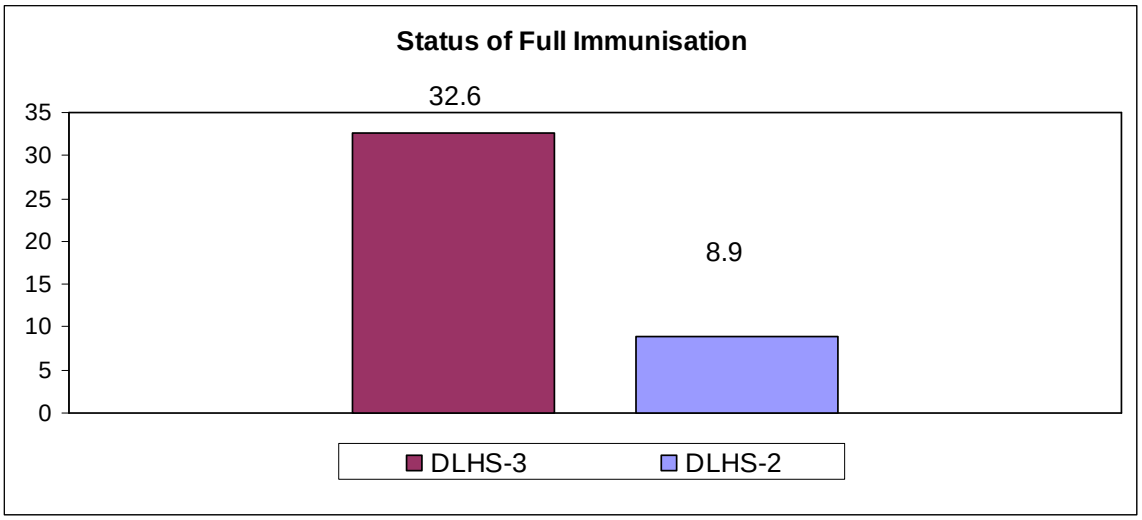
Goal- To bring down the Infant Mortality Rate (IMR) from the present level of 60 per thousand live births to less than 30 per thousand live births by 2011.

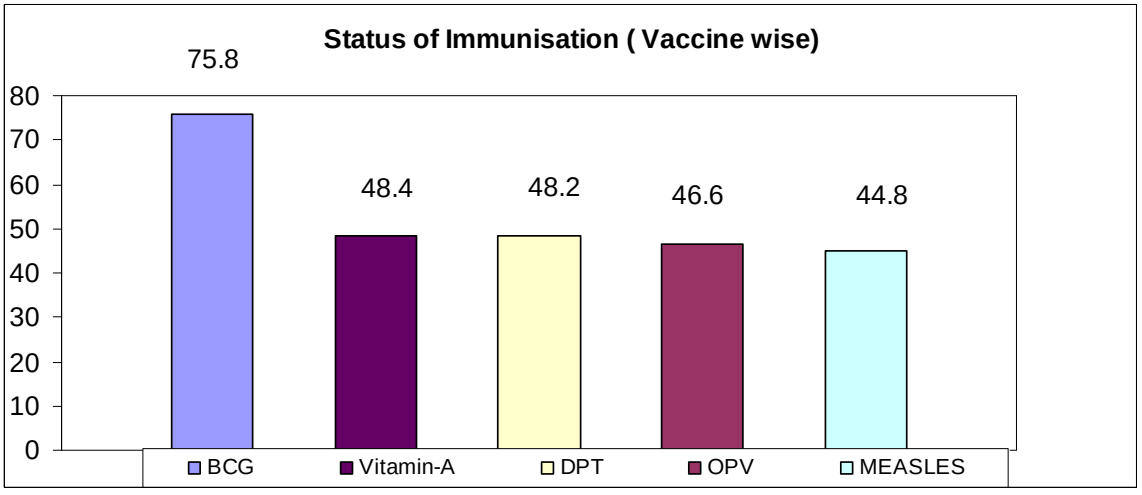
Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
To increase % of colostrums feeding from 13.8% to 75 % within 1 hr of birth	Myths and misconception about the colostrums & breast feeding	BCC activities by ASHA/ MAMTA and ANM for colostrums feeding	Colostrums feeding increased from 13.8% to 75 %	All the 4 quarters
To increase exclusive breastfeeding among 0-6 month children from 14.8% to 75 %	Myths and misconception about the breast feeding	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	▪ 25000 one to one meeting held by ASHA/ AWW ▪ Breast feeding increased up to 75 %	All the 4 quarters

