District Health Action Plan

2010-2011

District Health Society
Muzaffarpur

Foreword

The National Rural Health Mission envisages the planning process to be participatory and decentralized starting with the village. It seeks to empower the community by placing the health of the people in their own hands and determine the ways they would like to improve their health. This is the only way to ensure that health plans are need based. The state would play a facilitator's role.

NRHM was launched in April 2005. Department of Health, Government of Haryana is implementing the NRHM in right earnest. The State Health Society took a number of enabling actions. This created an environment conducive for decentralized planning by the district.

The District Action Plan is the most important aspect of the planning process as the Government of India and the state government would monitor the progress of implementation district wise. The district is also the key administrative unit for most of the development activities. This plan is based on 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 pubic/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.

I need to congratulate the department of Health and Family Welfare and State Health Society of Bihar for their dynamic leadership of the health sector reform programme and we look forward to a rigorous and analytic documentation of their experiences so that we can learn from them and replicate successful strategies. I also appreciate their decision to invite consultants (NHSRC/ PHRN) to facilitate our DHS regarding preparation the DHAP. The proposed location of HSCs, PHCs and its service area reorganized with the consent of ANM, AWW, male health worker and participation of community has finalized in the block level meeting.

I am sure that this excellent report will galvanize the leaders and administrators of the primary health care system in the district, enabling them to go into details of implementation based on lessons drawn from this study.

(Anand Kishore)
(District Magistrate)
Muzaffarpur

Acknowledgment

The Government of India has resolved to launch the National Rural Health Mission in April 2005 to carry out necessary architectural correction in the basic health care delivery system. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

District Action Plans is the most important unit of the planning process as the Government of India and the state government would monitor the progress of implementation district wise. The district is also the key administrative unit for most of the development activities. The District Action Plan adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

District Action Plan has vision to reduce the Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR) and the Total Fertility Rate (TFR) in the district within the period of the National Rural Health Mission. In addition to improving the maternal and child health, District Health Action plan has also emphasized on other thrusts area like; Malaria, Tuberculosis, Leprosy, Iodine Deficiency, Blindness, AID/HIV, RIT/STI, Acute Diarrhea, Typhoid and other common communicable and non-communicable diseases.

Under the National Rural Health Mission this District Health Action Plan of Muzaffarpur district has been prepared. From this, the situational analysis the study proceeds to make recommendations towards a policy on workforce management, with emphasis on organizational, motivational and capability building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps identified and addressed. It looks at how the facilities at different levels can be structured and reorganized.

I am grateful to the state level consultants (NHSRC/PHRN), ACMO, MOICs, member of DHS,Block Health Managers and ANMs,ASHAs and AWWs from their excellent effort we may be able to make this District Health Action Plan of Muzaffarpur District.

I hope that this District Health Action Plan will fulfill the intended purpose.

(Dr. Arjun Pd. Singh)
Civil Surgeon
Muzaffarpur

Chapter-1

Introduction

1.1 Background

Keeping in view health as major concern in the process of economic and social development revitalization of health mechanism has long been recognized. In order to galvanize the various components of health system, National Rural Health Mission (NRHM) has been launched by Government of India with the objective to provide effective health care to rural population throughout the country with special focus on 18 states which have weak public health indicators and/or weak infrastructure. The mission aims to expedite achievements of policy goals by facilitating enhanced access and utilization of quality health services, with an emphasis on addressing equity and gender dimension. The specific objectives of the mission are:

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

One of the main approaches of NRHM is to communities, which will entail transfer of funds, functions and functionaries to Panchayati Raj Institutions (PRIs) and also greater engagement of Rogi Kalyan Samiti (RKS). Improved management through capacity development is also suggested. Innovations in human resource management are one of the major challenges in making health services effectively available to the rural/tribal population. Thus, NRHM proposes ensured availability of locally resident health workers, multi-skilling of health workers and doctors and integration with private sector so as to optimally use human resources. Besides, the mission aims for making untied funds available at different levels of health care delivery system.

Core strategies of mission include decentralized public health management. This is supposed to be realized by implementation of District Health Action Plans (DHAPs) formulated through a participatory and bottom up planning process. DHAP enable village, block, district and state

level to identify the gaps and constraints to improve services in regard to access, demand and quality of health care. In view with attainment of the objectives of NRHM, DHAP has been envisioned to be the principle instrument for planning, implementation and monitoring, formulated through a participatory and bottom to up planning process. NRHM-DHAP is anticipated as the cornerstone of all strategies and activities in the district.

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

Stakeholders in Process

- *Members of State and District Health Missions*
- *District and Block level programme managers, Medical Officers.*
- *State Programme Management Unit, District Programme Management Unit and Block Program Management Unit Staff*
- *Members of NGOs and civil society groups*
- *Support Organisation – PHRN and NHSRC*

Besides above referred groups, this document will also be found useful by health managers, academicians, faculty from training institutes and people engaged in programme implementation and monitoring and evaluation.

1.2 Objectives of the Process

The aim of this whole process is to prepare NRHM – DHAP based on the framework provided by NRHM-Ministry of Health and Family Welfare (MoHFW). Specific objectives of the process are:

- ⇨ To focus on critical health issues and concerns specifically among the most disadvantaged and under-served groups and attain a consensus on feasible solutions
- ⇨ To identify performance gaps in existing health infrastructure and find out mechanism to fight the challenges
- ⇨ Lay emphasis on concept of inter-sectoral convergence by actively engaging a wide range of stakeholders from the community as well as different public and private sectors in the planning process
- ⇨ To identify priorities at the grassroots and curve out roles and responsibilities at block level in designing of DHAPs for need based implementation of NRHM

1.3 Process of Plan Development

1.3.1 Preliminary Phase

The preliminary stage of the planning comprised of review of available literature and reports. Following this the research strategies, techniques and design of assessment tools were finalized. As a preparatory exercise for the formulation of DHAP secondary Health data were complied to perform a situational analysis.

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

The Government of the State of Bihar is engaged in the process of re – assessing the public healthcare system to arrive at policy options for developing and harnessing the available human resources to make impact on the health status of the people. As parts of this effort present study attempts to address the following three questions:

1. How adequate are the existing human and material resources at various levels of care (namely from sub – center level to district hospital level) in the state; and how optimally have they been deployed?

2. What factors contribute to or hinder the performance of the personnel in position at various levels of care?

3. What structural features of the health care system as it has evolved affect its utilization and the effectiveness?

With this in view the study proceeds to make recommendation towards workforce management with emphasis on organizational, motivational and capacity building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps identified and addressed. It also commends at how the facilities at different levels can be structured and organized.

The study used a number of primary data components which includes collecting data from field through situation analysis format of facilities that was applied on all HSCs and PHCs of Vaishali district. In addition, a number of field visits and focal group discussions, interviews with senior officials, Facility Survey were also conducted. All the draft recommendations on workforce management and rationalization of services were then discussed with employees and their associations, the officers of the state, district and block level, the medical profession and professional bodies and civil society. Based on these discussions the study group clarified and revised its recommendation and final report was finalized.

Government of India has launched National Rural Health Mission, which aims to integrate all the rural health services and to develop a sector based approach with effective inter-sectoral as well as intra-sectoral coordination. To translate this into reality, concrete planning in terms of improving the service situation is envisaged as well as developing adequate capacities to provide those services. This includes health infrastructure, facilities, equipments and adequately skilled and placed manpower. District has been identified as the basic coordination unit for planning and administration, where it has been conceived that an effective coordination is envisaged to be possible.

This Integrated Health Plan document of Muzaffarpur district has been prepared on the said context.

1.3.3 Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon, ACMO(Nodal officer for DHAP formulation), all program officers and

NHSRC/PHRN as well as the MOICs, Block Health Managers, ANMs, as a result of a participatory processes as detailed below. After completion the DHAP, a meeting is organized by Civil Surgeon with all MOIC of the block and all programme officer. Then discussed and displayed prepared DHAP. If any comment has came from participants it has added then finalized. The field staffs of the department too have played a significant role. District officials have provided technical assistance in estimation and drafting of various components of this plan.

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 pubic/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.

Relevance of DHAPs

- Addressing local specificities
  - Epidemiological patterns, socio-economic conditions, cultural practices and systemic constraints
- Facilitating Convergence
  - Inclusion of health determinants such as water, nutrition and environment
  - District as the point of convergence for implementation for various policies, schemes and programmes of different department
- Efficient allocation and increased utilization of financial resources at the district level

Relevance of DHAPs

- Improving performance through decentralization
  - Transition from budget oriented plans to outcome oriented plans
  - Opportunity to incorporate inputs and insights from the grass-roots to above
  - Leads to improved capacity of the health system to facilitate planning, implementation and monitoring
- Public participation and ownership
  - Opportunity to incorporate issues raised in various community platforms such as VHSC, RKS, Gram Panchayat
  - Increased accountability

Process adopted at all level:

State level:

1. Fast track training on DHAP at state level.

2. Collection of Data through various sources

3. Understanding Situation & its analysis

4. Assessing Gap

District level:

1. conduction of district level workshop with Key Medical staff, Health Managers, civil society, Line department On DHAP at district level

2. Collection of Data through various sources

3. Understanding Situation & its analysis

4. Assessing Gap

5. Selection of nodal officers for assisting for BHAP preparation

6. District level meeting to compile information

7. 2nd round workshops on feed back for final draft submission

Block level:

1. Block level consultation workshop with ANM,civil society and block level line department

2. Block level meetings with ANM to discuss on format to be fill for situation analysis

3. Organizing meeting with key medical staff , civil society and line department to add any information in BHAP

4. Sharing of final draft with all through organizing meeting at PHC

Finally all BHAP will be submitted by respective PHC to DHS before the dead line and ultimately DHS with the support of line department in leadership of ACMO will incorporate the information from BHAP and prepare DHAP of the district.

Chapter 2
District Profile

History

Muzaffarpur district, 'The Land Of *Leechi*' was created in **1875** for the sake of administrative convenience by splitting up the earlier district of **Tirhut**. The present district of Muzaffarpur came to its existence in the **18th century** and named after ***Muzaffar Khan*,** an Amil (Revenue Officer*)* under British Dynasty. *Purbi Champaran* and *Sitamarhi* districts on North, on the South *Vaishali* and *Saran* districts, on the East *Darbhanga* and *Samastipur* districts and on the West *Saran* and *Gopalganj* districts surround Muzaffarpur. Now it has won international encomiums for its delicious *Shahi Leechi* and *China Leechi.*

It is, of course impossible to trace back the history of this region to its earliest origins, but we can trace back it's stream of strong heritage a very long way through the ancient Indian epic ***Ramayan,*** which still bears a significant role in Indian civilization. To initiate with the Legend*, Raj* ***a***, the mythological name of this entire region including eastern Nepal and northern Bihar. *Sitamarhi*, a place in this region, bears a value of sacred Hindu belief where, *Seeta (other name Vaidehi: The Princes of Videha)* sprang to life out of an earthen pot while *Rajarshi Janak* was tilling the land.

The recorded history of the district dates back to the rise of the *Vrijjan* Republic. The center of political power also shifted from *Mithila* to *Vaishali*. The Vrijjan Republic was a confederation of eight clans of which the *Licchavis* were the most powerful and influential. Even the powerful kingdom of *Magadh* had to conclude matrimonial alliances in 519 B.C. with the neighboring estates of the Licchavis. *Ajatshatru* invaded Vaishali and extended his sway over Tirhut. It was at this time that *Patliputra* (the modern *Patna*) was founded at the village *Patali* on the banks of the sacred river *Ganga* and Ajatshatru built an invincible fortress to keep vigil over the Licchavis on the other side of the river. *Ambarati*, 40 Kms from Muzaffarpur is believed to be the village home of *Amrapali*, the famous Royal court dancer of Vaishali.

Vaishali, a center of religious renaissance, *Baso Kund*, the birth place of Mahavir, the 24th Jain Tirthankar and a contemporary of Lord Buddha continue to attract visitors from across the international boarders.

From the visit of the *Hieuen Tsang's* till the rise of the *Pala dynasty*, Muzaffarpur was under the control of *Maharaja Harsha Vardhan*, a powerful sovereign of North India. After 647 A.D. the district passed on to the local chiefs. In the 8th century A.D. the Pala kings continued to have their hold over Tirhut until 1019 A.D. *Chedi* kings of Central India also exercised their influence over Tirhut till they were replaced by the rulers of the *Sena* dynasty towards the close of the 11the century.

Between 1211 & 1226, *Ghais-u-ddin Iwaz*, the ruler of Bengal, was the first Muslim invader of Tirhut. He, however, could not succeed in conquering the kingdom but extorted tributes. It was in 1323 that *Ghiyasuddin Tughlaq* established his control over the district.

The history of Muzaffarpur will remain incomplete without a reference to the *Simraon dynasty* (in the north-east part of *Champaran*) and its founder *Nanyupa Deva* who extended his power over the whole of Mithila and Nepal. During the regime of *Harasimha Deva*, the last king of the dynasty, *Tughlaq Shah* invaded Tirhut in 1323 and gained control over the territory. Tughlaq Shah handed over the management of Tirhut to *Kameshwar Thakur*. Thus, the sovereign power of Tirhut passed from the Hindu chiefs to the Muslims but the Hindu chief continued to enjoy complete autonomy uninterruptedly.

Towards the close of the 14th century the whole of North Bihar including Tirhut passed on to the kings of *Jaunpur* and remained under their control for nearly a century until *Sikandar Lodi* of Delhi defeated the king of Jaunpur. Meanwhile, *Hussain Shah*, the Nawab of Bengal had become so powerful that he exercised his control over large tracts including Tirhut. The emperor of Delhi advanced against Hussain Shah in 1499 and got control over Tirhut after defeating its Raja. The power of the Nawabs of Bengal began to wane and with the decline and fall of *Mahood Shah*, north Bihar including Tirhut formed a part of the mighty *Mughal Empire*. Though Muzaffarpur with the entire north Bihar had been annexed yet the petty powerful chieftains continued to exercise effective

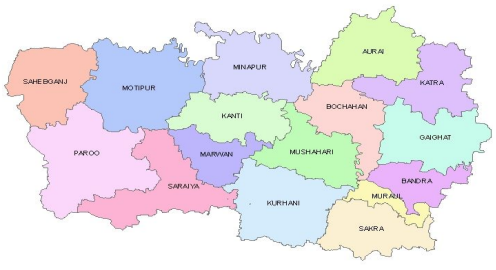
control over this area till the days of *Daud Khan*, the Nawab of Bengal. Daud Khan had his stronghold at Patna and Hajipur and after his fall a separate Subah of Bihar was constituted under the Mughal dynasty and Tirhut formed a part of it.

The victory of *East India Company* in 1764 at the battle of *Buxar* gave them control over whole of Bihar and they succeeded in subduing the entire district. The success of the insurgent at Delhi in 1857 caused grave concern to the English inhabitants in this district and revolutionary fervor began to permeate the entire district. Muzaffarpur played its role and was the site of the famous bomb case of 1908. The young Bengali revolutionary, *Khudi Ram Bose*, a boy of barely 18 years was hanged for throwing the bomb at the carriage of *Pringle Kennedy* who was actually mistaken for *Kingsford*, the District Judge of Muzaffarpur. After independence, a memorial to this young revolutionary patriot was constructed at Muzaffrapur, which still stands. The political awakening in the country after the First World War stimulated nationalist movement in Muzaffarpur district also. The visit of *Mahatma Gandhi* to Muzaffarpur district in December 1920 and again in January 1927 had tremendous political effect in arousing the latent feelings of the people and the district continued to play a prominent role in the country's struggle for freedom.

Muzaffarpur played a very significant role in the history of North-Eastern India. The peculiarity of Muzaffarpur in Indian civilization arises out of its position on the frontier line between two most vibrant spiritual influences and most significantly, to this day, it is a meeting place of Hindu and Islamic culture and thoughts. All sorts of modified institutions, representing mutual assimilation, rise along the boarder line. It has undoubtedly been this highly diversified element within her boundaries that has so often made Muzaffarpur the birthplace of towering geniuses.

<u>Geographical Location</u>

The District is located at 25^{O} 54' to 26^{O} 23' North latitude and 84^{O} 53' to 85^{O} 45' east longitude .This district is one of the oldest and largest trade centers in the entire state. it



shares boundaries with East Champaran, Sitamarhi, Vaishali, Saran, Darbhanga, Samastipur and Gopalganj district covering an area of 3,172 sq km having total population is 3 million.

