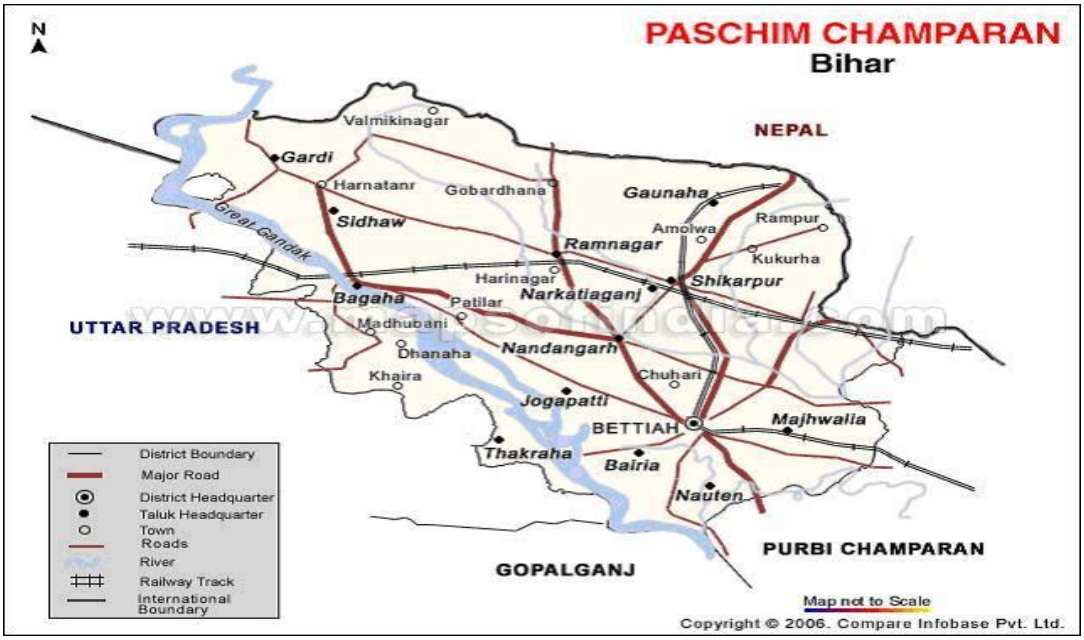
DISTRICT HEALTH ACTION PLAN
2010-2011



DISTRICT HEALTH SOCIETY
West-Champaran, Bihar

PREFACE

National Rural Health Mission (NRHM) is one of the major health schemes run by Ministry of health and family welfare, GoI. The basic concept of the mission is to enhance the access of Quality health services to the poorest of the poor of the society and improve the health status of the community. It envisages to improve the health status of the rural mass through various programmes. All the health services should be provided to the pregnant women such as ANC checkups, Post Natal Care, IFA tablets for restricting the enemia cases and other reproductive child health releted services. It also focuses on promotion of institutional delivery for restricting the infant and as well as maternal deaths. Immunization is also a very important component which plays a vital role in child and mother health. Family planning and control of other diseases are also other focus areas.

The NRHM has a strong realization that it is important to involve community for the improvement of health status of the community through various stake holders such as ASHA, AWWs, PRI, NGOs etc. ASHA is a link worker between the client and the health service providers. The skill of the health functionaries such as ANMs LHVs should be upgraded through proper orientation to ensure quality of care in health services . Apart from that there is a need to strengthen the infrastructure and area of human resource for getting the quality of care in health services at the health centres .

To achieve the better health status of the District, there is need to develop a District Health Action plan. There is need to conduct situational analysis by going through available data of healths delivery centres, and making community interaction at grassroot level with PRI, Local power group etc.

The District Health Society will develop a District Health Action Plan for the year 2010-2011 and implement the DHAP for betterment of the health status of the rural mass of the society.

Thanks to the Capacity Building Training organized by the State Health Society Bihar with support from National Health System Resource Centre (NHSRC) & Public Health Resource Network (PHRN) from 7th to 12th Septemmber 2009 that the planning team from the district got trained to be able to be confident enough to prepare the DHAP. The special efforts put in the process by Mr. Amit Achal (Dist. Nodal M&E Officer) & Other team members needs to be acknowledged. Without their untiring efforts this document would not have been out.

Civil Surgeon,
West Champaran

District Megistrate
West Champaran

CONTENTS **Page No.**

1. INTRODUCTION:

Health is a state of physical, mental & social well being & not merely an absence of disease or infirmity. Hence recognizing the importance of health in the process of economic & social development & improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission (NRHM) to carry out necessary architectural correction in the health care delivery system to achieve a positive health.