Providing Essential New Born Care at Facility level	Lack of training of Health personnel on New born care	Capacity building of Health personnel on New born care especially on danger signs	50 % of the available health personnel trained on New born Care	1,2,3 and 4th quar
	Lack of Infrastructure and necessary guidelines at health facilities for new born care at all the facilities including D.H	Construction of FBNCC at PHCs ,FRUs and D.H	17 FBNCC will be constructed	1,2,3 and 4th quar
		Procurement of logistics and dissemination to health facilities	All the newly constructed 17 FBNCC will be fully equipped with equipments	1,2,3 and 4th quar.
Providing Essential New Born Care at Community Level/Home based	Lack of Knowledge about the neo natal care care amongst the health personnel	Training of AWWs/ ASHA /ANMs/LHVs on neo natal care	75 % of the health personnel will be trained on NNC	1,2,3 and 4th quar.
		Training on Identifying danger signs of hypothermia, hypoxia and sepsis to ASHA, AWW .	75 % of the ASHA /AWW will be trained on danger signs	1,2,3 and 4th quar
		Educating the community about danger signs	25000 mothers will be educated on danger signs	1,2,3 and 4th quar
		Support for Pediatrician on call basis	No. of Pediatrician empanelled for on call basis	1st quarter .
Management of Diarohea and ARIs		To increase ORS distribution from 32.6 % to 75%	No. of ORS packets & Cotrimoxazole tablets distributed through AWWs	.2nd & 3rd quar.
		To increase treatment of diarrohoea from 80.9% to 100% within two weeks	No. of Referral cases of sick child to higher level	1,2,3 and 4th quar

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 06 vaccine prevented diseases

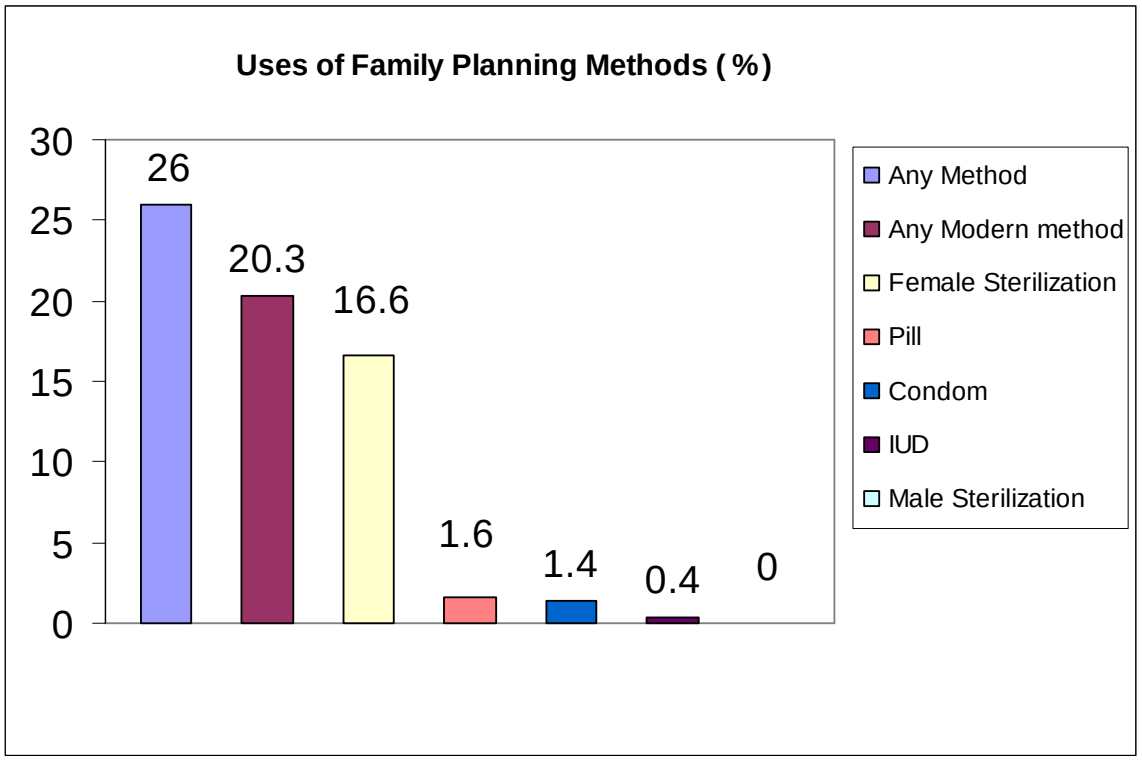
Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
To Increase in percentage of fully protected children in 12-23 months as per national immunization schedule to 32.6 % to 75 %	Human resource shortage at all levels	Recruitment of Health personnel	All the vacant post to be filled	1st and 2nd quarter
		Hired retired ANMs for holding immunization sessions in remote areas	300 retired ANMs hired	2nd quarter
	Hard to reach areas , Poor transportation	Providing Interest free loans to ANM to purchase Moped/Scooty for immunization in hard to reach areas	200 moped loans given to ANM	1st and 2nd Quar.
Shortage of vaccines & cold chain equipments	Inconsistent delivery of Vaccines & syringes to district	Streamline the procurement and supply chain of vaccines	All the facility have vaccines and cold chain equipments available for through the year	1st and 2nd
		Fund for Local Annual Maintenance contract for Cold Chain equipment	100 % maintenance of cold chain equipments	1,2,3 and 4th quarter