Boundary

orth	District Sitamarhi & East Champaran
South	District Vaishali & Saran
East	District Darbhanga & Samastipur
West	District Saran & Gopalganj

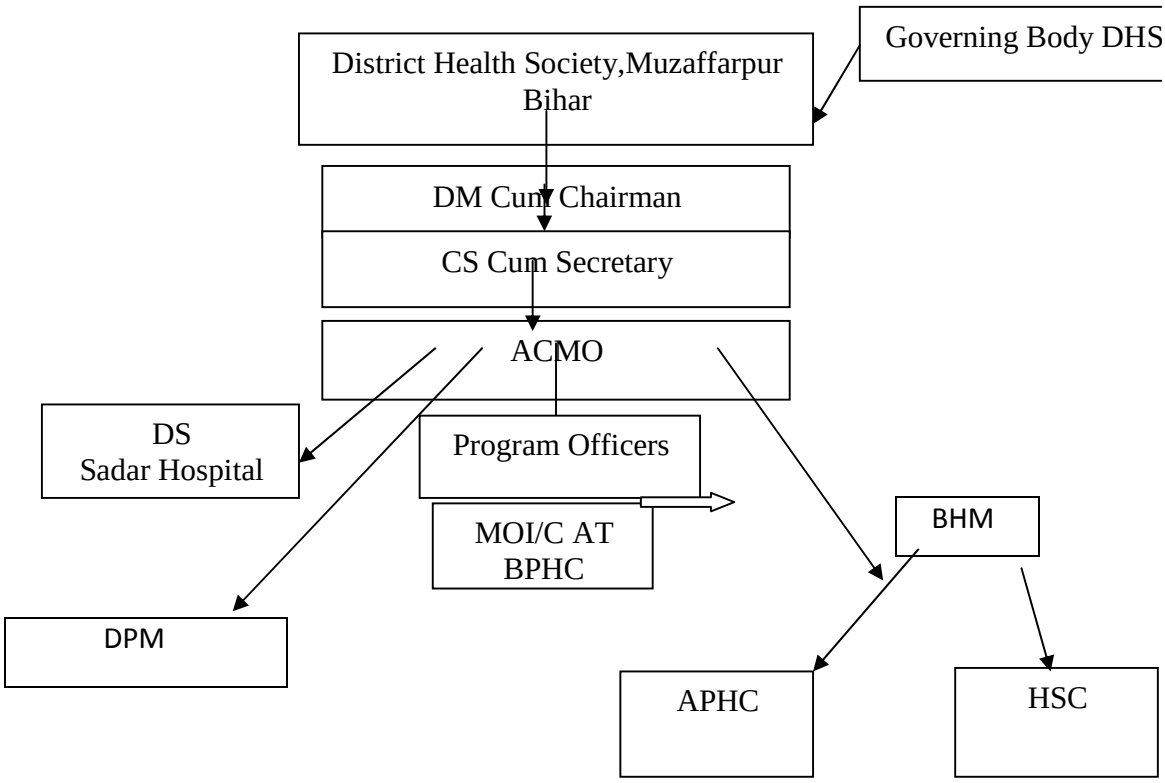
Location

Latitude	North 25^{O} 54' to 26^{O} 23'
Longitude	East 84^{O} 53' to 85^{O} 45'
Height from sea level	170 '

The Bagmati, Gandak, and Burhi Gandak are the important rivers. Main sources of economy are agriculture and industries. Paddy, maize, wheat, and lentils are some of the important crops. Muzaffarpur is famous for litchis and mangoes. There are sugar factories at Motipur, a thermal power station at Kanti, a wagon factory at Muzaffarpur, and pharmaceuticals at Narayanpur. This district exhibits a rare assimilation of Hindu and Islamic culture and thoughts. Much frequented tourist spots such as Hajipur, Sonepur, and Vaishali are near Muzzafarpur. The nearest airport is at Patna at a distance of 72 km.

District Health Administrative Setup

There are two sub divisions and 16 Blocks in the District. The District has 1811 revenue villages and 387 Gram panchayats. A few of the newly created Blocks are still in the formation process. The newly elected Panchayati Raj is enthusiastic to play important role in the District.


Governing Body DHS
District Health Society,Muzaffarpur Bihar
DM Cum Chairman
CS Cum Secretary
ACMO
DS
Sadar Hospital
Program Officers
MOI/C AT BPHC
BHM
DPM
APHC
HSC

MUZAFFARPUR AT A GLANCE

Muzaffarpur east and west are the two subdivision and there boundary represent two Lok Sabha (Parliamentary**) –** 1. Muzaffarpur 2. Vaishali.

PHC	Community Development Blocks	Towns
AURAI	AURAI	
BANDRA	BANDRA	
BOCHHA	BOCHHA	
GAIGHAT	GAIGHAT	
KANTI	KANTI	KANTI
KATRA	KATRA	
KURHNI	KURHNI	
MINAPUR	MINAPUR	
MOTIPUR	MOTIPUR	MOTIPUR
MURAUL	MURAUL	
MUSAHRI®	MUSAHRI®	
PAROO	PAROO	
SAHEBGANJ	SAHEBGANJ	
SAKRA (RH)	SAKRA	
SARAIYA	SARAIYA	
Muzaffarpur sadar hospital	Muzaffarpur (District HQ)	Muzaffarpur

Geographical Information

Geographical Area	317591 Ha.
Cultivated Area	247721 Ha.
Non – Cultivated Area	59270 Ha.
Net Shown Area	219963 Ha.
Slain Land	5230 Ha.
Irrigation Area	82964 Ha.
Horticulture Area	16667 Ha.

Important River

1	BAGMATI
2	GANDAK
3	BURHI GANDAK
4	LAKHANDEYEE

Demographic Data

CONTENTS	2001	1991	1981	1971	1961
Total Population	3743836	2953903	2357388	4840681	4118398
Male Population	1941480	1551637	1201064	2434111	2011539
Female Population	1802356	1402266	1156324	2406570	2106859
Urban Population		274965	190416	253962	188825
Male Female Ratio	1000:928	1000:904	1000:945	1000:953	1000:994
Sc Population	594577	464362	368176	----	-----
St Population	3472	1156	648	----	-----
Sc %	16.7%	15.72 %	15.62 %	----	----
St%	0.1%	0.04%	0.03%	----	----
Literate	1456901	851995	571843	----	----
Male Literate	943928	603298	418905	----	----
Female Literate	512973	248697	152938	----	----
Male Literacy Rate	60.19%	48.44%	34.90%	----	----
Female Literacy Rate	35.20%	22.33%	13.20%	----	----
Population Density	1180 PER Sq Km	931 PER Sq Km	743 PER Sq Km	----	----

Note : Population Of Sitamarhi & Vaishali District Included In 1971 & 1961 As It Was The Part Of Muzaffarpur District

COMPARATIVE POPULATION DATA (2001 CENSUS)

Basic Data	India	Bihar	Muzaffarpur
Population	1027015247	82878796	3743836
Density PER Sq Km	324	880	1180
Sex- Ratio	933	921	920
Literacy % Total	65.38	47.53	48.15
Male	75.85	60.32	60.19
Female	54.16	33.57	35.20

2.1 SOCIO-ECONOMIC PROFILE

Social:

- Muzaffarpur district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Muzaffarpur have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.

The literacy rate in (7 year and above) male is 60.2% and 35.2% in female as per the DLHS-3 has only 35.2%. whereas Educational Institution in this district is as below:

Institution	**No.**

PRIMARY & BASIC SCHOOL	2225
MIDDLE SCHOOL	397
HIGH SCHOOL	101
PROJECT SCHOOL	6
[10+2] HIGH SCHOOL	6
DEGREE COLLEGE	15
POST GRADUATE COLLEGE	4

- 15.7%(DLHS-3) of the population belongs to SC and 0.04%%(DLHS-3) to ST. There are at least 13% percent villages where the SC population is more than 40%. Some of the most backward communities are *Mushahar, Turha, Mallah* and *Dome*.

Economic:

- The main occupation of the people in Muzaffarpur is Agriculture, Fisheries and daily wage labour.
- Almost 20% of the youth population migrates in search of jobs to the metropolitan cities like Delhi,Punjab,Kolkata, Mumbai and Haryana etc.
- The main crops are Wheat, Paddy, Pulses, Oilseeds, Lichi and Mango.
- Sugarcane and Tobacco are the major cash crop of the community .

Demographic scenario of Muzaffarpur district.

According to Census of India 2001:

- The size of population of Vaishali district is above 3743836, comprising 5 % population of Bihar.
- Very high density of population (1180) which is still rising
- Decadal population growth rate of 26.39% as against 28.43% of the state as a whole. Thus the decadal growth rate of the district is slightly less than that of the state.
- Sex ratio of the population is 920 females per thousand males which is almost same as the sex ratio of the state. It is difficult to interpret the deficit of 80 females per thousand males in the district despite outward migration, predominantly of males in the working ages. A plausible explanation seems to be

that over the years male population has benefited more from the epidemiological transition than the female population.

- Only 6.9% of the population resides in the urban area, and the rest lives in the rural areas.

Based on these statistics one can say that Muzaffarpur district lacks urbanization and industrialization. As elsewhere in Bihar, Muzaffarpur suffers from lack of infrastructure facilities, lack of connectivity, and lack of social development and most people depend on small size agricultural land. Agricultural productivity is further affected adversely by recurrent floods and droughts (World Bank, 2005).

Rainfall and Flood and draught Situation

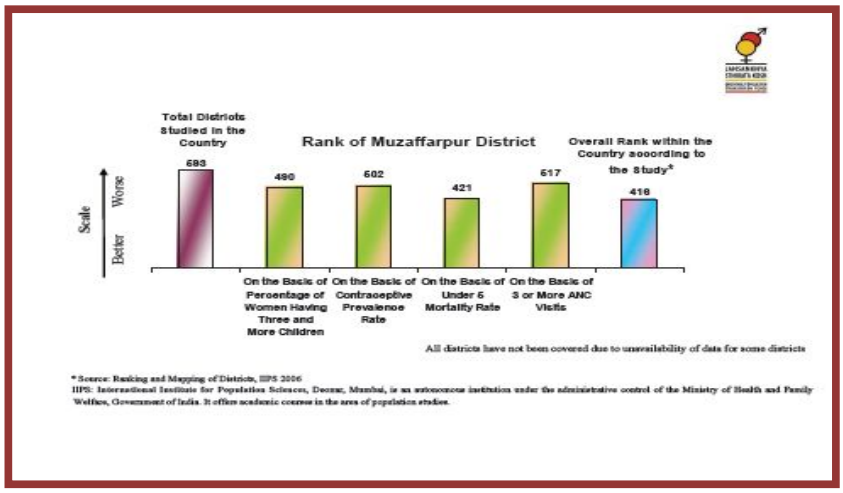
The district receives medium to heavy rainfall (average rainfall 1161 mm), and faces condition of severe flood. In the year 2007 the flood condition was so bad that almost 145 gram panchayats and 583 villages got marooned. Katra,Aurai,Bandra,Muraul and Bochha blocks were the worst affected blocks. According to the estimates of National Disaster Management Department, **in the year 2007, 1,64,237 people were directly affected by the floods.** Crops were damaged, and there was irreparable damage to property and huge loss of lives. **The economic loss due to floods this year amounts to Rs. 65 crore of crop loss, Rs. 25 crore of housing loss and Rs. 27 crore of public property loss.** The district has poor drainage system and nearly 4.5% of the area is water logged.

The district has a total geographical area of 317591ha. 247721 Ha. area comes under cultivated land Whereas 59270 ha. Of land comes under non cultivated Land , with no forest cover. That is 78% of the land is agricultural in this district and nearly 33% of the cultivated land is irrigated. Muzaffarpur district is also affected by droughts. Cycles of floods and droughts severally affect the food production and food distribution system, and lead to distressful situation for most people.

2.3 HEALTH PROFILE

General Status of health in Muzaffarpur district

In a study of 513 districts of the country (Jansankhya Sthirata Kosh", www.jsk.gov.in) in terms of overall rank in health it was found that Muzaffarpur district ranks 460 though on the basis of under-five mortality it ranked 274. whereas a study on Composite Index was done by the same agency in all districts of Bihar Muzaffarpur stood 6 rank in its State.



Filaria, Malaria, Dengue, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in Muzaffarpur district. Hepatitis, Diarrhea, Typhoid, Blindness and Leprosy are other high prevalence diseases. Kala-azar is an endemic problem in Bihar. As per DLHS 2002-2004 the prevalence percentage of kala-azar is 11.4% and TB is 4.3%. The overall prevalence of tuberculosis in India is 544 per 100,000 populations while in Muzaffarpur it is reported to be close to 618 per 100,000 (RCH, Round 2).

Table-: Infant Mortality Rate (IMR) and Child Mortality Rate (CMR)

Indicators	Rural			Urban			Total			
	M	F	T	M	F	T	M	F	T	
Infant Mortality Rate	41	57	50	34	36	35	40	56	48	**Muzaffarpur**
	56	60	58	41	42	42	55	58	57	**Bihar**
Child Mortality Rate	54	65	59	37	43	40	53	65	59	**Muzaffarpur**
	59	**69**	**64**	**42**	**46**	**44**	**57**	**66**	**62**	**Bihar**

Source: Population Foundation of India May 2008

The table gives the estimates of infant mortality rates and child mortality rates of Muzaffarpur and compared with the data of Bihar. **IMR in rural areas (50) are higher**

than the urban areas (35). **Also CMR in rural areas (59) is higher than in urban areas (40).** The differential ratio of infant mortality rate of male/female is 0.7 and rural/urban is 1.4. The differential ratio of child mortality rate of male/female is 0.8 and rural/urban is 1.5.

2.3.1 Health Status and Burden Of Diseases

Table. Case Fatality Rate

S.No.		2007		2008	
	Disease	Case	Death	Case	Death
1	Gastroenteritis	67	6	166	0
2	Diarrhea / Dysentery	1515	5	882	2
3	Cholera	0	0	0	0
4	Meningitis	0	0	0	0
5	Jaundice	0	0	0	0
6	Tetanus	0	0	0	0
7	Kala-azar	3275	6	2632	3
8	Malaria	0	0	0	0
9	Measles	0	0	0	0

As per the DLHS2 &3 Muzaffarpur showing this figure regarding health

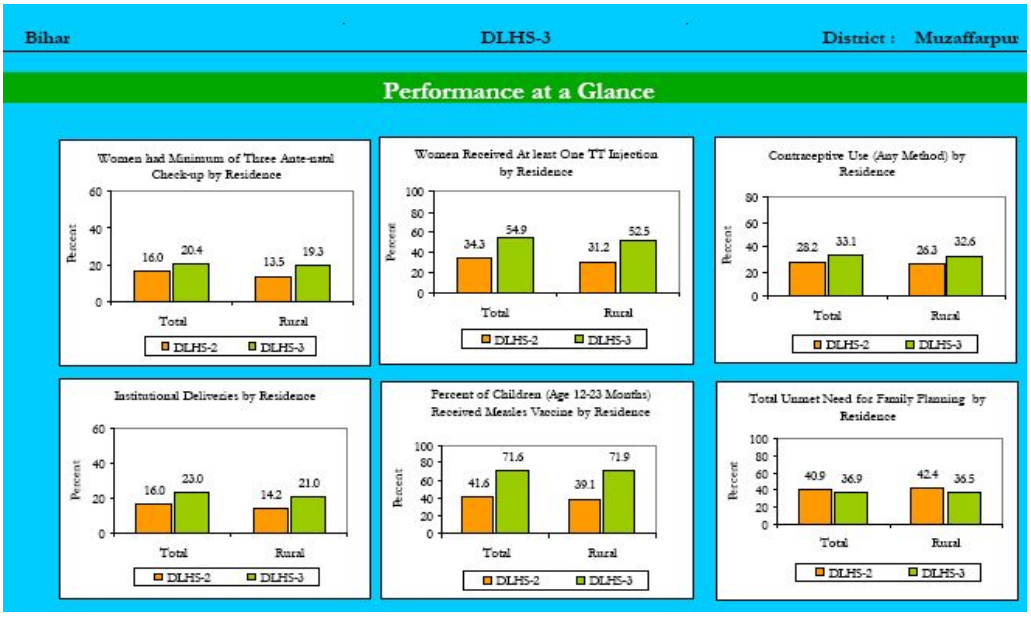


Table . Morbidity Due To Major Disease

S.No.	Disease	2007	2008
1	Kala-azar	3275	2632
2	T.B. (NSP)	997	575

3	Leprosy (PR/10000)	1.15	1.30

Table . Basic Health Status Indicators Of Muzaffarpur District

Indicators	Muzaffarpur	Bihar
Couple Protection Rate (CPR)	33%	
Crude Death Rate (CDR)	NA	8.1
Crude Birth Rate	31.9	30.4
Dacadal growth rate	26.7(1991-01)(DLHS-3)	
Infant Mortality Rate	61	61
Maternal Mortality Rate	371	371
Total Fertility Rate (TFR)	4.6	4
Under 5 Mortality Rate	NA	85
Still Birth Rate	NA	NA
Abortion rate	NA	NA

Table . Denoting Priority Areas in each of the Block

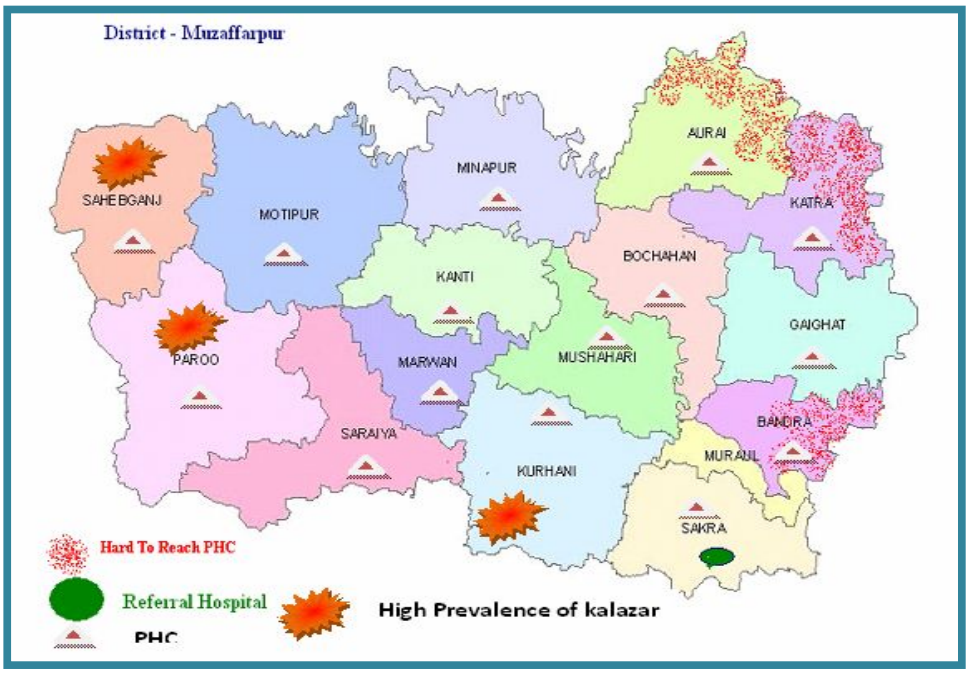
Block	Hard to Reach area
Katra	Whole villages
Aurai	Most of the villages
Bandra	Most of the villages

Note: During raining season i.e. From mid June to September almost 80 percent of the villages become hard to reach area.