The National Rural Health Mission (NRHM) seeks to provide effective health care to the entire rural population in the country with special focus on 18 states, which has weak public health indicators. It aims to undertake some architectural correction of the health system to enable it to be effective in providing "Health for All". The mission envisages strategy for integrating ongoing vertical programs of health and family welfare, addressing issues related to the determinants of health like sanitation, nutrition and safe drinking water. The National Rural Health Mission seeks to adopt sector wide approach and aims at systemic reforms to enable efficiency in health services delivery.

A synergistic approach needs to be adopted integrating the segments of nutrition, sanitation, hygiene & safe drinking water, the mechanism to bring about the expected change includes increased public expenditure on health, rending the geographical insolence in health infrastructure, positioning of manpower, decentralization, district management of health programs, community participation & up gradation of present health systems meeting Indian Public Health Standard in each block of the district. Hence the goal of promotion of district health plan is to improve the availability of and access to quality health care by people especially for those residing in far off rural areas, the vulnerable sections of the society especially women & children.

Bihar is among the 18 selected states (EAG) that would get benefited under the NRHM. In this state all the districts would be covered under NRHM mission from 2005-2012. Some of the most important aspects of the mission are –

- Decentralized Village and District Level Health Planning and Management,
- Appointment of Accredited Social Health Activist (ASHA) to facilitate access to health services,
- Strengthening the public health service delivery infrastructure, particularly at village, primary and secondary levels,
- Mainstreaming and improving the Management Capacity to organize health systems and services in public Health.

Therefore the making of District Health Plan has been an exercise of vital importance in response to effective launch and implementation of NRHM. For this the Village Health Plans, plans for Water Supply, provision of proper Sanitation and Nutrition would form the core unit of action proposed. Implementing Departments would integrate into District Health Mission for management and monitoring of the district level plan.

2. WEST CHAMPARAN DISTRICT AT A GLANCE:

Brief History

West Champaran District was carved out of the old Champaran District in the year 1972 as a result of re-organization of the District in the state. It was formerly a subdivision of Saran District and then Champaran District with its Head quarters as Bettiah. It is said that Bettiah got its name from Baint (Cane) plants commonly found in this district. The name Champaran is a degenerate form of Champaka aranya, a name which dates back to the time when the district was a tract of the forest of Champa (Magnolia) trees & was the abode of solitary asectics.

As per District Gazetteer, it seems probable that Champaran was occupied at an early period by races of Aryan descent and formed part of the country in which the Videha Empire ruled. After the fall of Videhan Empire the district formed part of the Vrijjain oligarchical republic with its capital at Vaishali of which Lichhavis were the most powerful and prominent. Ajatshatru the emperor of Magadh, by tact and force annexed Lichhavis and occupied its capital, Vaishali. He extended his sovereignty over Paschim Champaran which continued under the Mauryan rule for the next hundred years. After the Mauryas, the Sungas and Kanvas ruled over the Magadh territories. The district thereafter formed part of the Kushan Empire and then came under Gupta Empire. Along with Tirhut, Champaran was possibly annexed by Harsha during whose reign Huen- Tsang, the famous Chinese pilgrim, visited India. During 750 to 1155 AD , the Palas of Bengal were in the possession of Eastern India and Champaran formed the part of their territory. Towards the close of the 10th century Gangaya Deva of the Kalacheeri dynasty conquered Champaran. He was succeeded by Vikramaditya of the Chalukya dynasty.

During 1213 and 1227, the first Muslim influence was experienced when Ghyasuddin Iwaz the Muslim governor of Bengal extended his influence over Tribhukti or Tirhut .It was however, not a complete conquest and he was only able to have Tirhut from Narsinghdeva, a Simraon king. In about 1320, Ghyasuddin Tughlaq annexed Tirhut to the Tughlaq Empire and placed it under Kameshwar Thakur, who established Sugaon or Thakur dynasty. This dynasty continued to rule the area till Nasrat Shah, son of Allauddin Shah attacked Tirhut in 1530, annexed the territory, and killed the Raja and thus put an end to the Thakur dynasty. Nasrat Shah appointed his son-in-law as viceroy of Tirhut and thence forward the country continued to be ruled by the Muslim rulers. After the fall of Mughal Empire the British rulers came to power in India.