Poor monitoring		Involvement of CDPO& Health Managers for Monitoring	100 % session site will be monitored by CDPOs and BHM	
Myths and misconception about the immunization	Some communities have misconception about the immunization they boycott the Immunisation	One to one meeting by ASHA/AWW with parents of the child	80 % increase in Immunisatiom rate	1,2,3 and 4th quarter
		Involvement of opinion leader, religious leader and PRIs		
		Advertisement through local cable channels		
		Wall writing , street play , Hoardings		
To strengthen the Muskan Ek Abhiyan Program	Inconsistent Payment of incentive money to ASHA/AWW/ANM	Consistent payment of incentive money to ASHA/AWW/ANM	100 % payment will be made to ASHA/AWW/ANM	1,2,3 and 4th quarter
	Low motivation			
To Strengthen immunization in Urban areas	Inadequate health infrastructure in urban areas	Establishment of Urban Health center/Programme	10 urban health centers will be established	1st and 2nd quarter.
	Poor Coordination	PPP with Pvt. Clinics/NGO Hospital	PPP with 25 NGOs for immunisation	1st and 2nd quarter.

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 2.1 by 2011 , In order to achieve this, reduce current unmet need for FP by 75%.

Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
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	Through out the year
		IUD insertion at HSC level through out the year	257 HSCs will be provided the services of IUD insertion .	Through out the year
		Organizing IUD camps at Block level	300 IUD camps will be organized at Block level .	Through out the year
		Training of service providers on Minilap , NSV & IUD insertion	▪ No. of ANMs get trained on Minilap , NSV and IUD insertion ▪ No. of Doctors trained on Minilap, NSV and IUD insertion	Through out the year
		Upgrading facilities for sterlisation services	17 health facilities has been upgraded for sterlization services	Through out the year
Lack of equipments for Minilap , NSV and IUD insertion kit	All the health facilities lacking the required amount of above equipments	Need based procurement of drugs , equipment and instruments	All the health facilities have required no. of instruments	1st and 2nd quarter
To reduce unmet Need for Terminal Methods	Poor Accessibility of sterlisation services	Accrediation of private providers for providing sterilization Services at their facility.	20 Private providers accredited for sterilization services . 6000 sterilization will be done at Pvt. Accredited Hospitals	1st ,2 ,3 and 4th quarter

To Increase NSV cases 0 % to 20 % (DLHS-3)	Poor male participation.	PHCs / Referal / District Hospital to provide fixed day female sterilization services.	No. of PHCs / Referal / District Hospital to provide fixed day female sterilization services.	Through the year
		Promotion of postpartum sterilization	1000 postpartum sterlisation.,	Through out the year
		Organisation of Female sterlisation camp	500 camps has been organized	Through out the year
		Organizing Fixed day NSV camp	. 200 NSV camps organized .	Through out the year
			2000 NSV cases	
	Poor IEC on NSV/ Family planning services	Area wise BCC / IEC on NSV	No. of BCC/IEC activities to be done	Through out the year
		One to one meeting with eligible couple by ASHA/LHV	No. of one to one meeting conducted by AHSA/LHV	Through out the year
		Block level PRI orientation on availability of F.P Services	16 Block level orientation will be organized	1st and 2nd quarter
		Block level ICDS orientation on availability of F.P Services	16 Block level orientation will be organized	1st and 2nd quarter
		Block level SHG orientation on availability of F.P Services	16 Block level orientation will be organized	2nd and 3rd quarter

		Block level ASHA/AWW orientation on availability of F.P Services	16 Block level orientation will be organized	2nd and 3rd quarter
		AWC level mothers & adolescents meeting at village level	2301 AWC level meeting will be organized .	Through out the year
To ensure quality of services	Lack of knowledge on **standards & quality assurance of sterilisation services**	Organizing health mela focusing on MH, FP , child health **Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services**	16 health melas will be organized. No. of Manuals printed and disseminated	2nd and 3rd quarter 1st quarter
Monitoring & evaluation of Services		Monitor quality of services & utilization	Quarterly visit of accrediated facility by QAC.	Through out the year
			Quarterly visit of District Hospital/Ref. Hospital and PHCs for monitoring of quality of services provided	Through out the year

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.