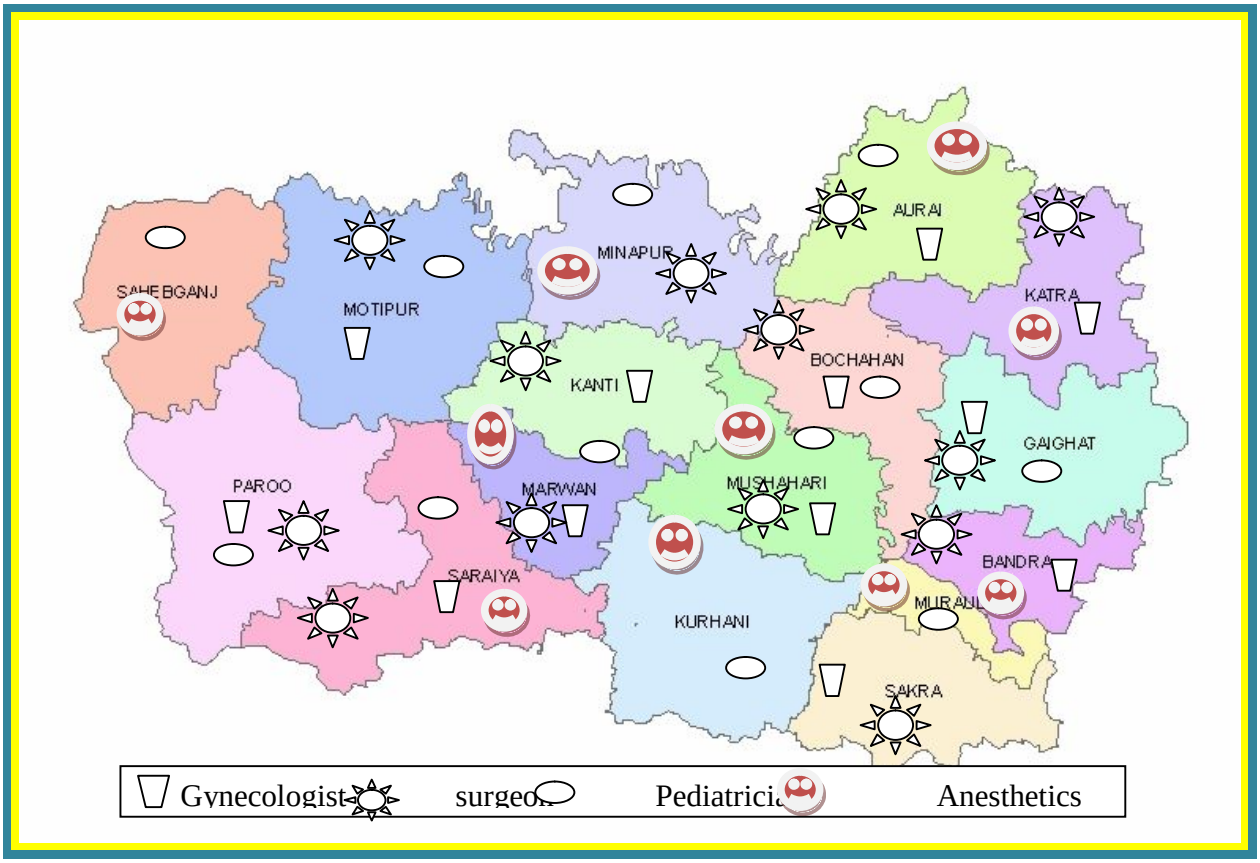
2.3.2 Public Health Care Delivery System: Organisational Structure and Infrastructuretable Health Care Institutions in the District

S.No.	Type of Institutions	Number	No. of Beds*
1	District Hospital	1	318
2	Referal	1	30
3	Block PHCs	16	96
4	APHCs (Old)	43	60
5	APHCs (New)	14	0
6	Sub-centres (Old)	473	0
7	Sub Centre (New)	5	0

8	Anganwadi Centres	3211	-
9	Others (Pvt. Facility accreditated)	5	70



Map showing PHC and APHC



Map showing specialist doctors position blockwise

2.5 NON-GOVERNMENT ORGANIZATIONS (NGO) IN THE DISTRICT

Adithi, Nirdesh, Ramani, AGSC, PGVSS, Center Direct, WDC, Seva Kendra, Mission of charity, IDF, Nidan, GJKP etc

Chapter 3

Situation Analysis

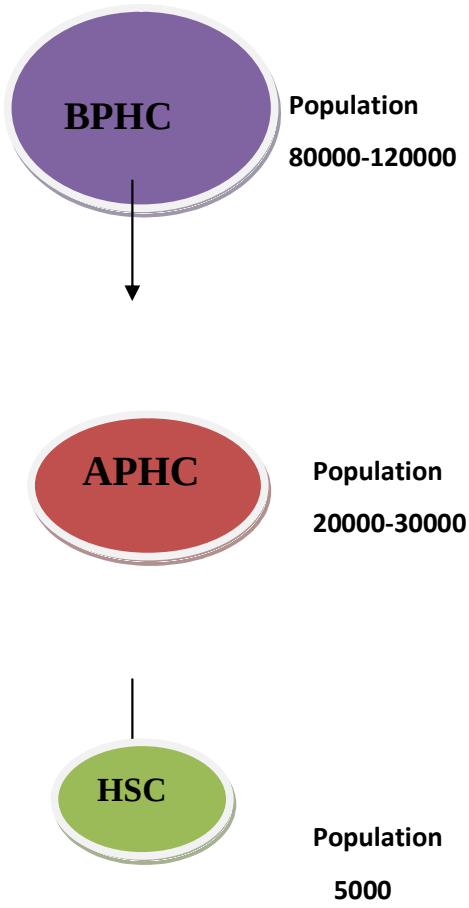
In the present situational analysis of the blocks of district Muzaffrapur the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from census 2001, report of DHS office, Muzaffrapur and various websites as well as other sources. These indicators help in pointing to the health scenario in Muzaffrapur from a quantitative point of view, while they cannot by themselves provide a complete picture of the status of health in the district. However, it is useful to have outcome data to map the effectiveness of public investment in health. Further, when data pertaining to vital rates are analyzed in conjunction with demographic measures, such as sex ratio and mean age of marriage, they throw valuable light on gender dimension. Table below indicates the Health indicators of Muzaffrapur district with respect to Bihar and India as a whole.

Table 3.1: Health Indicators

Indicator	Muzaffrapur	Bihar	India
CBR	31.9	29.2	23.8
CDR	NA	8.1	6
IMR	61	61	58
MMR	371	371	301
TFR	4.6	4	2.68
CPR	33	34.1	56.3
Complete Immunization	26.1	32.8	44

Sources: DLHS3, NFHS3, SRS2007

3.1.1. GAPS IN INFRASTRUCTURE:



First contact point with community

Introduction:

Health Sub Centre is very important part of entire Health System. It is first available Health facility nearby for the people in rural areas.

We are trying to analyze the situations at present in accordance with Indian Public Health Standards.

1. **<u>Infrastructure for HSCs:</u>**

IPHS Norms:

A Sub-centre should have its own building. If that is not possible immediately, the premises with adequate space should be rented in a central location with easy access to population.

i. Location of the centre: The location of the centre should be chosen that:

   a. It is not too close to an existing sub centre/ PHC

   b. As far as possible no person has to be travel more than 3 Km to reach the Sub centre

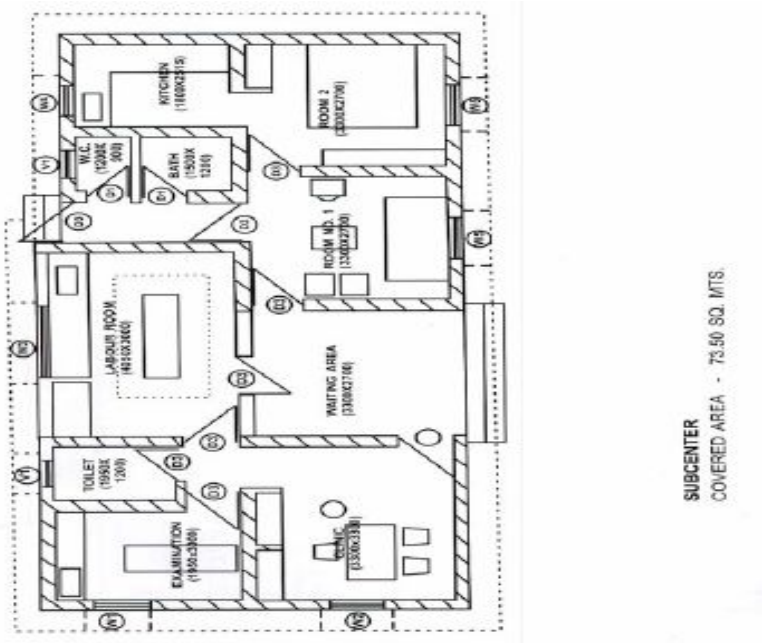
   c. The Sub Centre Village has some communication network (Road communication/Public Transport/Post Office/Telephone)

   d. Accommodation for the ANM/Male Health Worker will be available on rent in the village if necessary.

   For selection of village under the Sub Centre, approval of Panchayats as may be considered appropriate is to be obtained.

ii. The minimum covered area of a Sub Centre along with residential Quarter for ANM will vary from 73.50 to 100.20 sq mts. depending on climatic conditions(hot and dry climate, hot and humid climate, warm and humid climate), land availability and with or without a labor room. A typical layout plan for Sub-Centre with ANM residence as per the RCH Phase-II National Program me implementation Plan with area/Space Specifications is given below

Typical Layout of Sub- Centre with ANM Residence



Waiting Area : 3300mm x 2700mm

Labour Room : 4050mm x 3300mm

Clinic room: 3300mm x3300mm

Examination room : 1950mm x 3000mm

Toilet : 1950mm x 1200mm

Residential Accomodation : this should be made available to the Health workers with each one having 2 rooms, kitchen, bathroom and WC. Residential facility for one ANM is as follows which is contiguous with the main subcentre area.

Room -1 (3300mm x 2700mm)

Room-2(3300mm x 2700mm)

Kitchen-1(1800mm x 2015mm)

W.C.(1200mm x 900mm)

Bath Room (1500mm x 1200mm)

One ANM must stay in the Sub-Centre quarter and houses may taken on rent for the other/ANM/Male Health worker in the sub centre village. This idea is to ensure that at least one worker is available in the Sub-Centre village after the normal working hours. For specifications the "Guide to health facility design" issued under Reproductive and Child Health Programme(RCH-I and II) of Government of India, Ministry of Health and Family Welfare may be referred.

Health Sub Centers:

Total population of the district as per 2001 census is 3746714. After considering 2.674 percent growth rate of the total population it comes around 4751108 (Decadal Growth Rate26.74). After considering projected population in 2008, the district needs altogether 749 HSCs to cater its whole population. At present Muzaffrapur has 473 established Health Sub Centers and 276 more Health sub centers are proposed to be formed. Again, out of 473 established HSCs, only 169 have their own buildings, 136 run in rented houses and the rest in other buildings. All these 169 HSCs need renovation work. All the above mentioned HSCs need equipments, drugs, furniture and stationeries.

Health Sub Centers:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	A. Out of 473 HSCs only 169 are having own building	In adequate facility in constructed building and lack of community ownership	Enhance visibility of HSC through hardware activity by the help of community participation .	A**Strengtheing of HSCs having own buildings**
	B. In existing 169 buildings 26 are in running comparatively in good condition, 6 are in under constriction ,one is very poor condition and one is constructed but not hand over to health department.			B.1.White washing of HSC buildings. B.2.Organize adolescent girls for wall painting and plantation./hire local painter for colure full painting of HSC walls. List out all services which is provided at HSC level. On the wall. B.3.Gardening in HSC premises by school children.
	C.No one building is having running water and electric supply.			C.Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental.
	D. Lack of equipments and ANM are reluctant to keep all equipments in HSC . E. Lack of appropriate furniture	. Operational problem in availability of equipment in constructed HSC		D.1.Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/) D.2. Purchase of equipments according to services Purchase one almiaria for keep all equipment safely and it could be keep in AWW / ASHA house.

	1.Non payment of rent of 136 HSCs for more than three years	1.Non payment of rent	Regularizing rent payment	**3B. Strengthening of HSCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries
	1.The district still needs 276 more HSCs to be formed.	1. Land Availability for new construction 2. Constraint in transfer of constructed building		**3C. Construction of new HSCs** C1. Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings.
	Non participation of Community in monitoring	Monitoring	Ensuring community Monitoring	1. Biannual facility survey of HSCs through local NGOs as per IPHS format

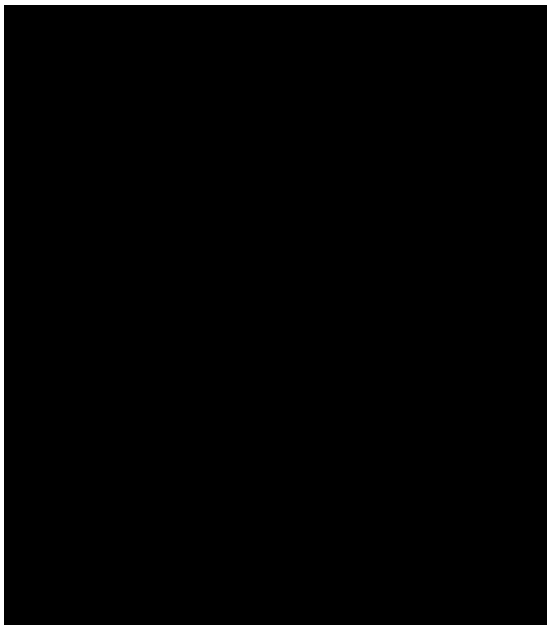
	construction work			2. Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 3. Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4. Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 5. Monthly Meeting of one representative of VHSC/Mothers committees on construction work
	1. Lack of community ownership in the	1.Community ownership	Strengthening of VHSCs, PRI	1.Formation and strengthening of VHSCs, Mothers committees 2."Swasthya Kendra chalo abhiyan" to strengthen community ownership 3.Nukkad Nataks on Citizen's charter of HSCs as per IPHS 4.Monthly meetings of VHSCs, Mothers committees

Services of HSCs:

As per IPHS norms a sub center provides interface with the community at the grass root level providing all the health care services. Of particular importance are the practices packages of services such as immunization, ANC, NC and PNC, prevention of malnutrition and common childhood diseases, family planning services and counseling. They also provide elementary drugs

for minor ailments such as ARI, diarrhea, fever, worm infestation etc. And carry out community need assessment. Besides the above the government implements several national health and family welfare programs which again are delivered through these frontline workers.

As per the DLHS-3(2007-08)reports the percentage of full immunization(BCG, 3 doses each of DPT and Polio and measles) coverage(12-23 months) in the district is 56.4%. And BCG coverage of the district is 89.5%. 3 doses of polio vaccine is 72.5%, 3 doses of DPT vaccine is 71.4% and Measles Vaccine is 72.3%. The coverage of Vitamin A supplementation for the children 9 months to 35 months is 66.6 percent.