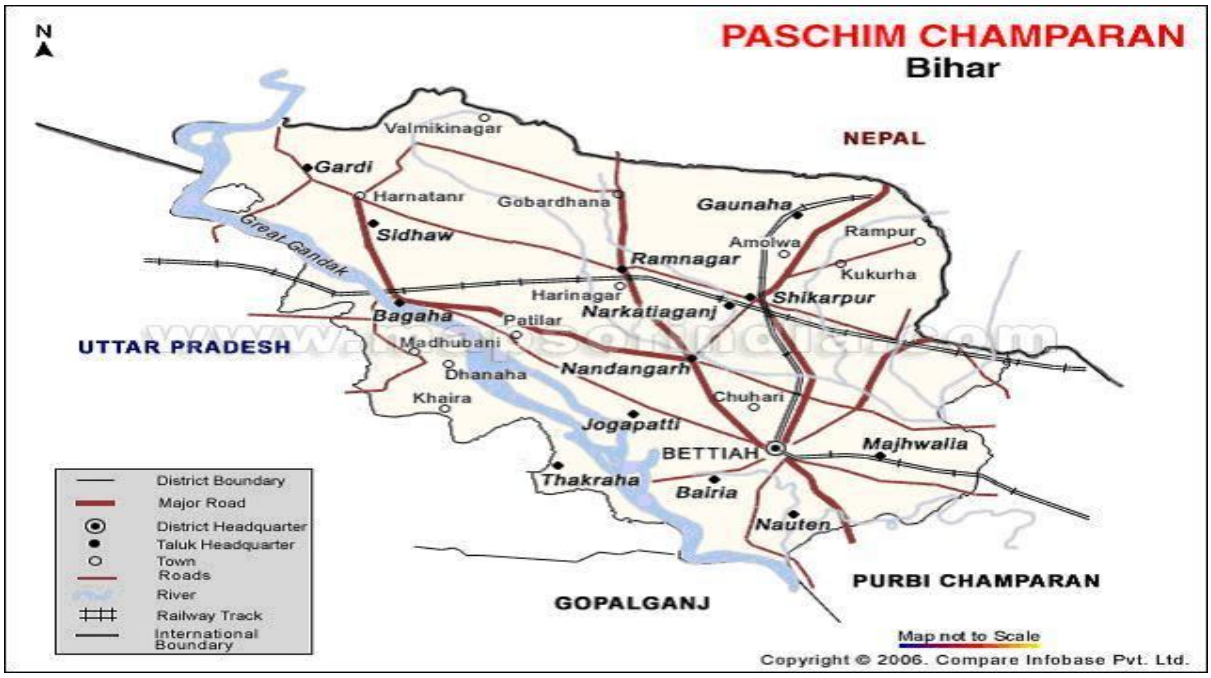
The history of the district during the late medieval period and the British period is linked with the history of Bettiah Raj. Bettiah Raj has been mentioned as a great estate. It traces its descent from one Ujjain Singh and his son, Gaj Singh, who received the title of Raja from the Emperor Shah Jahan (1628-58). The family came into prominence as independent chief in the 18th century during the downfall of the Mughal Empire. At the time when Sarkar Champaran passed under British rule, is was in the possession of Raja Jugal Kishore Singh, who succeeded Raja Dhurup Singh in 1763. The Raj was succeeded by the descendents of Raja Jugal kishore Singh. Harendra Kishore Singh, the last Maharaja of Bettiah, died in 1893, issueless and was succeeded by his first wife, who died in 1896. The estate came under the management of Court of Wards since 1897 and was held by the Maharaja's junior widow, Maharani Janki Kuar.

The British Raj palace occupies a large area in the centre of the town. In 1910 at the request of Maharani, the palace was built after the plan of Graham's palace in Calcutta. The Court Of Wards is at present holding the property of Bettiah Raj.

The rise of nationalism in Bettiah in early 20th century is intimately connected with indigo plantation. Raj Kumar Shukla, an ordinary raiyat and indigo cultivator of Champaran met Gandhijii and explained the plight of the cultivators and the atrocities of the planters on the raiyats. Gandhijii came to Champaran in 1917 and listened to the problems of the cultivators and the started the movement known as Champaran Satyagraha Movement to end the oppression of the British indigo planters. By 1918 the long standing misery of the indigo cultivators came to an end and Champaran became the hub of Indian National Freedom Movement and the launch pad of Gandhi's Satyagraha.

Location

Location on global Map between 26°16' and 27°31' north latitude and 83°50' and 85°18' east longitude



Boundary

North	:	Hilly region of Nepal
South	:	Gopalganj & part of Purbi Champaran District
East	:	Purbi champaran District
West	:	Padrauna & Deoria District of Uttar Pradesh

Total Area of the District: 5228 Sq. Kms.