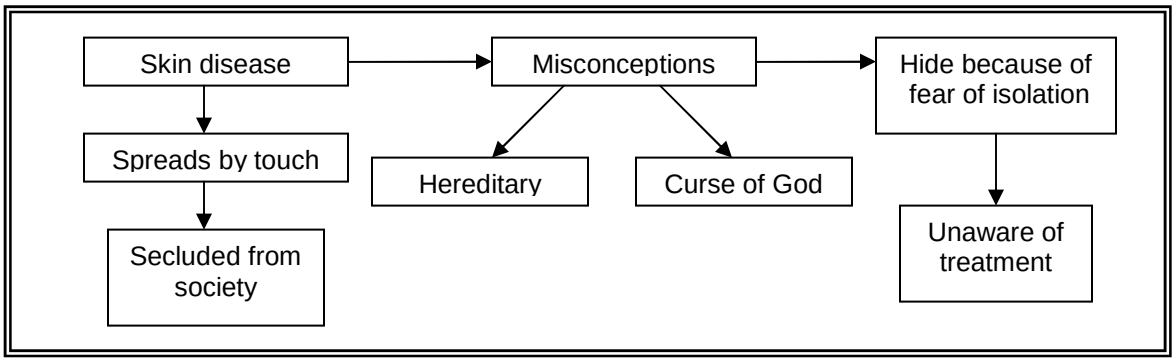
NATIONAL LEPROSY ERADICATION PROGRAMME

B.2 National Leprosy Elimination Programme

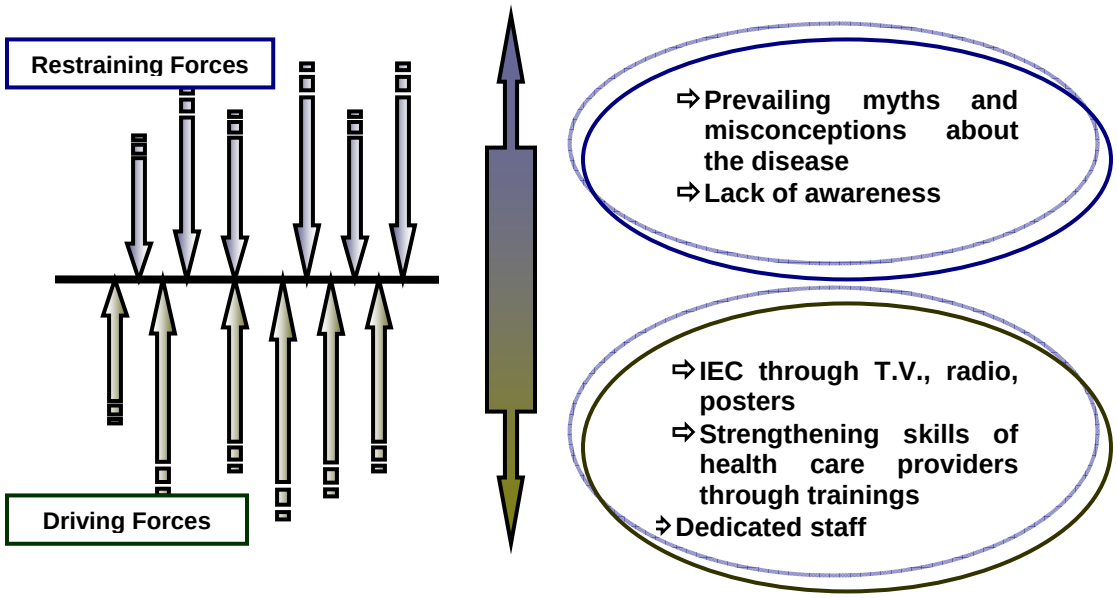
Leprosy is a chronic infectious disease caused by M. Leprae, an acid-fast, rod shaped bacillus. The disease mainly affects the skin, the peripheral nerves, mucosa of the upper respiratory tract and also the eyes, apart from some other structures. Leprosy has afflicted humanity since time immemorial. 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
Increase awareness among the community about the disease	BCC to motivate patients having suggestive symptoms to go for self reporting	Using ASHA and AWW to disseminate information during VH&N day
	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.