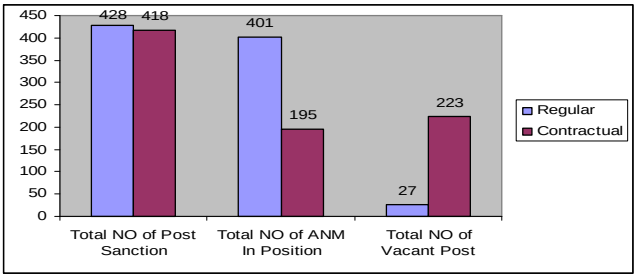


Sub Heads	Gaps	Issues	Strategy	Activities
Service performance	Unutilized untied fund at HSC level	Operationalization of Untied fund.	Capacity building of account holder of untied fund	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts
	No ANC at HSC level	Improvement in quality of services like ANC, NC and PNC, Immunization	Strengthening one HSC per PHC for institutional delivery in first	1. Identification of the best HSC on service delivery 2.Listing of required

			quarter	equipments and medicines as per IPHS norms 3. Purchasing/ indenting according to the list prepared 4.Honouring first delivered baby and ANM
	Only 14.2% PW registered in first trimester PW with three ANCs is 15.1%, TT1 coverage is 35.4%, Family Planning Status: Any method-43.6% Any modern method-39.8% No sterilization at HSC level IUD insertion - 0.5% Pills-1.5% Condom-1.9% Total unmet need is 32.7%, for spacing-14.9	Improvement in quality of services like ANC, NC and PNC, Immunization and family planning	1.Phase wise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. 2. Community focused family planning services	1 Gap identification of 39 HSCs through facility survey 2. Eligible Couple Survey 3. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 4. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 5. Training of ANMs on IUD insertion
	Lack of counseling services	Training	Training	1. Training to ANMs on ANC, NC and PNC, Immunization and other services.
	HSC unable to implement disease control programs	Integration of disease control programs at HSC level.	Implementation of disease control programs through HSC level	1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of

				disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.
	80% of the HSC staffs do not reside at place of posting	Absence of staffs	Community monitoring	1. Submission of absentees through PRI
	Problem of mobility during rainy season	Communication and safety		1.Purchasing Life saving jackets for all field staffs 2. Providing incentives to the ANMs during rainy season so that they can use local boats.
	Lack of convergence at HSC level	Convergence	Convergence	1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. 2. Monthly Video shows in all schools of the concerned HSC area schools on health, nutrition and sanitation issues.
	Lack of proper reporting from field Lack of appropriate HMIS formats and formate	Reporting	Strengthening of reporting system	1.Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc 2.Printing of adequate number of reporting formats and registers 3. Hiring consultants to develop software for reporting.

Human Resource



Total No of HSC -473
APHC-43
PHC-16
RF-02
DH-01

Source: DHS Muzaffrapur Report

Sub Heads	Gaps	Issues	Strategy	Activities
Human Resource	1.Out of 473 HSCs…….. don't have either ANMs or Male worker, 2….. don't have ANMs 3.Out of ….. sanctioned post of LHVs only ….. are placed	Filling up the staff shortage	Staff recruitment	1.Selection and recruitment of ….ANMs 2.Selection and recruitment of …male workers
	1.Out of ….. ANMs …. Are trained on different services.	Untrained staffs	Capacity building	1.Training need Assessment of HSC level staffs 2.Training of staffs on various services
	The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities	Training	Strengthening of ANM training school	1.Analyzing gaps with training school 2.Deployment of required staffs/trainers 3.Hiring of trainers as per need 4. Preparation of annual training calendar issue wise as per guideline of Govt. of India.

				5.Allocation of fund and operationalization of allocated fund
Drug kit availability	1.No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, 2.No Drug kit for AWCs(@one kit per annum,) 3.No ASHA kit	Indenting	Strengthening of reporting process and indenting through form 6	1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports
	Only need based emergency suuply Irregular supply of drugs	Logistics		1.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2. Hiring vehicles for supply of drug kits through untied fund. 3.Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)
		Operationalization	Couriers for vaccine and other drugs supply	1 Hiring of couriers as per need 2 Payment of

				courier through ANMs account
			Phase wise strengthening of APHCs for vaccine / drugs storage	1.Purchasing of cold chain equipments as per IPHS norms 2. training of concerned staffs on cold chain maintenance and drug storage

Additional PHCs:

There are 43 APHCs functioning in the district and 78 more are proposed to be established.

Additional PHC:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
nfrastructure	1.The district altogether need 116 APHCs but there are 43 APHCs functioning in the district and 78 more are proposed to be established. 2. Four more are required to be formed. 3.Out of 43 APHCs only 16 are having own building 4.Existing 16 buildings are not properly maintained 5.Non payment of rent of 14 APHCs for more than three years Lack of equipments, Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries	Lack of facilities/ basic amenities in the constructed buildings Non payment of rent Land Availability for new construction Constraint in transfer of constructed building . Lack of community ownership	Strengthening of VHSCs, PRI and formation of RKS Strengthening of Infrastructure and operationalization of construction works in Three phase	1."Swasthya Kendra chalo abhiyan" to strengthen community ownership 2.Nukkad Nataks on Citizen's charter of APHCs as per IPHS 3. Registration of RKS 4.Monthly meetings of VHSCs, Mothers committees and RKS **A.Strengtheing of APHCs having own buildings** A.1Rennovation of APHCs buildings A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries **B. Strengthening of APHCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund/ RKS from t he month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need

			Monitoring	B6 Printing of formats and purchase of stationeries 3C. Construction of new APHC buildings as standard layout of IPHS norms. C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New APHC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed APHCs buildings. 4 Biannual facility survey of APHCs through local NGOs as per IPHS format 4.1 Regular monitoring of APHCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on

				construction work.
Human Resource	Out of 43 APHCs…….. don't have doctors, …….. don't have A grade nurse, ….don,t have ANMs, ……..don' have pharmacist. Out of ….. ANMs …. Are trained. The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities Out of ….. Sanctioned post of LHVs only ….. are placed Most of the APHC staffs are deputed to respective PHCS hence APHCS are defunct	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	1.Selection and recruitment of ….Doctors/Grade A nurse/ANMs 2.Selection and recruitment of …male workers 3. Sending back the staffs to their own APHCs. 1.Training need Assessment of APHC level staffs 2.Training of staffs on various services 1. EmoC. Training to at least one doctor of each APHC 2.Analyzing gaps with training school 3.Deployment of required staffs/trainers 4.Hiring of trainers as per need 5. Preparation of annual training calendar issue wise as per guideline of Govt of India. 6.Allocation of fund and operationalization of allocated fund
Drug kit availability	No drug kit as such for the APHCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 2 and 6	1.Weekly meeting of APHC staffs at PHC for promoting APHC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports 2.Ensuring supply of Kit A

	(DDT, MDT, DOTs, DECs)and contraceptives, Only need based emergency suuply Irregular supply of drugs		Couriers for vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the APHC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through APHC account 4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage
Service performance	RKS has not been formed at any of the APHC. Unutilized untied fund at APHC level No institutional delivery at APHC level No OPD At any of the APHC No inpatient facility available No ANC, NC and PNC and family planning services. No lab facility No Ayush practitioner posted No rehabilitation services No safe MTP service	Formation of RKS Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps. Integration of disease control programs at APHC level. Family Planning services Convergence Operational issues	Capacity building of account holder of untied fund Phase wise strengthening of 16 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through APHC level where APHC will work as a resource center	1.Training of signatories on operating Untied fund /RKS account, book keeping etc 2. Assigning PHC RKS accountant for supporting operationalization of APHC level accounts 2. Timely disbursement of untied fund/ seed money for APHCs RKS. 3. 1 Gap identification of 16 APHCs through facility survey 2.strengtheing one APHC per PHC for institutional delivery in first quarter 3.Owner ing first delivered baby and ANM 1 Review of all disease control programs APHC wise in existing Tuesday weekly meetings at PHC with form 6

	No OT/ dressing and Cataract operation services. Approx 80% of APHC staffs not reside at place of posting Lack of counseling services Problem of mobility during rainy season Lack of convergence at APHC level Operational gaps: There is no link between HSCs and APHCs and the same way there is no link between APHC and PHC	Convergence	for HSCs. At present the same is being done by PHC only. Community focused Family Planning services PPP Convergence	2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 5.Weekly meeting of the staffs of concerned HSCs (as assigned to the APHC) 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1.Outsourcing services for Generator, fooding, cleanliness and ambulance 1. Fixed Saturday for meeting day of ANM, AWW, ASHA, LRG with VHSCs rotation wise at all villages of the respective HSC.

Primary Health centers: The district has 16 PHCs, two referral hospitals and a District hospital. The PHC of Sakra and referral hospital of Sakra is running in the same building.

Primary Health Centers:(6 bedded)				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	All PHCs are running with only six bed facility. At present 16 PHC are working with average 10 deliveries per day, 4 inpatient Kala-azar, 10 FP operation/emergency operations and 120 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms.(List attached, Annexure..) The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also under utilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries Operation of RKS: Lack in uniform process of RKS operation. Lack of community participation in the functioning of RKS. Lack of facilities/ basic amenities in the PHC buildings	Available facilities are not compatible with the services supposed to be delivered at PHCs. Quality of services Community participation.	Upgradation of PHCs into 30 bedded facilities. ISO certification of selected PHCs in the district. Strengthening of BMU Ensuring community participation.	1.Need based (Service delivery)Estimation of cost for upgradation of PHCs 2. Preparation of priority list of interventions to deliver services. 1. Selection of any two PHCs for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers, Accountants in all institutions.(16 PHCs, 2 Referals and Sadar hospital.) 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community

				representatives on erecting boundary, beautification etc, 2. Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS. 3.Strengtheing of PHCs 1.Rennovation of PHCs 2. Purchase of Furniture 3. Prioritizing the equipment list according to service delivery and IPHS norms. 4. Purchase of equipments 5. Printing of formats and purchase of stationeries 1. Biannual facility survey of PHCs through local NGOs as per IPHS format 2. Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.
			Strengthening of Infrastructure and operationalization of construction works	
			Monitoring	

Human Resource	As per IPHS norms each PHC requires the following clinical staffs:(List attached) But the actual position is General Surgeon 13/16 Physician ---/16 Gynecologist 4/16 Pediatrics 4/16 Anesthetist 2/16 As per IPHS norms each PHC requires the following para medical support:(List attached) But the actual position is Nurse midwife 68/152 Dresser…../16 Pharmacist/compounders…/16 Lab technician…./16 Radiographer…./16 Ophthalmic assistant…/16 Statistical assistants…./16 OT attendants…/16 Registration clerck…/16 Untrained doctors/ANMs in emergency obstetrics care. Only 14 BHMs and 11 accountants are placed at present. Demotivated BPMU staffs	staff shortage Untrained staffs	Staff recruitment Capacity building	1. Selection and recruitment of …..Doctors 2.Selection and recruitment of …ANMs/ male workers 3. 2.Selection and recruitment of …paramedical/ support staffs 4.Appointment of Block Health Managers, Accountants in all institutions.(16 PHCs, 2 Referals and Sadar hospital.) 1.Training need Assessment of PHC level staffs 2.Training of staffs on various services 3.Trainings of BHM and accountants on their responsibilities. 4. Trainings of BHM on implementation of services/ various National program programs.
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time. Only … % essential drugs are rate contracted at state level . Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all PHCs 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months

	procurement and transportation.			buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	1. Exessive load on PHC in delivering all services i.e. 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC. 2. Total 42 seats of Regular and 20 seats of contractual doctors in the district is vacant. 3. None of the PHC provides 24 hour blood transfusion services, however PHC sakra has been provided the equipments for blood storage unit. 4.8 PHC does not have laboratory facilities. 5. … Lab services provided by PPP services have fled away. 6. Only six PHC provides adolescent sexual and reproductive health services. 13.Health facility with AYUSH services is not being provided 14. Referal a. No pick up facility for PW or patients. b.BPL patients are not exempted in paying fee of ambulance. c. Lack of maintenance of	Optimun Utilization of Human Resources Epidemic outbreaks and Need based intervention in epidemic areas. Service Load centered at PHC	Quality improvement in residential facility of doctors/ staffs. Recruitment Proper and timely information of outbreaks	1. Hiring of rented houses from RKS fund for the residence of doctors and key staffs. 2. Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patient's treatment. 3. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day 1.Selection and appointment of contractual doctors and staffs 1. Mapping of the areas having history of outbreaks disease wise. 2.Developing micro plans to

	ambulances d. Shortage of ambulances 15. Quality of food, cleanliness (toilets,Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC. 16. All PHCs have their own generator sets. 17. In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases. 18. Several cases of theft of instruments, computers, and submersible pumps etc at PHCs. 19. No guidance to the patients on the services available at PHCs. 20.Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular. 21. Lack of inpatient facility for kala-azar patients. 22.Lack of councelling services 23.Problem of mobility during rainy season 24.Lack of convergence 25. Lack of timely reporting and delay in data collection	Availability of AYUSH pathy. Insecurity (Staff and Properties) Govts existing services like lab, x-ray, generator, fooding and cleanliness services.	Strengthening of equipments and services and increase in the number of ambulances. Strengthening of AYUSH services at PHC level in the first level. Confidence building measures Strengthening of the Govts existing services like lab, x-ray, generator, fooding and cleanliness services. Creating friendly environment	address epidemic outbreaks 2.Assigning areas to the MOs and staffs 3.Motivating ASHA on immediate information of outbreaks 4. Purchasing folding tents, beds and equipments and medicines to organize camps in epidemic areas. 1. Repairing of all defunct Ambulances 2. Repairing of PHcs gensets and initiating their use. 3. Hiring of ambulances as per need. 1. Appointment of one AYUSH practitioner and Yoga teacher in every PHC 1.Insurance of all properties and staffs of PHC 2.Placing one TOP in every PHC 1. Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate. 2.Recruitment of lab technicians as required 3. Purchase of equipments/

			HMIS and strengthening of reporting process	instruments for strengthening lab. 4. Hiring of menial workers for cleanliness works. 1. Assigning LHV for counseling work 2. Wall writing on every section of the building denoting the facilities 3. Name plates of doctor 4. Displaying Roster of doctors with their details. 5. Gardening 6. Sitting arrangement for patients 7. Installation of LCD TV with cable connection 8.Installation of safe drinking water equipments/water cooler, 9.Installation of solar heater system and light with the help of BDO/Panchayat 9. Apron with name plates with every doctors 10. Presence of staffs with uniform and name plates. 1.Orientation of the staffs on indicators of reporting formats 2.Puchase of Laptops for DPMs and BHMs

District Hospital:

District Hospital Muzaffrapur:				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	1.There are 218 beds in the Sadar hospital which is not adequate as per the requirement. 2. At present District hospital is working with average 25 deliveries per day, 30 inpatient Kala-azar, 20 FP operation/emergency operations and 800 OPD per day. This huge workload is not being addressed with only 218 beds inadequate facility. 3. Lack of equipments as per IPHS norms and also under utilized equipments. 4.Lack of appropriate furniture 5.Operation of RKS: Delayed process of operation. Delay in disbursement of fund 6.Lack of facilities/ basic amenities in the PHC buildings 7.Huge workload in central registration unit 8. No sitting arrangement for patients. 10. No safe drinking water facility. 11. Half of the hospital area remains dark at night. 12. Delivery room lacks beds, labor table, stretchers, and equipments. 13. No proper gate and boundary wall. 14. No proper post mortem room and equipments. 15. Heavy water logging during rainy season. 16. Buildings for ICU, Causality ward are ready but due to lack of equipments, facilities are not functional.	Lacks in infrastructure	Strengthening of infrastructure	1. Purchase of 500 beds. 2. Repairing of beds. 3. Listing of required equipments as per IPHS norms and their purchase. 4. Listing of required furniture and their purchase. 5. Simplifying process of RKS operation. 6. Computerization of registration system for the OPD/IPD patients. 7.Construction of shed for waiting patients 8. Installation of 3 Water cooler freezes as per requirement. 9. Installation of seven vapor lights as per requirements. 10. Rennovation of boundary wall and gate. 11. Construction of new Post mortem room with all facilities. 12. Renovation of drainage system and internal road level upgradation. 13. Construction of enquiry counters at the gate. 14. Hiring of ambulances. 15. Construction of

	17. No use of paying wards. 18. No enquiry counters as such for the patients. 20. No residential facilities for doctors and staffs. 21. No canteen facility			new residential buildings. 16. Hiring of rented houses from RKS fund for the residence of doctors, BMU and key staffs. 16. Tender for canteen facility. 17. Sitting arrangement for patients 18. Installation of LCD TV with cable connection
Human Resource	1.Post of gynecologist and pathologist are vacant. 2.Post of one dresser, one OT assistant and one ophthalmic assistant are vacant.	Lack in Staff position	Recruitment Deputing staffs	1. Appointment of gynecologist and pathologist on contract basis. 2. Appointment of one dresser, one OT assistant and one ophthalmic assistant on contract basis. 1. Deputation of required staffs from field.
Drug kit availability	1. Irregular supply of drugs because of lack of fund disbursement on time. 2. Only … % essential drugs are rate contracted at state level. 3. There is no clarity on the guideline for need based drug procurement and transportation. 4. Lack of proper space, furniture and equipments for drug storage	Improper Supply and logistics Lack in storage facility		1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store keeper.
Service performance	1.Exessive load in delivering all services 2. Blood storage unit is present but not utilized 3.No 24hrs Lab facility			1. Incentivizing doctors/ staffs on their performances especially on OPD, IPD, FP operations,

	4.Health facility with AYUSH services is not being provided 5. Referral a. No pick up facility for PW or patients. b. BPL patients are not exempted in paying fee of ambulance. c. Lack of maintenance of ambulances d. Shortage of ambulances 6. No guidance to the patients on the services available at DH. 7. Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.			Kala-azar patient's treatment. 2. Purchase of equipments for Blood storage unit, 3. IEC on blood storage unit. 4. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day 5. Repairing of all defunct Ambulances 6. Hiring of ambulances as per need. 7. Appointment of one AYUSH practitioner and Yoga teacher 8. Purchase of equipments/ instruments for strengthening lab. 9. Wall writing on every section of the building denoting the facilities 10. Name plates of doctor 11. Displaying Roster of doctors with their details. 12. Gardening 13. Apron with name plates with every doctors 14. Presence of staffs with uniform and name plates.

MATERNAL HEALTH					
Sl. No.	**Strategy**	**Activity**	**Input**	**Breakup**	**Budget**
1	Operationalise FRUs				
2	Operationalise 24x7 PHCs:	1. Upgradation of Labour Room including construction of labor room	As per Annexure - 1	@ Rs. 500000X16	8000000
		2. Recruitement of 3 Staff Nurses per PHC	3 X 16 = 48	@ Rs. 7500X3*16*12	4320000
		3. Maternal Ward	Building, 20 Beds, 20 Mattress, 20 Side Table, 20 Chairs, Baby coat-6, Pillow- 20, Bed Sheets & Pillow Cover - 7 sets		
3	MTP services at health facilities	1.Equipment for MTP		@ Rs. 10000 per phc for 16 phc	160000
		2. Training of Doctors	2 doctors per phc		32000
		3. Training of Staff Nurses			48000
4	RTI/STI services at health facilities				
5	Operationalise Sub-centres	1. Recruitment of 1 Male Worker for HSC			
		2. Furniture	As per Annexture 4 of IPHS Standard for HSC	@ Rs. 50000 per hsc for 473 existing and 110 newly created sub center	29150000
		3. Equipment	As per Annexture 5 of IPHS Standard for HSC	@ Rs. 50000 per hsc for 473 existing and 110 newly created sub center	29150000
		4. Safe Drinking Water	Hand pump per HSC	@ Rs. 10000 per hsc for 473 existing and 110 newly created sub center	5830000
		5. Registers for Sub centers	As per Annexture 7 of IPHS Standard for HSC	@ Rs. 1000/- per sub center for 583 HSC	583000

MATERNAL HEALTH					
Sl. No.	**Strategy**	**Activity**	**Input**	**Breakup**	**Budget**
		6. SBA Training for ANMs		118 Batch of 4 ANMs @ Rs. 43304/- per batch	5109872
		7. Sanitation	Toilets	473 X 1 @ Rs. 50000	23650000
6	Referral Transport	1. Ambulance Services to PHCs & APHCs	Ambulance for 16 PHCs & 43 APHCs	@ Rs. 500 p. m. per ambulance	10767500
		2.IEC activity in village level			
7	Institutional Deliveries	1. Strengthening PHC for 24X7	As per Operationalise 24x7 PHCs		
		2. Using Bio Metric System for registration of payment of beneficiaries			
		3. Incentivie for beneficiaries		Approx 4000 delivery p.m. @ Rs. 2000/- per beneficiary	96000000
		4. C-Section in all PHCs	Surgical instruments		240000
			training of doctors		
		5. Canteen thorugh PPP			
8	IMNCI Training		Training of ANM & AWW - 36 Batches of 24 each	For 864 ANM/AWW	3612924

Child Health					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
1	Facility Based Newborn Care/FBNC	1. Neo Natal ICU	incubater		
			baby warmer		
			suction		
			a/c		
			Ambu Bag		
			oxygen cyllander		3400000
2	To increase fully immunised children from 57.4% (DLHS-3) to 80%	Strengthening of Routine Immunisation			
		Awareness through IEC/BCC			
3	To increase Vitamine A Supplement in children of 9 to 35 months from 50.8% (DLHS-3) to 90%	Strengthening of Routine Immunisation			
		Awareness through IEC/BCC			
4	To increase number of children breastfed within one hour of birth from 15.5% (DLHS-3) To 50%	Maternity ward where PNC will be done			
		Appointment of MAMTA			
		Awareness through IEC/BCC			
5	Malnutrition	NRC should be started in every PHC of district			
		Orientation of ASHA on Malnutrition			
		Awareness through IEC/BCC			

Routine Immunisation

	Strategy	Activity	Input	Breakup	Budget
1	RI strengthening project	1. Cold chain Maintenance	a. Proper Storage Room		
			b. Proper Wiring		
			c. Voltage Stabilizer		
			d. Vaccine Carrier		
			e. Ice Pack		
			f. Ice Box		
			g. Deep Freezer		
			h. ILR		
		2. Vehicle for Monitoring			
		3. Training of Cold Chain Handler			
		4. Continuous and regular vaccine supply	a. Quarterly estimation		
			b. Buffer stock should be maintained		
		5. Health Workers Training on R/I		Honorarium + TA for Participants @ Rs. 250 for 2 days of trainee (ANM 585+ 210 to be selected, LHV- 15, Male HW - 107)	229250
				Honorarium of 3 trainers @ Rs. 600 for 2 days training for 31 Batches	55800
				Contingency @ Rs. 100/- per participant per day(incl of refreshment, venue, TV/LCD hiring and logistics	183400

Routine Immunisation

	Strategy	Activity	Input	Breakup	Budget
		6. Hep. A & B vaccine should be added in R/I			
		7. AMC should be at district level			
		Strengthening of Reporting System	Stationeries	Printing of MCH cards, formats, Muskan registers, etc.	1000000
			Mobile Phone for HSC	473 HSC @ Rs. 2500	1182500
				recharge @ Rs. 300/- p.m. per HSC	1702800
				@ Rs. 5000/- p.m.	60000
2	R/I Data Center at district level				

FAMILY PLANNING					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
1	**Terminal/Limiting Methods**				
1.1	Equipments for operation			2 Sets for each PHC + 5 Sets for Sadar Hospital	370000
1.2	Female Sterilisation camps	Target 21000 Family Planning Operations	incentives	16000 through PHCs + Sadar & 5000 through accrediated institution	23500000
1.3	NSV camps	Target 2000	incentives		3000000
2	**Spacing Methods**				
2.1	IUD	IUD services at HSC level	IUD insertion kit		
			IUD - regular and continuous supply		
2.3	OC Pills		regular and continuous supply		
2.4	Condoms		regular and continuous supply		
3	**IEC & BCC**	Motivation of ASHA			
		Nukkad Natak			
		Hoarding board			
		Advertisement through FM radio, television			

ASHA					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
1	**Selection & Training of ASHA**	1. ASHA to be selected proportionate to current population			
		2. Training of all 5 Modules			
		3. BHM should be added in TOT			
2	**Strengthening of ASHA**	1. ASHA should work as DOT provider at HSC level			
3	Asha Divas	Incentive of asha			2038800
		Asha divas exps			407760
4	Procurement of ASHA Drug Kit				2000000

Institutional Strengthening					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
1	**Strngthening of PHC, APHC & REFERRAL**				
		OPD of APHC, PHC & REFERRAL	1. Waiting Hall		
			2. Registration Counters		
			3. Doctor's cabin		
			4. OPD Room		
			5. Instruments -	Stethoscope	
				BP Instrument	
				Weighing Machine	
				Thermometer	
			6. Lack of Man Power	Doctors	
				Paramedical Staff	
				Registration Counter's Staff	
			7. Furniture	Examination Table	
				Writing Table	
				Bench	
				Stool	
				Chair	
			8. Electrical Appliances	Fan	
				Light	
			9. Data operator for registration and drug distribution stock keeping	PHC-16, SADAR- 2	
			10. Printed Registers	Master register	
				Doctor wise OPD register	
			11. Stationeries	OPD slip	

Institutional Strengthening					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
		Safe Drinking Water	Boring	PHC-14 APHC-43 Referral - 1	
			Over Head Tank	PHC-14 APHC-43 Referral - 1	
			Motor Pump	PHC-14 APHC-43 Referral - 1	
			Fittings		
			Water Purifer	PHC-16 APHC-43 Referral - 1	
			Water Cooler	PHC-16 APHC-43 Referral - 1	
		Sanitation	Toilets for male	PHC-14 X 2 APHC-43 X 1 Referral - 1 X 3	
			Toilets for female	PHC-14 X 2 APHC-43 X 1 Referral - 1 X 3	
		IPD Strengthening	Indoor Ward / Building		
			Furniture		
			Stationeries	BHT, Discharge slip, registers etc.	
		Safe Drinking Water	Over Head Tank	PHC-14 APHC-43 Referral - 1	
			Fittings		
			Water Purifer	PHC-16 APHC-43 Referral - 1	

Institutional Strengthening					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
			Water Cooler	PHC-16 APHC-43 Referral - 1	
		Sanitation	Toilets with Bathroom for male	PHC-14 X 2 APHC-43 X 1 Referral - 1 X 3	
			Toilets with Bathroom for female	PHC-14 X 2 APHC-43 X 1 Referral - 1 X 3	
		Isolation Ward in PHC	4 Beds, 4 Mattress, 4 Side Table, 4 Chairs, Pillow- 4, Bed Sheets & Pillow Cover - 7 sets	X 16 PHC	
			Electrical Appliances	Fan	
				Light	
			Curtain		
		Emergency in PHC	Emergency room with casualty ward		
			Stretcher		
			Wheel Chair		
			Security of staff at night - Night Armed Guard		
			Duty room for Doctor and Staff		
			24 hrs Pathology and X-ray facility		
			Oxygen Cyllander		
2	**Strngthening of Sadar Hospital**	OPD	1. Waiting Hall		
			2. Registration Counters - 2		
			3. Doctor's cabin		

Institutional Strengthening					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
			4. Instruments -	Stethoscope	
				BP Instrument	
				Weighing Machine	
				Thermometer	
			6. Lack of Man Power	Specialist Doctors- Cardiac, Anesthetics, Neuro surgen	
				Paramedical Staff	
				Registration Counter's Staff	
				Sonologists	
			7. Furniture	Examination Table	
				Writing Table	
				Bench	
				Stool	
				Chair	
			8. Electrical Appliances	Fan	
				Light	
			9. Data operator for registration and drug distribution stock keeping	PHC-16, SADAR- 2	
			10. Printed Registers	Master register	
				Doctor wise OPD register	
			11. Stationeries	OPD slip	
		Safe Drinking Water	Tube well	1	
			Over Head Tank	2	
			Motor Pump	2	
			Fittings		

Institutional Strengthening					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
			Water Purifer	10	
			Water Cooler	10	
		Sanitation	Toilets for male	4	
			Toilets for female	4	
		IPD Strengthening			
			Furniture	chair,bed with mattress,side table, saline stand 300 pcs each side screen	
			Stationeries	BHT, Discharge slip, registers etc.	
		Safe Drinking Water	Over Head Tank	5	
			Fittings		
			Water Purifer	50	
			Water Cooler	5	
		Sanitation	Toilets with Bathroom for male	10	
			Toilets with Bathroom for female	10	
			Electrical Appliances	Fan	
				Light	
			Curtain		
		.	Oxygen pipe line facility in all wards		
		ICU	A/C		
			Oxygen Cylinder		
			Incubate		
			Furniture	Bed 10, chairs 10,	
			Specialized Drugs		
			ECG machine		

Institutional Strengthening					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
			Suction Machine		
			Heart Beat Monitor 10		
			Training of Para Medical Staff for ICU Handling		
		Emergency	Emergency room with casualty ward		
			Casualty OT		
			Stretcher		
			Wheel Chair		
			Security of staff at night - Night Armed Guard		
			Duty room for Doctor and Staff		
			24 hrs Pathology and X-ray facility		
			Oxygen Cyllander		
3	Blood Storage Centre	Blood Storage Center should be functional for 6 proposed CHC and 1 Referral Hospital, Saraiya	Blood Bank refrigerator, incubator, microscope etc.@ Rs. 125000 per set		875000
4	Strengthening of DMU	Honourarium to DPM, DAM and DA		Rs 30000 pm for DPM, Rs 26000 pm for DAM and Rs 22000pm for DA	936000
		Office Expenses	Office Rent	4000*12	48000
			Electricity/Gen. Set	4000*12	48000
			Telephone, Fax	5000*12	60000
			Copier Machine		60000

Institutional Strengthening					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
			Stationeries	10000*12	120000
			Travel Expenses & Fooding	10000*12	120000
			Vehicle hiring + Fuel Charge	20000*12*2	480000
			Postage & Courier	3000*12	36000
			Meeting Expenses	5000*12	60000
			Miscellaneous	5000*12	60000
			Honorarium of Data Operator	5700*2*12	136800
5	Strainthening of BMU	Honourarium to HM & Accountant		Rs 20000 pm for BHM & Rs 15000 pm for Accountant	6720000
		Office Expenses			
			Telephone, Fax	1500*12*16	288000
			Stationeries	5000*12*16	960000
			Travel Expenses & Fooding	5000*12*16	960000
			Vehicle hiring + Fuel Charge	10000*12*16	1920000
			Postage & Courier	250*12*16	48000
			Meeting Expenses	5000*12	60000
			Miscellaneous	1000*12*16	192000
			Honorarium of Data Operator	5200*12*16	998400
6	Untied fund for Sub-Centres			@ Rs. 10000 per annum	4730000

Institutional Strengthening					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
7	Upgradation of CHCs to IPHS			For 4 PHCs @ Rs. 20 lakh	8000000
8	District Action Plan			@ Rs. 10000 per PHC for block level meeting, etc.	160000
				@ Rs. 50000 for district	50000
9	Corpus Grant to HMS/RKS			@ Rs. 500000/- p.a. for block level and Rs. 1500000/- p.a. for district level R.K.S.	8500000
10	Untied Grant for PHC/APHC				2950000
11	Rent for HSC		131 @ Rs. 500/- p.m. for approx. 3 yrs.		2358000
12	Rent for APHC		8 @ Rs. 1200/- p.m. for approx. 3 yrs.		345600

Kalazar					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
1	**Kalazar / Maleria**				
1.1	**Strengthening the coverage of DDT Spray**	Special Module for ASHA Training on Kalazar			
		DDT Spray	Wages for SFW @ Rs. 113/- per day for 60 days		1010220
			Wages for FW@ Rs. 92/- per day for 60 days		4112400
			DDT Requirement {1,01,373 kg - 62,940 (available) } = 38,433 k.g.		
			Transportation		35000
			Contingency		59600
			Supervision		28000
			Vehicle for PHC		630000
			Vehicle for District		90000
			Training of MO, SFW, FW		255377
1.2	Motivation of Patients	Loss of Wages		@Rs. 5 lacs per PHC for 16 PHC and @ Rs. 10 lacs for Sadar Hospital	9000000
1.3	Rapid Maleria Test	Test should be conducted at PHC level	Appointment of L.T.		
	TOTAL				15220597

T. B.					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
	Strengthening of T.B. Programme (Based on Planned Activities)	Civil Works			245000
		Laboratory materials			350000
		Honorarium			40000
		IEC/Publicity			193800
		Equipment Maintenance			65000
		Training			50000
		Vehicle maintenance			284800
		Vehicle hiring			205000
		NGO/PP Support			260000
		Miscellaneous			105000
		Contractual Services			3009000
		Printing			120000
		Medical Colleges			382000
		Procurement - Vehicles			400000
		Procurement - Equipments			10000
	TOTAL				5719600

Filaria					
	Strategy	**Activity**	**Input**	**Breakup**	**Budget**
1	Eradication of Filaria	MDA round	District Coordination Meeting		14473
			IEC Activities		186015
			Training of MO & Paramedical Staff		130740
			Line listing of Lymphoedema and Hydrocele cases Mopping, Morbidity Management & Operational Cost for these activities,		103650
			Night Blood Survey		54789
			POL		49020
			Training of Drug Distributors		469100
			Honorarium of Drug Distributors		539700
			Training of Supervisor		50400
			Honorarium of Supervisor		75600
			Regular and timely supply of Drug		
		Hydrocell Operation to be started in each PHC	Training of Doctors		
		Referral of patients suffering from elephantisis to specialised centers	Orientation of ASHA, ANM for motivating patient for treatment.		
		Awareness through IEC/BCC			
					1673487

Leprosy				
	Strategy	**Activity**	**Input**	**Budget**
1	Awareness generation	IEC on Leprosy	Rs 6000 per PHC in a year for 16 PHC & Rs. 10,000 for Sadar	106000
	Staff Recruitment in contract basis	Recruitment of staff		
	Strengthen Health Care Services	Orientation of MOs and staffs of Leprosy	NA	0
		Case validation, to have check on wrong diagnosis and re registration	NA	0
		ASHA Training for Prompt and early detection of the cases to avoid deformity and disability,	NA	0
		Ulcer care foot ware reorientation training of medical & para medical staff.	Rs2000 per PHC & sadar	34000
		Effective Coordination between Leprosy Mission Hospital and DLO	NA	
	Establishing Lab	Establishing Lab at district level	Rs 200000	200000
		Recurring expenditure like reagents	Rs 1000 per month	12000
2	Increasing mobility	Updation of master register	NA	0
		Mobility support for DLO	RS 3000 per month	36000
		Office expenses	Rs 2000 per month	24000
				412000