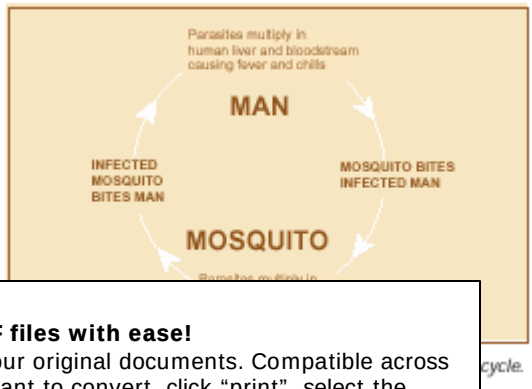
Katihar is a Kala azar & Malaria prone district of Bihar .

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

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.

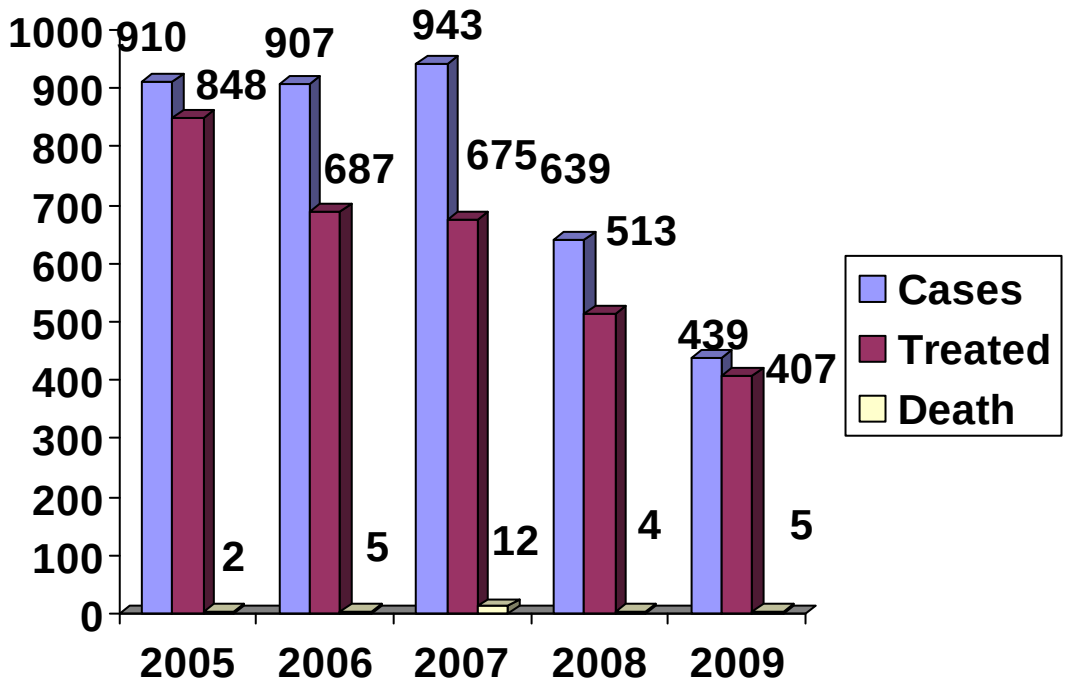
Goal- To reduce mortality and morbidity due to Malaria

<table>
<tr><th>Objectives</th><th>Constraints</th><th>Strategies</th><th>Activities</th></tr>
<tr><td rowspan="6">Early Case Diction and Prompt Treatment</td><td>Lack of Knowledge about malaria prone areas</td><td>Identify pockets populations at risk to have increased access to early diagnosis and prompt treatment</td><td>House to house survey by ASHA/AWW/MHW etc</td></tr>
<tr><td rowspan="2">Lack of Human resources such as Malaria inspector , Lab Technician</td><td rowspan="2">Appointment of L.T and Malaria inspector on Contract basis</td><td>Publication of vacancies</td></tr>
<tr><td>Recruitment & selection of H.R</td></tr>
<tr><td rowspan="3">Lack of FTDs & DDC</td><td rowspan="3">For complete surveillance of fever cases identification and treatment, role of FTDs and DDCs are very important Establishments of FTDs and DDCs</td><td>Appointment of Malaria link workers on contract basis</td></tr>
<tr><td>Training of Malaria link workers</td></tr>
<tr><td>Establishment of Fever Testing depots at every 5000 Population</td></tr>
<tr><td></td><td></td><td>Establishment of Drug distribution center at every 5000 Population.</td></tr>
</table>

		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 2011.