Structured approaches for State/ District/ Block PIP planning

National Rural Health Mission

Strategy & Activity Plan with budget

Name of the District: Muzaffarpur

Sr. NO	STRATEGIES	Activities	Component Code (only at state level)	Output 2012	Activity Plan										Budget Plan									
					2009-2010FY				2010-2011 FY						2009-2010 FY						2010-2011 FY			
					Activity planned (X)	Activity Executed (Y)	Variance (X-Y)	Reasons for Variance	Activity planned including previous yrs gap {Z=(X-Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised (Y x (A)} = D	Advance	under or over-utilised Budget {(B-D) =E	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9		11		12	8	13		15
A		RCH			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
A.1		MATERNAL HEALTH																						
A.1		1. Mater-nal Health																						
	A.1.1	1.1Operationalise facilities (dissemination, monitoring & quality) (details of infrastructure & human resources, training, IEC / BCC, equipment, drug and supplies in relevant sections)																						
	A.1.1.1	1.1.1 Operationalise Block PHCs/ CHCs/ SDHs/ DHs as FRUs																						
	A.1.1.1.1	1.1.1 Operationalise FRUs (Diesel, Service Maintenance Charge, Misc. & Other costs) 1.1.1.1 Operationalise Blood Storage units in FRU			2	1	1		2		2				224000	448000	368000	34144	225856	333856	224000	448000		

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					1	2	3		5	6					8	9	-	11		12	8	13		15
	A.1.1.2	1.1.2 Operationalise 24x7 PHCs (Organise workshops on various aspects of operationalisation of 24x7 services at the facilities @ Rs. 25,000 / year / district)			1	0	1		1			1			25000	25000	25000	0	0	25000	25000	25000		
	A.1.1.3	MTP services at health facilities					0									0	0			0	0	0		
	A.1.1.4	RTI/STI srvices at health facilities					0									0	0			0	0	0		
	A.1.1.5	Operationalise Sub-centres					0									0	0			0	0	0		
	A.1.2	1.2 Referral Transport					0									0	0			0	0	0		
	A.1.2.1	1.2.1. To develop guidelines regarding referral transport of the pregnant women and sick new born / children and dissemination of the same @ Rs. 50,000 for the state					0									0	0			0	0	0		
	A.1.2.2	1.2.2. Payment to Ambulances for all PHCs @ Rs. 200 / case of pregnancy for Jehanabad district (Pilot basis)					0									0	0			0	0	0		
	A.1.3.	1.3. Integrated outreach RCH services					0									0	0			0	0	0		

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					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9	-	11		12	8	13		15
	A.1.3.1	1.3.1. RCH Outreach Camps in un-served/ under-served areas			123	0	123		123		30	31	31	31	200	24600	24600	0	0	24600	743	91389		
	A.1.3.2.	1.3.2. Monthly Village Health and Nutrition Days at AWW Centres					0									0	0			0	0	0		
	A.1.4	1.4. Janani Evam Bal Suraksha Yojana/JBSY					0									0	0			0	0	0		
	A.1.4.1	1.4.1 Home deliveries (500/-)			477	0	477		500		125	125	125	125	500	238500	238500	0	49733	238500	500	250000		
	A.1.4.2	1.4.2 Institutional Deliveries					0									0	0			0	0	0		
	A.1.4.2.1	1.4.2.1 Rural (A) Institutional deliveries (Rural) @ Rs.2000/- per delivery for 10.00 lakh deliveries			44970	20980	23990		46000		11500	11500	11500	11500	2000	89940000	89939133	31500539	4500000	58438594	2000	92000000		
	A.1.4.2.2	1.4.2.2 Urban (B) Institutional deliveries (Urban) @ Rs.1200/- per delivery for 2.00 lakh deliveries			8994	7191	1803		12000		3000	3000	3000	3000	1200	10792800	10793234	5571000	344561	5222234	1200	14400000		

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					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9		11		12	8	13		15
	A.1.4.2.3	1.4.2.3 Caesarean Deliveries (Facility Gynec, Anesth & paramedic) 10.3.1 Incentive for C-section(@1500/-(facility Gynec. Anesth. & paramedic)			265	417	-152		1000		250	250	250	250	1500	397500	397416	43600	0	353816	1500	1500000		
	A.1.4.3	1.4.3 Other Activities(JSY) 1.4.3. Monitor quality and utilisation of services and Mobile Data Centre at HSC and APHC Level and State Supervisory Committee for Blood Storage Unit					0									900468	900468	0	0	900468		1000000		
		Total (JSY)					0									0	0			0	0	0		
	A.1.5	1.5 Other strategies/activities					0									0	0			0	0	0		
	A.1.5.1	1.5.1 Maternal Death Audit 1.1.3 Survey on maternal and perinatal deaths by verbal autopsy method (in two districts) @ 850 per death					0									0	0			0	0	0		
A.2		2. Child Health					0									0	0			0	0	0		

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					1	2	3		5	6					8	9		11		12	8	13		15
	A.2.1	2.1. Integrated Management of Neonatal & Childhood Illness/IMNCI (Monitor progress against plan; follow up with training, procurement, review meetings etc) 2.1. IMNCI (details of training, drugs and supplies, under relevant sections) 2.1.1. Monitor progress against plan; follow up with training, procurement, review meetings etc					0									0	0			0	0	0		
	A.2.2	2.2 Facility Based Newborn Care/FBNC in districts (Monitor progress against plan; follow up with training, procurement, view meeting etc.) 2.2.1. Implementation of FBNC activities in districts. (Monitor progress against plan; follow up with training, procurement, etc.)			129	0	129		129		32	32	32	33	872	112488	112760	0	0	112760	872	112488		
	A.2.3.	2.3 Home Based New born care/HBNC					0									0	0			0	0	0		

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					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9	-	11		12	8	13		15
	A.2.4	2.4 School Health Programme (Details annexed)			2790		2790		9905						2495	6961741	6961741	626245	0	6335496	2495	24712975		
	A.2.5.	2.5 Infant and Young Child Feeding/IYCF					0									0	0			0	0	0		
	A.2.6.	2.6 Care of sick children & severe malnutrition					0									0	0			0	0	0		
	A.2.7.	2.7 Management of Diarrhoea, ARI and Micro nutrient					0									0	0			0	0	0		
A.3		3.Family Planning					0									0	0			0	0	0		
	A.3.1.	3.1.Terminal/Limiting Methods					0									0	0			0	0	0		
	A.3.1.1.	3.1.1. Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services			1	0	1		2		1	0	0	0	25000	25000	25000	0	0	25000	25000	50000		
	A.3.1.2	3.1.2 Female Sterilisationcamps					0									0	0			0	0	0		
	A.3.1.3 3.1.2.2.	3.1.3 3.1.2.2. NSV camps (Organise NSV camps in districts @Rs.10,000 x 500 camps)			7	0	7		19				10	9	10000	70000	70000	0	0	70000	10000	190000		

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					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9		11		12	8	13		15
	A.3.1.4	3.1.4 Compensation for female sterilisation 3.1.2.3. Compensation for female sterilisation at PHC level in camp mode 3.1.2.1. Provide female sterilisation services on fixed days at health facilities in districts (Mini Lap)			18106	1890	16216		25000		2500	2500	10000	10000	1000	18106000	18106000	1940509	615986	16165491	1000	25000000		
	A.3.1.5 3.1.2.4	3.1.5 Compensation for male slerilisation 3.1.2.4. Compensation for NSV Acceptance @50000 cases x1500			1030	16	1014		1000		100	100	400	400	1500	1545000	1545508	0	105873	1545508	1500	1500000		
	A.3.1.6 3.1.3.1	3.1.6 Accreditation of private providers for sterilisation services 3.1.3.1 Compensation for sterilization done in Pvt.Accredited Hospitals (1.50 lakh cases)			3339	2173	1166		7000		500	500	2000	4000	1500	5008500	5008500	1780050	50000	3228450	1500	10500000		
	A.3.2	3.2. Spacing Methods					0		0							0	0			0	0	0		
	A.3.2.1	3.2.1. IUD Camps					0		0							0	0			0	0	0		
	A.3.2.2	3.2.2 IUD services at health facilites/compensation			8	0	8		16		4	4	4	4	10000	80000	81000	0	0	81000	10000	160000		

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											Q1	Q2	Q3	Q4										
					1	2	3		5	6					8	9	-	11		12	8	13		15
	A.3.2.3	Accreditation of private providers for IUD insertion services					0		0							0	0			0	0	0		
	A.3.2.4	Social Marketing of contraceptives					0		0							0	0			0	0	0		
	A.3.2.5 3.2.2.	3.2.5 3.2.2. Contraceptive Update Seminars (Organise Contraceptive Update seminars for health providers (one at state level & 38 at district level) (Anticipated Participants-50-70)					0		0							0	0			0	0	0		
	A.3.3	3.3 POL for Family Planning for 500 below sub-district facilities					0		0							168856	168856	0	10000	168856	0	200000		
	A.3.4	3.4 Repair of Laproscopes (Rs. 5000 x 40 nos.)					0		0							0	0			0	0	0		
	A.3.5	3.5 Other strategies/activities 3.1.4. Monitor progress, quality and utilisation of services 3.5. Establishing Community Based Condom and OCP Distribution Centres (pilot in one district/1 PHC)					0		0							16604	16604	0	0	16604	0	25000		

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					1	2	3		5	6					8	9	-	11		12	8	13		15
A.4		4. Adolescent Reproductive and Sexual Health (ARSH)					0		0							0	0			0	0	0		
		(Details of training, IEC/BCC in relevant sections)					0		0							0	0			0	0	0		
	A.4.1	Adolescent services at health facilites. 4.1.1. Disseminate ARSH guidelines.4.1.2. Establishing ARSH Cells in Facilities 4.1.2.1. Developing a Model ARSH Cell for the facilities 4.1.2.2. Establishing ARSH Cell at Patna District Hospital 4.1.2.3. Establishing ARSH Cell is 50% PHCs of Patna District 4.2 Conducting ARSH Camps at all PHCs for a week (as ARSH Week) 4.2.2 Establishing Youth friendly health clinics in Urban Area/ Universities Campus / Market Place			1	0	1		2		1		1		25000	25000	25000	0	0	25000	25000	50000		
	A.4.2	4.2 Other strategies/activities					0		0							0	0			0	0	0		

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											Q1	Q2	Q3	Q4										
					1	2	3		5	6					8	9	-	11		12	8	13		15
A.5		5. Urban RCH					0		0							0	0			0	0	0		
	A.5.1	5.1. Urban RCH Services (Development of Micro-plans for each urban area already mapped for delivery of RCH services, both outreach and facility based through private agencies/institutions/organisations-50lakhs & Operationalising 20 UHCs through private clinics @540000/- pm					0		0							0	0			0	0	0		
A.6		6 Tribal Health					0		0							0	0			0	0	0		
	A.6.1	Tribal RCH services					0		0							0	0			0	0	0		
	A.6.2	Other strategies/activities					0		0							0	0			0	0	0		
A.7		7. Vulnerable Groups					0		0							0	0			0	0	0		
	A.7.1	7.1 Services for Vulnerable groups					0		0							0	0			0	0	0		
	A.7.1	7.1 Services for Vulnerable groups					0		0							0	0			0	0	0		
	A.7.2	7.2 Other strategies/activities					0		0							0	0			0	0	0		
A.8		8. Innovations/PPP/NGO					0		0							0	0			0	0	0		

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					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9	-	11		12	8	13		15
	A.8.1	8.1.PNDT and Sex Ratio 8.1.1. Orientation programme of PNDT activities, Workshop at State, District and Block Level (1+38+533) (amount Rs.50 Lakhs) 8.1.2 Monitoring at District level and Meetings of District level Committee (100 Lakhs)			10	0	10		12		3	3	3	3	25000	250000	251595	0	0	251595	25000	300000		
	A.8.2.	Public Private Partnerships					0		0							0	0			0	0	0		
	A.8.3	NGO Programme					0		0							0	0			0	0	0		
	A.8.4	Other innovations (if any)					0		0							0	0			0	0	0		
A.9		INFRASTRUCTURE & HR					0		0							0	0			0	0	0		
	A.9.1	Contracutal Staff & Services					0		0							0	0			0	0	0		
	A.9.1.1	9.1.1 ANMs 10.1.1.2. Hiring of 1000 Retired ANMs or ANMs from other states for out reach services @ Rs. 5000 / month / ANM			480	0	480		480		120	120	120	120	5000	2400000	2400000	0	0	2400000	5000	2400000		
	A.9.1.2	9.1.2 Laboratory Technicians - payment @ Rs. 6500 per month for 3 persons in one unit = Rs. 234000			2	0	2		2		2				234000	468000	468000	0	0	468000	234000	468000		

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					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9		11		12	8	13		15
	A.9.1.3	Staff Nurses					0		0							0	0			0	0	0		

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					2009-2010FY				2010-2011 FY						2009-2010 FY						2010-2011 FY			
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											Q1	Q2	Q3	Q4										
					1	2	3		5	6					8	9	-	11		12	8	13		15
	A.9.1.4	9.1.4 Doctors and Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians) Hiring Specialists 1.1.1.1 Operationalise Blood Storage units in FRU -Salary of Medical Officer - 1,82,40,000/-; 10.1.2.1. Empeanelling Gynaecologists for gynaecology OPD in under or un served areas @ Rs. 1000/- week x 52 weeks ; 10.1.2.3. Empanelling Gyaneocologists for PHCstoprovide OPD services @ Rs. 300/- weekx 52 weeks; 10.1.2.4 Hiring Anaesthetist positions @ Rs.1000 per case x 120000; 10.1.2.5. Hiring Paediatrician for facilities where there are vacant Paediatricians positions @ Rs. 35,000/- month (2 per district); 10.1.2.6 Hiring Gynaecologists for facilities that have vacant positions @ Rs. 650 per case x 75000 cases				0	0		0						8682460	8682460	0	0	8682460	0	8682460		

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					1	2	3		5	6					8	9	-	11		12	8	13		15
	A.9.1.5	Other contractual Staff 9.1 Fast-Track Training Cell in SIHFW 9.2 Filling Vacant Position at SIHFW/Hiring Consultant at SIHFW 10.1.1 Honorarium of Voluntary Workers @ of 1200/- PA x 3106 No.			171	0	171		171						1200	205200	205376	0	0	205376	1200	205200		
	A.9.1.6	Incentive/Awards etc. 8.2.1 Incentive for ASHA per AWW center (80000x200 per month) and Incentive toANMs per Aganwari Centre under Muskan Programme (@80000 x Rs.150 Per Month			3532	3532	0		4700						4200	14834400	14836877	9489200	8529881	5347677	4200	19740000		
	A.9.2	9.2. Major civil works (new construction/extension/addition)					0		0							0	0			0	0	0		
	A.9.2.1	9.2.1 Major Civil works for operationalisation of FRUS					0		0							0	0			0	0	0		
	A.9.2.2	9.2.2 Major Civil works for operationalisation of 24 hour services at PHCs					0		0							0	0			0	0	0		
	A.9.3	9.3 Minor Civil Works					0		0							0	0			0	0	0		

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					2009-2010FY				2010-2011 FY						2009-2010 FY						2010-2011 FY			
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					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9		11		12	8	13		15
	A.9.3.1	9.3.1 Minor civil works for operationalisation of FRUs 10.4.1 Facility improvement for establishing New Born Centres at 76 FRUs across the state - @ Rs. 50,000 / per FRU			2	1	1		2						50000	100000	100000	45500	0	54500	50000	100000		
	A.9.3.2	9.3.2 Minor civil works for operationalisation of 24 hour services at PHCs 10.4.2. Facility improvement for establishing New Born Centres at PHCs across the state - @ Rs. 25,000 / per PHC			14	14	0		15		4	2	4	5	25000	350000	350000	9000	62000	341000	25000	375000		
	A.9.4	9.4 Operationalise IMEPat health facilites					0		0							0	0			0	0	0		
	A.9.5	9.5 Other Activities					0		0							0	0			0	0	0		
A.10		10. Institutional Strengthening					0		0							0	0			0	0	0		
	A.10.1	10.1 Human Resource Development					0		0							0	0			0	0	0		
	A.10.2	10.2 Logistics management/improvement					0		0							0	0			0	0	0		

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					1	2	3		5	6					8	9	-	11		12	8	13		15
	A.10.3	10.3 Monitoring Evaluation/HMIS 11.3 Monitoring & evaluation through monitoring cell at SIHFW					0		0							0	0			0	0	0		
	A.10.4	10.4 11.4 Sub-centre rent and contingencies @ 1770 no. x Rs.500/- x 60 months			127	0	127		127						30000	3810000	3831300	0	0	3831300	6000	762000		
	A.10.5.	10.5. Other strategies/activities TA & DA for the 30 days contact programme					0		0							0	0			0	0	0		
A.11		11 Training					0		0							0	0			0	0	0		
	A.11.1	11.1 Strengthening of Training Institutions					0		0							0	0			0	0	0		
	A.11.2	11.2 Development of training packages					0		0							0	0			0	0	0		
	A.11.3	11.3 Maternal Health Training					0		0							0	0			0	0	0		