- 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

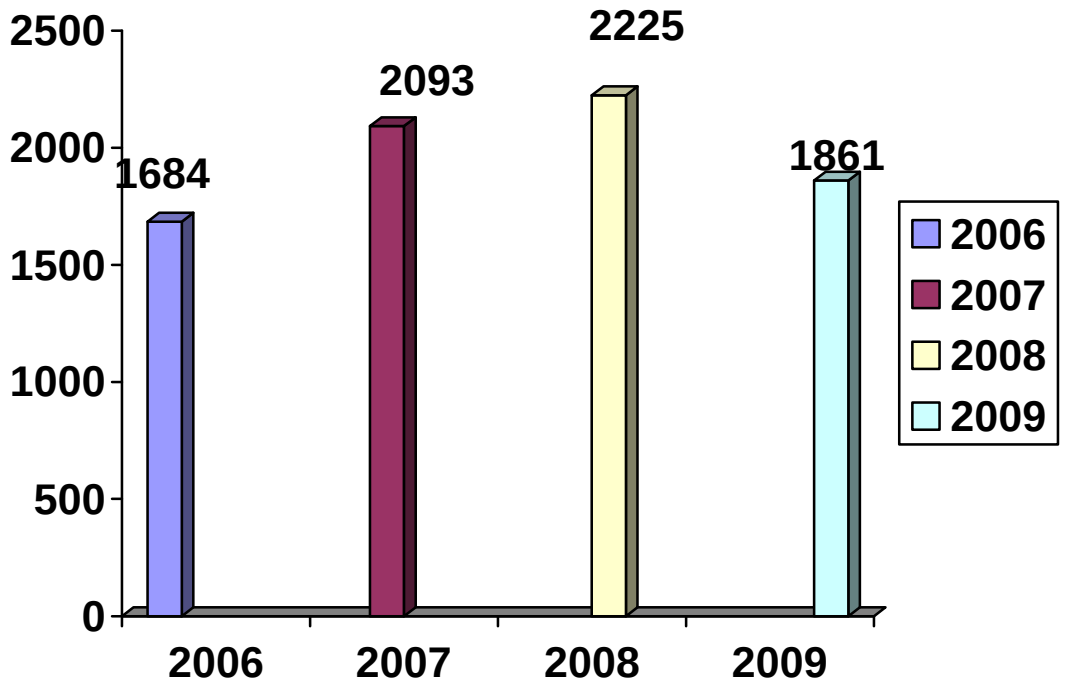
- Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.
- Continuous use of vector control measures.
- Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.
- IEC for ensuring community awareness and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

NATIONAL BLINDNESS CONTROL PROGRAMME

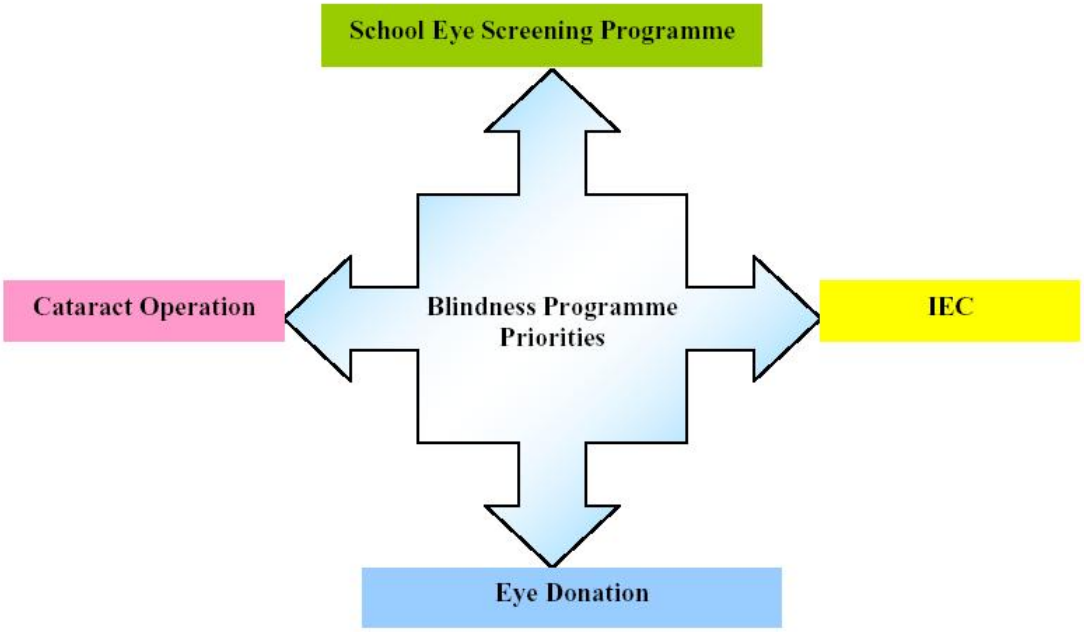
B.4 NATIONAL BLINDNESS CONTROL PROGRAMME

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 1916 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 .

Sl. No.	Issues in Planning in ASHA	Current Status as per evidence from data triangulation	Activities to be undertaken to achieve targets	Outputs to be achieved	Time Frame for 2010-11
1	Lack of Human Resource	At District and Block level one DCM /DATA assistant, Block organizer had sanctioned in last PIP but they are not yet appointed, appointment process has been initiated. - At the Cluster level ASHA facilitator (1 ASHA for 20 ASHA) had sanctioned in last PIP but they are not yet appointed, appointment process has been initiated.	Recruitment of the Personnel at all the levels - Induction Training/ Orientation of the same. - 1.	Human Resource in place With proper orientation training for effective implementation of the programme	1st and 2nd Quarter
2	ASHA Selection	2549	1916 Selected	Target selection to be completed	1st Quarter
3	1. ASHA Trainings - Lagging and Qualitative Issues		Creation of training Pool at the District and Block Levels 1. Develop user friendly training methodology and the training	Completion of Module 1, 2, 3 and 4 trainings and rolling out of	1st, 2nd and 3rd Quar

	2. Technical backstopping in Training		modules. 2. Print the modules in prescribed time, 3. Disseminate the modules from District to block. 4. Work on the training modalities 6. Provide the supportive supervision to maintain quality checks and control at Block level.	Module 5 training	
4	ASHA Drug Kit- Incompetent Kit bags/ Non availability of Kit bags and Drugs	- Kit bag available to ASHAs not adequate	- Provision of Drug Kit Bag to ASHAs (Kits provided earlier are not designed to keep medicines) through tender after designing. - Strengthening of processes with the Facilitate the procurement process and supply it to ASHA. Develop the mechanism to maintain at least two months stock of medicines with ASHA. - Training of ASHAs	- Better health Care of the community - Self- Help Mechanism will be developed	1st quarter

BUDGET

	Budget Head					
Slno.	1. Maternal Health	Q.1	Q.2	Q.3	Q.4	Total
1.1	Operationalise Blood Storage units in FRU	136000.00				136000.00
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
	RCH out reach camps	18665.25	18665.25	18665.25	18665.25	74661.00
1.4	Home deliveries	35000.00	35000.00	35000.00	35000.00	140000.00
1.5	(A) Institutional deliveries (Rural) @ Rs.2000/- per delivery	7532297.50	7532297.50	7532297.50	7532297.50	30129199.00
1.6	(B) Institutional deliveries (Urban) @ Rs.1200/- per delivery	1086370.00	1086370.00	1086370.00	1086370.00	4345480.00
	incentive for C-section(@1500/-(facility Gynec. Anesth. & paramedic)	496895.75	496895.75	496895.75	496895.75	1987583.00
1.7	Incentive for MAMTA @ Rs. 100 per delivery	625000.00	625000.00	625000.00	625000.00	2500000.00
1.9	Monitor quality and utilisation of services@	124464.25	124464.25	124464.25	124464.25	497857.00
	Total Maternal Health	10054692.85	9943692.75	9918692.75	9918692.75	39835780.00
	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	66367.00	00	00	00	66367.00
2.4	Home Based Newborn care	500000.00	500000.00	500000.00	500000.00	2000000.00
2.5	School Health Programme (Details annexed)	1135936.20	1135936.20	1135936.20	1135936.20	4543744.80
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	3956933.2	3890566.2	3890566.2	3890566.2	15628631.8
	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	400000.00	400000.00	400000.00	500000.00	1700000.00
3.4	Compensation for female sterilisation at PHC level in camp mode	3378000.00	3378000.00	3378000.00	3378000.00	13512000.00
3.5	Compensation for NSV Acceptance	48622.50	48622.50	48622.50	48622.50	194490.00
3.7	Compensation for sterilization done in Pvt. Accredited Hospitals cases)	2000000.00	2000000.00	2000000.00	2000000.00	8000000.00
3.8	Monitor progress, quality and	2740.75	2740.75	2740.75	2740.75	10963.00