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					2009-2010FY				2010-2011 FY						2009-2010 FY						2010-2011 FY			
					Activity planned (X)	Activity Executed (Y)	Variance (X--Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X--Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	{X x (A)} = B Budget Planned	(< or > than planned) Budget received B or C	Budget utilised {Y x (A)} = D	Advance	{(B--D) =E under or over-utilised Budget	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9		11		12	8	13		15
	A.11.3.1	11.3.1 Skilled Birth Attendance /SBA 12.1.2 Skilled Attendance at Birth / SBA--Two days Reorientation of the existing trainers in Batches 12.1.3 Strengthening of existing SBA Training Centres 12.1.4 Setting up of additional SBA Training Centre-one per district 12.1.5 Training of Staff Nurses in SBA (batches of four) 12.1.6 Training of ANMs / LHVs in SBA (Batch size of four) 20 batches x 38 districts x Rs.59,000/-			21	6	15		20		5	5	5	5	59000	1239000	1257600	125000	27412	1132600	59000	1180000		
	A.11.3.2	EmOC Training 12.1.3 EmOc Training of (Medical Officers in EmOC (batchsize is 8)					0		0							0	0			0	0	0		
	A.11.3.3	11.3.3 Life Saving Anaesthesia Skills training 12.1.5 Training of Medical Officers in Life Saving Anaesthesia Skills (LSAS)					0		0							0	0			0	0	0		

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					1	2	3		5	6					8	9		11		12	8	13		15
	A.11.3.4	11.3.4 MTP Training 12.1.6.1 Training of nurses/ ANMs in safe abortion 12.1.8 Training of Medical Officers in safe abortion			1	0	1		1		1				25000	25000	25000	0	0	25000	25000	25000		
		Training of Medical Officers in safe abortion			0	0	0		1		1				50000	0	0	0	0	0	50000	50000		
	A.11.3.5	11.3.5 RTI/STI Training - Medical officers			0	0	0		1		1				0	0	0			0	52050	52050		
		ANM/Staff Nurse			0	0	0		1		1				0	0	0			0	44850	44850		
	A.11.3.6	Dai Training					0		0							0	0			0	0	0		
	A.11.3.7	Other MH Training					0		0							0	0			0	0	0		
	A.11.4	IMEP Training					0		0							0	0			0	0	0		
	A.11.5	11.5 Child Health Training					0		0							0	0			0	0	0		
	A.11.5.1	11.5.1 IMNCI 12.2.1.1. TOT on IMNCI for Health and ICDS worker 12.2.1.2. IMNCI Training for Medical Officers (Physician) 12.2.1.3. IMNCI Training for all health workers 12.2.1.4. IMNCI Training for ANMs / LHVs/ AWWs 12.2.1.6 Followup training (HEs,LHVs)					0		0							0	0			0	0	0		

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					2009-2010FY				2010-2011 FY						2009-2010 FY						2010-2011 FY		
					Activity planned (X)	Activity Executed (Y)	Variance (X--Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X--Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	{X x (A)} = B Budget Planned	(< or > than planned) Budget received B or C	Budget utilised {Y x (A)} = D	Advance	{(B--D} =E under or over-utilised Budget	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9	-	11		12	8	13		15
		Physician training			5	0	5		5		1	1	1	2	164105	820525	725325	0	0	725325	164105	820525		
		IMNCI TOT'			5	1	4		5		1	1	1	2	153200	766000	766000	145000	8200	621000	153200	766000		
		IMNCI for Health Worker			60	30	30		60		15	15	15	15	113900	6834000	6834000	2384474	156707	4449526	113900	6834000		
		IMNCI Follow up			0		0		30			10	10	10	91100	0	0	0	0	0	91100	2733000		
	A.11.5.2	11.5.2 Facility Based Newborn Care 12.2.2.1 SNCU Training 12.2.2.2.NSU (TOT)					0		0							0	0			0	0	0		
		SNCU Training			0	0	0		1			1			92000	0	0	0	0	0	92000	92000		
		NSU (TOT)			0	0	0		1			1			51750	0	0	0	0	0	51750	51750		
	A.11.5.3	11.5.3 Home Based Newborn Care					0		0							0	0			0	0	0		
	A.11.5.4	11.5.4 Care of Sick Children and severe malnutrition					0		0							0	0			0	0	0		
	A.11.5.5	11.5.5 Other CH Training (Pl. Specify)					0		0							0	0			0	0	0		
	A.11.6	11.6 Family Planning Training					0		0							0	0			0	0	0		
	A.11.6.1	12.6.1 Laproscopic Sterilisation Training					0		0							0	0			0	0	0		
	A.11.6.2	11.6.2 Minilap Training12.3.2.1. Minilap training for medical officers/staff nurses (batch size of 4)			0	0	0		4		1	1	1	1	28000	0	0	0	0	0	28000	112000		

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Sr. NO	STRATEGIES		Component Code (only at state level)	Output 2012	Activity Plan										Budget Plan									
					2009-2010FY				2010-2011 FY						2009-2010 FY						2010-2011 FY			
		Activities			Activity planned (X)	Activity Executed (Y)	Variance (X--Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X--Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	{X x (A)} = B Budget Planned	(< or > than planned) Budget received B or C	Budget utilised {Y x (A)} = D	Advance	{(B--D) =E under or over-utilised Budget	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9		11		12	8	13		15
	A.11.6.3	11.6.3 NSV Training 12.3.3 Non-Scalpel Vasectomy (NSV) Training					0		0							0	0			0	0	0		
	A.11.6.4	11.6.4 IUD InsertionTraining 12.3.4 IUD Insertion (details in Annexure) 12.3.4.1 State level (TOT for the districts) 12.3.4.2 District level training (one district total) 12.3.4.3 PHC level training (for one district only)					0		0							0	0			0	0	0		
	A.11.6.5	Contraceptive Update Training					0		0							0	0			0	0	0		
	A.11.6.6	Other FP Training					0		0							0	0			0	0	0		
	A.11.7	11.7 ARSH Training 12.4.1 ARSH training for medical officers 12.4.3 One Day ARSH Orientation by the MOs of 25% ANMs 12.4.4 One Day ARSH Orientation of PRI by the MOs of50% ANMs			0	0	0		1		1				8350	0	0	0	0	0	8350	8350		
	A.11.8	11.8 Programme Management Training					0		0							0	0			0	0	0		

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					1	2	3		5	6					8	9		11		12	8	13		15
	A.11.8.1	11.8.1 SPMU Training 12.5.4 State PMU to be trained/attend workshops in various areas like HR, Procurement & Logistics, PPP, FRU review and/or undertake study of various programmes in one good and one poor performing districts					0		0							0	0			0	0	0		
	A.11.8.2	11.8.2 DPMU Training 12.5.1 Training of DPMU staff @ 38 x Rs.10,00012.5.2. Training of SHSB/DAM/BHM on accounts at Head Quarter level @ 6x1500x12=1,08,000/- + DAM=38x1500x4 + BHM=538x1500x4 12.5.3 Training for ASHA Help Desk to DPMs (38), Block level organisers (533) and MOICs (533), @ 1104 x 1000/-			1	0	1		1		1				158000	158000	158000	0	0	158000	158000	158000		
	A.11.9	Other Training					0		0							0	0			0	0	0		

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					1	2	3		5	6					8	9		11		12	8	13		15
	A.11.9.1	11.9.1 Continuing Medical & Nursing Education 11.2 Training of 20 (for total state) regular Government doctors in Public Health at Public Health Institute, Gujarat or at Wardha institute or Vellore institute to increase their administrative skills @ Rs.50,000/-					0		0							0	0			0	0	0		
A.12		12. BCC/IEC (for NRHM Part A, B & C)					0		0							0	0			0	0	0		
	A.12.1	12.1 Strengthening of BCC/IEC Bureaus (State and District Levels)					0		0							0	0			0	0	0		
	A.12.2	12.2 Development of State BCC/IEC strategy 13.3 Concept and material development workshops by State BCC/IEC Cell 13.8 Establishment cost of the State BCC/IEC Cell 13.10 Technical support at District level			1	0	1		1			1	0		25000	25000	25000	0	0	25000	25000	25000		
	A.12.3	12.3 Implementation of BCC/IEC stretegy					0		0							0	0			0	0	0		

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											Q1	Q2	Q3	Q4										
					1	2	3		5	6					8	9		11		12	8	13		15
	A.12.3.1	12.3.1 BCC/IEC activities for MH					0		0							0	0			0	0	0		
	A.12.3.2	BCC/IEC activities for CH					0		0							0	0			0	0	0		
	A.12.3.3	12.3.3 BCC/IEC activities for FP					0		0							0	0			0	0	0		
	A.12.3.4	12.3.4 BCC/IEC activities for ARSH					0		0							0	0			0	0	0		

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					1	2	3		5	6					8	9		11		12	8	13		15
	A.12.4	12.4 Other activities 13.4 State Level events 13.5 District Level events (Radio, TV, AV, Human Media as per IEC strategy dissemination) 13.6 Printed material (posters, bulletin, success story reports, health calendar,Quarterly magazines & diaries etc) 13.7 Block level BCC interventions (Radio, kalajattha and for IEC strategy dissemination) 13.11 Media Advertisements on various health related days 13.12 Various advertisements/tender advertisements/EOIs in print media at State level 13.13 Developing Mobile Hoarding Vans and A V Van for State and District 13.14 Hiring an IEC Consultancy at state level for operationation of BCC Strategy. (@ Rs. 50000 x 1 x 12) 13.16 Implementation of specific interventions including innovations of BCC strategy/plans block level 13.17 Implementation of specific interventions including innovations of BCC strategy/plans District level (Rs. 5000 x 38 x 12) 13.18 Implementing need based IEC Activities in Urban Areas (Support for Organization of need based IEC			16	16	0		0						107375	1718000	1718000	90390	213700	1627610	107375	0		

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					2009-2010FY				2010-2011 FY						2009-2010 FY						2010-2011 FY			
					Activity planned (X)	Activity Executed (Y)	Variance (X-Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X-Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	{X x (A)} = B Budget Planned	(< or > than planned) Budget received B or C	Budget utilised {Y x (A)} = D	Advance	{(B-D) =E under or over-utilised Budget	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9	-	11		12	8	13		15
		for Blocks					0		15		4	4	4	3	100000	0	0			0	100000	1500000		
		for District					0		1		1				500000	0	0			0	500000	500000		
		Sub-total IEC/BCC					0		0							0	0			0	0	0		
A.13		Procurement					0		0							0	0			0	0	0		
	A.13.1	13.1 Procurement of Equipment					0		0							0	0			0	0	0		
	A.13.1.1	13.1.1 Procurement of equipment 14.2. Equipments for EmOC services for identified facilities (PHCs, CHCs) @ Rs 1 Lac / facility / year (in two districts - kishanganj and jehanabad) 14.4. Equipments / instruments for Blood Storage Facility / Bank at facilities 14.6. Equipments / instruments, reagents for STI / RTI services @ Rs. 1 Lac per district per year			1	0	1		2			2			132895	132895	132895	0	0	132895	132895	265790		
	A.13.1.2	13.1.2 Procurement of equipment : CH					0		0							0	0			0	0	0		
	A.13.1.3	13.1.3 Procurement of equipment : FP					0		0							0	0			0	0	0		
	A.13.1.4	13.1.4 Procurement of equipment : IMEP					0		0							0	0			0	0	0		

Structured approaches for State/ District/ Block PIP planning

National Rural Health Mission

Strategy & Activity Plan with budget

Name of the District: Muzaffarpur

Sr. NO	STRATEGIES		Component Code (only at state level)	Output 2012	Activity Plan										Budget Plan								
					2009-2010FY				2010-2011 FY						2009-2010 FY						2010-2011 FY			
		Activities			Activity planned (X)	Activity Executed (Y)	Variance (X-Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X-Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised {Y x (A)} = D	Advance	under or over-utilised Budget {(B-D) =E	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9	-	11		12	8	13		15
	A.13.2	13.2 Procurement of Drugs & supplies					0		0							0	0			0	0	0		
	A.13.2.1	13.2.1 Drugs & Supplies for MH					0		0							0	0			0	0	0		
	A.13.2.2	13.2.2 Drugs & Supplies for CH					0		0							0	0			0	0	0		
	A.13.2.3	13.2.3 Drugs Supplies for FP					0		0							0	0			0	0	0		
	A.13.2.4	13.2.4 Supplies for IMEP					0		0							0	0			0	0	0		
	A.13.2.5	General drugs & supplies for health facilities					0		0							0	0			0	0	0		
A.14		14. Prog. Manag-ement					0		0							0	0			0	0	0		
	A.14.1	Strengthening of State Society/SPMU 16.1. Strengthening of State society/State Programme Management Support Unit 16.1.1. Contractual Staff for SPMU recruited and in position 16.5.1. Last pay drawn – Pension = Approx exp of Rs.20,000/-PM @ 20,000x6x12					0		0							0			0	0		0		

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National Rural Health Mission

Strategy & Activity Plan with budget

Name of the District: Muzaffarpur

Sr. NO	STRATEGIES	Activities	Component Code (only at state level)	Output 2012	Activity Plan 2009-2010FY: Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity Plan 2010-2011 FY: Activity planned including previous yrs gap {Z+(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities Q1	Q2	Q3	Q4	Budget Plan 2009-2010 FY: Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised {Y x (A)} = D	Advance	under or over-utilised Budget {(B~D) =E	Budget Plan 2010-2011 FY: Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
					1	2	3		5	6					8	9		11		12	8	13		15
	A.14.2	14.2 Strengthening of District Society/DPMU 16.2.1. Contractual Staff for DPMSU recruited and in position			1	1	0		1		1				739200	739200	739184	396600	0	342584	813120	813120		
	A.14.3	14.3 Strengtheningof Financial Management Systems 16.3.1.Training in accounting procedures 16.3.2. Audits 16.3.2.1. Audit of SHSB/ DHS by CA for 2009-10 16.4 Appointment of CA 16.4.1 At State level 16.4.2 At District level 16.5 Constitution of Internal Audit wing at SHSB			1	0	1		1		1				240000	240000	240000	0	0	240000	240000	240000		

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Name of the District: Muzaffarpur

Sr. NO	STRATEGIES	Activities	Component Code (only at state level)	Output 2012	Activity Plan										Budget Plan									
					2009-2010FY				2010-2011 FY						2009-2010 FY						2010-2011 FY			
					Activity planned (X)	Activity Executed (Y)	Variance (X-Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X-Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	{X x (A)} = B Budget Planned	(< or > than planned) Budget received B or C	Budget utilised {Y x (A)} = D	Advance	{(B-D) =E under or over-utilised Budget	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
					1	2	3		5	6	Q1	Q2	Q3	Q4	8	9		11		12	8	13		15
	A.14.4	14.4 Other activities (Programme management expenses,mobility support to state,district, block) 16.1.2. Provision of mobility support for SPMU staff @ 12 months x Rs.10.00 lakhs Updgration of SHSB Office 16.2.2.Provision of mobility support for DPMU staff @ 12 months x 38 districts x Rs.69945.17/-			1	1	0		1		1				840000	840000	839344	521918	0	317426	840000	840000		
		Total Prog. Mgt.					0		0							0	0			0	0	0		
A.15		Others/Untied Funds					0		0							0	0			0	0	0		
		Total RCH II Base Flexi Pool					0		0							0	0			0	0	0		
		Total JSY, Sterilisation and IUD Compensation, and NSV Camps					0		0							0	0			0	0	0		
		Grand Total RCH II					0		0							0	0			0	0	0		
																179523737	179393276	54703169	14899909	124690107		222358947		

Structured approaches for State/ District/ Block PIP planning

National Rural Health Mission

Strategy & Activity Plan with budget for 2010 - 2011

Name of the District: Muzaffarpur

Sr. NO		Activities	Output 2012	Activity Plan										Budget Plan									
				2009-2010 FY				20010-2011 FY						2009-2010FY							2010-2011FY		
				Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	{X x (A)} = B Budget Planned	(< or > than planned) Budget received B or C	Budget utilised {Y x (A)} = D	Advance	{(B~D)} =E under or over-utilised Budget	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Remarks
										Q1	Q2	Q3	Q4										
B																							
			Please Note: plan all possible activities you think necessary for your area to realistically operationalise each strategy. Consider during planning: Infrastructure, Human Resources- all specialist, Para medics etc, Infection control & Environmental Plan, Logistics Management, HMIS, Monitoring & evaluation, Training- PMU, Dai, others, BCC/ IEC, Procurement of equipments/ Drugs, Strengthening Societies, PMU, RKS, VHSC, AYUSH inputs, initiatives for quality management																	
B.1	Decentrlisation																						1.1
	B.1.11	ASHA Support system at State level				0		0							0	0			0	0	0		
	B.1.12	ASHA Support System at District Level		1	0	1		1		1				48000	48000	36000	0	0	36000	48000	48000		
	B.1.13	ASHA Support System at Block Level		16	0	16		16		16				150000	2400000	2850000	0	0	2850000	150000	2400000		
	B.1.14	ASHA Support System at Village Level		1827		1827		1827						1800	3288600	208080	0	0	208080	1800	3288600		
	B.1.15	ASHA Trainings				0		0							0	0			0	0	0		
	B.1.16	ASHA Drug Kit & Replenishment		3984	0	3984		4700						600	2390400	1047200	0	0	1047200	600	2820000		
	B.1.17	Emergency Services of ASHA		0	0	0		300						2200	0	0	0	0	0	2200	660000		
	B.1.18	Motivation of ASHA		3984	0	3984		3984						725	2888400	2933350	0	0	2933350	725	2888400		
	B.1.19	Capacity Building/Academic Support programme		0	0	0		26						1000	0	0	0	0	0	1000	26000		
	B.1.2	ASHA Divas				0		0							0	0			0	0	0		