	utilisation of services					
3.10	**IUD Camps**	**60000.00**	**60000.00**	**60000.00**	**60000.00**	**240000.00**
3.11	**Organise Contraceptive Update seminars for health providers**	**0.00**	**25000.00**	**25000.00**	**0.00**	**50000.00**
3.12	**NSV Training**	**75000.00**	**75000.00**	**000**	**00**	**150000.00**
	IUD insertion Training	**100000.00**	**100000.00**	**00**	**00**	**200000.00**
	Minilap Training	**125000.00**	**125000.00**	**00**	**000**	**250000.00**
	Block level PRI orientation on Availability of FP services	**100000.00**	**100000.00**	**00**	**00**	**200000.00**
	Block level ICDS orientation on Availability of FP services	**125000.00**	**125000.00**	**00**	**00**	**250000.00**
	Block level SHG orientation on Availability of FP services	**125000.00**	**125000.00**	**125000.00**	**125000.00**	**500000.00**
	Block level ASHA/AWW orientation on Availability of FP services	**250000.00**	**250000.00**	**250000.00**	**00**	**750000.00**
	AWC level mother & adolescents meeting at village level	**1000000.00**	**1000000.00**	**1000000.00**	**1100000.00**	**4100000.00**
	Organising health melas focusing on MH FP and child health	**250000.00**	**250000.00**	**250000.00**	**250000.00**	**1000000.00**

	Total Family Planning	**8774548.75**	**8799548.75**	**8274548.75**	**8199548.75**	**34048195.00**
	4. Adolescent Reproductive and Sexual Health					
4.1	**Disseminate ARSH guidelines.**	**25000.00**	**0**	**0.00**	**0.00**	**25000.000**
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	**25000.00**	**00**	**16062.50**	**16062.50**	**57125.00**
	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 District and Block Level**	**67612.75**	**67612.75**	**67612.75**	**67612.75**	**270451.00**
6.3	**MUSKAAN**	**00**	**00 0**	**00**	**00**	**00**
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
6.7	Interest free loan to ANM for scooty/moped	3500000.00	3500000.00	000	0000	7000000.00
	Total Innovations	6263918.86	6196306.11	2763918.86	2763918.86	18055675.44
	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	1484891.00	1484891.00	1484891.00	1484891.00	5939564.00
7.12	Facility improvement for establishing New Born Centres - @ Rs. 50,000 / per FRU	50000.00	00	0.00	0.00	50000.00
7.13	Facility improvement for establishing New Born Centres at PHCs across the state - @ Rs. 25,000 / per PHC	150000.00	000	0.00	0.00	150000.00
	Total Infrastructure and Human Resources	2095298.00	1859898.00	1859898.00	1859898.00	7674971.00
	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	0.00	11079.89	0.00	0.00	11079.89
8.15	Training for ASHA Help Desk to DPMs (/	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 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 Abortion	0.00	53629.62	0.00	0.00	53629.62
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	0.00	48000.00	0.00	0.00	48000.00

	FP centres					
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**	**258720.00**	**258720.00**	**258720.00**	**258720.00**	**1034880.00**
11.2	**.Provision of equipment/furniture and mobility support for DPMU staff @ 12 months 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	574739.5	574739.5	574739.5	574739.5	2298958.00

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. 4000.00 PM for 12 Months	12000.00	12000.00	12000.00	12000.00	48000.00
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. 115 Per ASHA/PM	879405.00	879405.00	879405.00	879405.00	3517620.00
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	**6819968.00**	**6768988.00**	**1836147.00**	**1836147.00**	**17261250.00**
19. Institutional Strengthening						
19.1	Sub-centre rent and contingencies @ Rs.500/- x 60 months	52875.00	52875.00	52875.00	52875.00	211500.00
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. 12000.00 pm for 12 months**	**3744000.00**	**3744000.00**	**3744000.00**	**3744000.00**	**14976000.00**
19.14	**Honorarium for Contractual ANM @ Rs. 8000.00 pm for 12 months**	**8280000.00**	**8280000.00**	**8280000.00**	**8280000.00**	**33120000.00**
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**	**2438400.00**	**2438400.00**	**2438400.00**	**2438400.00**	**9753600.00**
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	**56019292.00**	**70493625.29**	**68758625.29**	**19098062.00**	**214369604.58**
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**

SUMMARY OF BUDGET

Slno.	Budget Head	Amount
1	Maternal Health	39835780.00
2	Child Health	15628631.80
3	Family Planning	34048195.00
4	ARSH	57125.00
5	Vulnerable group programme	1202743.50
6	Innovation	18055675.44
7	Infrastructure & Human Resource	7674971.00
8	Training	3280345.09
9	BCC/IEC	3038213.73
10	Procurement of equipments	8017433.60
11	Programme Management	2298958.00
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	17261250.00
19	Institutional strengthing	214369604.00
20	Routine Immunisation & Pulse polio	42084716.25
	Total	**428306578.41**