Structured approaches for State/ District/ Block PIP planning

National Rural Health Mission

Strategy & Activity Plan with budget for 2010 - 2011

Name of the District: Muzaffarpur

Sr. NO		Activities	Output 2012	Activity Plan										Budget Plan								
				2009-2010 FY				20010-2011 FY						2009-2010FY						2010-2011FY		
				Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity planned including previous yrs gap {Z=(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	{X x (A)} = B Budget Planned	(< or > than planned) Budget received B or C	Budget utilised {Y x (A)} = D	Advance	{(B~D) =E under or over-utilised Budget	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Remarks
										Q1	Q2	Q3	Q4									
B				-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
			Please Note: plan all possible activities you think necessary for your area to realistically operationalise each strategy. Consider during planning: Infrastructure, Human Resources- all specialist, Para medics etc, Infection control & Environmental Plan, Logistics Management, HMIS, Monitoring & evaluation, Training- PMU, Dai, others, BCC/ IEC, Procurement of equipments/ Drugs, Strengthening Societies, PMU, RKS, VHSC, AYUSH inputs, initiatives for quality management																	
		ASHA Divas		3984	3256	728		4700						1380	5497920	3680640	587070	452235	3093570	1380	6486000	
		Prize		0	0	0		16						2000	0	0	0	0	0	2000	32000	
		Identity Card		3984	0	3984		4700						20	79680	79680	0	0	79680	20	94000	
	B.1.21	Untied Fund for Health Sub Center, Additional Primary Health Center and Primary Health Center				0		0							0	0			0	0	0	
		for HSC		473	473	0		722						10000	4730000	4730000	1079728	3505796	3650272	10000	7220000	
		Orientation @ phc level		15	15	0		16						3000	45000	45000			45000	3000	48000	
		Orientation @ district level		1	1	0		1						2000	2000	2000			2000	2000	2000	
		Review meeting @ district on quarterly basis		4	0	4		4						10000	40000	40000			40000	10000	40000	
		for PHC/APHC		58	58	0		137						25000	1450000	1450000	114359	1057601	1335641	25000	3425000	
	B.1.22	Village Health and Sanitation Committee		1730	600	1130		1827						10000	17300000	17297500	0	9135000	17297500	10000	18270000	
		Orientation @ phc level		0	0	0		16						2500	0	0	0	0	0	2500	40000	
	B.1.23	Rogi Kalyan Samiti - PHC		15	15	0		16						100000	1500000	2000000	300000	247756	1700000	100000	1600000	
	B.1.24	Orientation of member RKS@ phc level		0	0	0		16						2500	0	0	0	0	0	2500	40000	
		RKS - Sadar Hospital		1	1	0		1						500000	500000	500000	99369	25631	400631	500000	500000	
B.2		Infrastrure Strengthening				0		0							0	0			0	0	0	
	B.2.1	Construction of HSCs (315 No.)		8	0	8		20						950000	7600000	7600000	0	0	7600000	950000	19000000	
	B.2.2	Construction of PHCS		0	0	0		0							0	0			0	0	0	
	B.2.2.1	construcion of residetial quarters of old APHC for staff nurse		1	0	1		5						3000000	3000000	3000000	0	0	3000000	3000000	15000000	
	B.2.2.2	Construction of building of APHCs where land is available		1	0	1		11						5315000	5315000	5315000	0	0	5315000	5315000	58465000	
	B.2.3	Up gradation of CHCs as per IPHS standards		6	0	6		10						4000000	24000000	24000000	0	0	24000000	4000000	40000000	

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National Rural Health Mission

Strategy & Activity Plan with budget for 2010 - 2011

Name of the District: Muzaffarpur

Sr. NO		Activities	Output 2012	Activity Plan										Budget Plan								
				2009-2010 FY				20010-2011 FY						2009-2010FY						2010-2011FY		
				Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity planned including previous yrs gap {Z=(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised (Y x (A)} = D	Advance	under or over-utilised Budget {(B~D} =E	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Remarks
										Q1	Q2	Q3	Q4									
B				-	-	-	-	-		-	-	-	-	-	-	-	-	-	-	-	-	
			Please Note: plan all possible activities you think necessary for your area to realistically operationalise each strategy. Consider during planning: Infrastructure, Human Resources- all specialist, Para medics etc, Infection control & Environmental Plan, Logistics Management, HMIS, Monitoring & evaluation, Training- PMU, Dai, others, BCC/ IEC, Procurement of equipments/ Drugs, Strengthening Societies, PMU, RKS, VHSC, AYUSH inputs, initiatives for quality management																	
	B.2.4	Infrastructure and service improvement as per IPHS in 48 (DH & SDH) hospitals for accreditation or ISO : 9000 certification			0		0							0	0			0	0	0	
	B.2.5	Upgradation of ANM Training Schools	1	1	0		1						5000000	5000000	5000000	0	450000	5000000	5000000	5000000	
	B.2.6	Annual Maintenance Grant for PHC	15	15	0		16						100000	1500000	1500000	40210	379790	1459790	100000	1600000	
		for Sadar Hospital	1	1	0		1						500000	500000	500000	65000	60000	435000	500000	500000	
B.3		TOTAL INFRASTRUCTURE strengthening			0		0							0	0			0	0	0	
	B.3	Contractual Manpower			0		0							0	0			0	0	0	
	B.3.1 A	Incentive for PHC doctors & staffs	1	0	1		1						664065	664065	664065	0	0	664065	664065	664065	
	B.3.1 B	Salaries for contractual Staff Nurses	136	68	68		152						90000	12240000	12259099	2602200	319550	9656899	90000	13680000	
	B.3.1.C	Contract Salaries for ANMs	200	302	-102		302						72000	14400000	14400000	9350506	450841	5049494	96000	28992000	
	B.3.1. D	Mobile facility for all health functionaries	1	0	1		1						2138837	2138837	2138837	0	0	2138837	2138837	2138837	
	B.3.1. D	Block Programme management Unit	15	15	0		16						528000	7920000	10320744	3228906	528814	7091838	530400	8486400	
	B.3.4	Addl. Manpower for NRHM	1	0	1		1						738000	738000	738000	0	0	738000	738000	738000	
B.4		PPP Initiativs			0		0							0	0			0	0	0	
	B.4.1	102-Ambulance service (state-806400) @537600 X 6 Distrrict	1	1	0		1		1				492000	492000	492000	369000	0	123000	492000	492000	
	B.4.2	1911- Doctor on Call & Samadhan	1	1	0		1		1				168000	168000	136000	56000	0	80000	168000	168000	
	B.4.3	Addl. PHC management by NGOs	0	0	0		0							0	0			0	0	0	
	B.4.5	SHRC			0		0							0	0			0	0	0	
	B.4.6	Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP)	17	0	17		17						86312	1467304	1467300	0	0	1467300	86312	1467304	
	B.4.7	Dialysis unit in various Government Hospitals of Bihar			0		0							0	0			0	0	0	

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										Q1	Q2	Q3	Q4									
B				-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
			Please Note: plan all possible activities you think necessary for your area to realistically operationalise each strategy. Consider during planning: Infrastructure, Human Resources- all specialist, Para medics etc, Infection control & Environmental Plan, Logistics Management, HMIS, Monitoring & evaluation, Training- PMU, Dai, others, BCC/ IEC, Procurement of equipments/ Drugs, Strengthening Societies, PMU, RKS, VHSC, AYUSH inputs, initiatives for quality management																	
	B.4.8	Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar		1	1	0		1						4800000	4800000	4800000	0	3000000	4800000	4800000	4800000	
	B.4.9	Providing Telemedicine Services in Government Health Facilities				0		0							0	0			0	0	0	
	B.4.10	Outsourcing of Pathology and Radiology Services from PHCs to DHs			16	-16		17						660000	0	0	0	0	0	660000	11220000	
	B.4.11	Operationalising MMU		1	0	1		1		1				5616000	4212000	4212000	0	0	4212000	5616000	5616000	
	B.4.14	Monitoring and Evaluation (State District & Block Data Centre)				0		0							0	0			0	0	0	
		Data Operator's Honorarium @ phc & sadar		16	16	0		17						62400	998400	1938000	0	468000	1938000	96000	1632000	
		Data Operator @ DHS for monitoring		0	0	0		2							0	0			0	96000	192000	
		Data Center @ DHS		2	2	0		2						66000	132000	132000		0	132000	96000	192000	
		Stationeries & Misc.				0		1							0	0			0	120000	120000	
		EPBAX System				0		1							0	0			0	25000	25000	
		Web Server maintenance				0		1							0	0			0	20000	20000	
		SMS Server						1							0	0			0	20000	20000	
8	B.4.15	Generic Drug Shop				0		0							0	0			0	0	0	
	B.4.16	Nutritional Rehabilitation Centre		1	0	1		1						2467200	2467200	2467000	0	0	2467000	2467200	2467200	
	B.4.17	Hospital Maintenance				0		0							0	0			0	0	0	
	B.4.18	Providing Ward Management Services in Government Hospitals 3000000/-		0	0	0		1						0	0	0			0	3000000	3000000	
	B.4.19	Provision for HR Consultancy services				0		0							0	0			0	0	0	
	B.4.2	Advanced Life Saving Ambulance		0	0	0		1							0	0			0	989000	989000	

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				2009-2010 FY				20010-2011 FY						2009-2010FY						2010-2011FY		
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										Q1	Q2	Q3	Q4									
B				-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
			Please Note: plan all possible activities you think necessary for your area to realistically operationalise each strategy. Consider during planning: Infrastructure, Human Resources- all specialist, Para medics etc, Infection control & Environmental Plan, Logistics Management, HMIS, Monitoring & evaluation, Training- PMU, Dai, others, BCC/ IEC, Procurement of equipments/ Drugs, Strengthening Societies, PMU, RKS, VHSC, AYUSH inputs, initiatives for quality management																	
		TOTAL PPP INITIATIVES				0		0							0	0			0	0	0	
B.5	B.5	Prourement of supplies				0		0							0	0			0	0	0	
	B.5.1	Delivery kits at the HSC/ANM/ASHA (no.200000 x Rs.25/-)		2566	0	2566		5500						25	64150	64142	0	0	64142	25	137500	
	B.5.2	SBA Drug kits with SBA-ANMs/ Nurses etc (no.50000 /38x Rs.245/-)		1104	0	1104		1104						245	270480	270464	0	0	270464	245	270480	
	B.5.3	Availability of Sanitary Napkins at Govt. Health Facilities @25000/district/year		1	0	1		2						25000	25000	25000	0	0	25000	25000	50000	
	B.5.4	Procurement of beds for PHCs to DHs		390	0	390		780						4522	1763580	1763640	0	0	1763640	9000	7020000	
		TOTAL PROCUREMENT OF SUPPLIES				0		0							0	0			0	0	0	
B.6		Procurement of Drugs				0		0							0	0			0	0	0	
	B.6.1	Cost of IFA for Pregnant & Lactating mothers (Details annexed)		9611855	0	9611855		9611855						0.11	1057304.05	1057304	0	0	1057304	0.11	1057304.05	
	B.6.2	Cost of IFA for (1-5) years children (Details annexed)		36141040	0	36141040		36141040						0.05	1807052	1807052	0	0	1807052	0.05	1807052	
	B.6.3	Cost of IFA for adolescent girls (Details annexed)		15070109	0	15070109		15070109						0.11	1657711.99	1657711.99			1657711.99	0.11	1657711.99	
		TOTAL PROCUREMENT OF DRUGS				0		0							0	0			0	0	0	
B.7		Mobilisation & Management support for Disaster Management				0		0							0	0			0	0	0	
B.8		Health Management Information System				0		0							0	0			0	0	0	
B.9		Strenthening of Cold Chain (infrastrcure strengthening)				0		0							0	0			0	0	0	
	B.9.1	Refurbishment of existing Warehouse for R.I. as well as provision for hiring external storage space for (during Immunization Campaigns) Logistics at State HQ @Rs 1500000/-				0		0							0	0			0	0	0	

Structured approaches for State/ District/ Block PIP planning

National Rural Health Mission

Strategy & Activity Plan with budget for 2010 - 2011

Name of the District: Muzaffarpur

Sr. NO		Activities	Output 2012	Activity Plan										Budget Plan								
				2009-2010 FY				20010-2011 FY						2009-2010FY						2010-2011FY		
				Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity planned including previous yrs gap {Z=(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised (Y x (A)} = D	Advance	under or over-utilised Budget {(B~D} =E	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ±E} = BP	Remarks
										Q1	Q2	Q3	Q4									
B				-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
			Please Note: plan all possible activities you think necessary for your area to realistically operationalise each strategy. Consider during planning: Infrastructure, Human Resources- all specialist, Para medics etc, Infection control & Environmental Plan, Logistics Management, HMIS, Monitoring & evaluation, Training- PMU, Dai, others, BCC/ IEC, Procurement of equipments/ Drugs, Strengthening Societies, PMU, RKS, VHSC, AYUSH inputs, initiatives for quality management																	
	B.9.2	Refurbishment of existing Cold chain room for district stores in all districts with proper electrification,Earthing for electrical cold chain equipment and shelves and dry space for non elecrtical cold chain equipment and logistics @Rs 300000 Lakhs per district x 38 districts		1	0	1		1						300000	300000	700000	0	0	700000	300000	300000	
	B.9.3	Earthing and wiring of existing Cold chain rooms in all PHCs @Rs 10000/- per PHC x 533 PHCs		19	15	4		16						10000	190000	190000	0	20000	190000	10000	160000	
B.10		Preparation of Action Plan				0		0							0	0			0	0	0	
	B.10.1	Preparation of District Health Action Plan (Rs. 2 lakhs per district x 38)		1	1	0		1						100000	100000	100000	33000	0	67000	200000	200000	
	B.10.2	Preparation of State Health Action Plan @ 5 lakhs				0		0							0	0			0	0	0	
B.11		Mainstreaming Ayush under NRHM		76	0	76		76						273600	20793600	20793600	0	0	20793600	273600	20793600	
B.12		Continuing Medical & Nursing Education				0		0							0	0			0	0	0	
B.13		RCH Procurement of Equipments				0		0							0	0			0	0	0	
	B.13.1	Procurement of Equipments/instruments for Anesthesia				0		0							0	0			0	0	0	
	B.13.2	Equipment for ICU		1	0	1		1						1705263	1705263	1705263	0	0	1705263	1705263	1705263	
	B.13.3	Equipments/instruments for ANC at Health Facility (Other than SubCentre) @ 50,000 per district per year		0	0	0		1						50000	0	0	0	0	0	50000	50000	
	B.13.4	Equipments for the Labour Room		16	0	16		16						223121	3569936	3569936	0	0	3569936	223121	3569936	
	B.13.5	Equipments for SNCU &NSU		17	0	17		0						131287	2231879	2231872	0	0	2231872	131287	0	
	B.13.5.A	SNCU for 23districts unit cost of Rs. 2377258		0	0	0		1						0	0	0			0	2377258	2377258	
	B.13.5.B	NSU for 530 PHCs unit cost of Rs. 139492		0	0	0		16						0	0	0	0	0	0	139492	2231872	
	B.13.6	NSV Kits		18	0	18		18						1100	19800	20000	0	0	20000	1100	19800	
	B.13.7	IUD insertion kit		1	0	1		17						15000	15000	15000	0	0	15000	15000	255000	

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Name of the District: Muzaffarpur

Sr. NO		Activities	Output 2012	Activity Plan										Budget Plan								
				2009-2010 FY				20010-2011 FY						2009-2010FY						2010-2011FY		
				Activity planned (X)	Activity Executed (Y)	Variance (X-Y)	Reasons for Variance	Activity planned including previous yrs gap {Z=(X-Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	{X x (A)} = B Budget Planned	(< or > than planned) Budget received B or C	Budget utilised {Y x (A)} = D	Advance	{(B-D) =E under or over-utilised Budget	Tentative Unit Cost (A)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Remarks
										Q1	Q2	Q3	Q4									
B																						
			Please Note: plan all possible activities you think necessary for your area to realistically operationalise each strategy. Consider during planning: Infrastructure, Human Resources- all specialist, Para medics etc, Infection control & Environmental Plan, Logistics Management, HMIS, Monitoring & evaluation, Training- PMU, Dai, others, BCC/ IEC, Procurement of equipments/ Drugs, Strengthening Societies, PMU, RKS, VHSC, AYUSH inputs, initiatives for quality management																	
	B.13.8	Minilap sets		13	0	13		17						3000	39000	39474	0	0	39474	3000	51000	
B.14		Additionalitiesfor NVBDCP under NRHM				0		0							0	0			0	0	0	
		Total for Equipment Procurement				0		0							0	0			0	0	0	
															177522562	175989954	17925348	20101014	158064606		320326583	