As the district has its border with Nepal, it has an international importance. The international border is open with five blocks of the district, namely, Bagaha-II, Ramnagar, Gaunaha, Mainatand and Sikta, extending from north-west corner to south-east covering a distance of 35 Kms.

District Headquarters	:	Bettiah
Distance of Bettiah from Patna	:	210 Kms. (By road)
Police Districts under West Champaran	:	1. Bettiah, and 2. Bagaha
Subdivisions under West Champaran	:	1. Bettiah 2. Narkatiyaga 3.Bagaha

No. of Development Blocks	:	18
No. of Panchayats	:	315
No. of Villages	:	1483
Total Length of the Railways tracks within the district :		220Kms

Education

This district has a literacy rate of 39.63%. There are a few schools in the district which are amongst the best in North Bihar.

No. of govt Primary Schools	:	1340
No. of Middle Schools	:	284
No. of High Schools	:	68 (including Minority and Project Schools)
No. of constituent Colleges	:	3
Industrial Training Institute	:	1

Industrialization

Agriculture is the main source of income of the people in West Champaran. Some agro-based industries have flourished here and are being run successfully. Sugar mills are established at Majhaulia, Bagaha, Ramnagar, Narkatiaganj, Chanpatia and Lauria. The last two units are closed at present. Some rice mills are also being run successfully and the produce is being marketed to different places outside the district. Cottage industries based on local available natural and agricultural produce catering the local needs such as Gur (raw-sugar), basket, rope, mat weaving etc are also popular.

Land use pattern

Mainly three types of crops are produced in this district – Bhadai (Autumn crop), Aghani (Kharif) and Rabbi (Spring crop). Bhadai crops comprise mainly Maize and Sugarcane. The main crops of Aghani season are paddy, potato etc. Wheat, Barley, Arhar (Cajamus indicus) are main Rabbi crops. Main crops of the low lying land in northern region of the district is paddy. Land use pattern figures are as follows:-

Total Area of the district	-	11,96,819 Acre
Forest land	-	2,26,790 Acre
Agricultural land	-	5,15,097 Acre
Non-agricultural land	-	68,283 Acre
Land under water	-	1,73,078 Acre
Homestead Land	-	1,84,764 Acre

Natural Divisions

The District is divided into few distinct tracts. The first consists of the hilly tract of Someswar and Dun range in the north at the foot hills of Himalayas. It is noticeable that the soil even at the foot of the hills has no rocky formation and wherever water can be impounded,a rich growth of crop is possible. The hilly streams, however, play havoc by bringing down huge quantities of sand & destroying cultivable lands. The hills contain large stretches of forests.

Next to the hilly area comes the Terai region which is largely populated by Tharus of the District.

The Terai region is followed by fertile plains occupying the rest of the district. This plain itself is divided into two well defined tracts by the little Gandak and have markedly distinct characteristics. The northern portion is composed of old alluvium & has a considerable area of low land. It is traversed by a number of streams flowing southwards. The southern portion of the tract is characterized by stretches of upland varied in places by large marshy depressions known as chaurs.

The Gandak or Narayani and Sikrahana or little Gandak are the two important rivers of this district.

Climatic Conditions

The climate of the district is cooler & damper than the adjoining districts. The terai area comprising mainly Ramnagar, Bagaha & Narkatiaganj is considered unhealthy while all other area have a healthy climate. Winter begins in November and lasts till Feburary, followed by hot summer months when temperature rises to maximum 43° Celsius. Rains set in during the later part of June. The district receives some winter rain also.

Communication

The district still lags behind in having sufficient communication linkage by metalled roads within its territory. National Highway 28 B cris-crosses this district. While it is well connected with the State capital by road.

The railways were introduced in 1888 when Bettiah was linked with Muzaffarpur. The line was extended subsequently to Bhikna Thori on the Indo-Nepal Border. A line also runs from Narkatiaganj to Bairgania vai Raxaul. The construction of Chhitauni Rail Bridge has resulted in a direct link of the district with Gorakhpur, Lucknow, Delhi, and Mumbai by train.

Bettiah and Valmikinagar have small airports with facility for landing of small planes. The airport at Valmiki Nagar is metalled.

Flora & Fauna

The district has suffered large scale denudation of forests. Forests are confined to the northern tract & particularly the Sumeswar & the Dun ranges are covered with forests. Sal, Sisam, Tun & Khair are among the trees found in this region. In terai region clumbs of bamboo, sabai grass & narkat reed are found in abundance.

The types of animals available in the forests of the district are tiger, leopard, panther wild pig, nilgai, monkeys(both red and black faced), bear, dear, sambhar, bison, wolves & wild goats.

Three types of quails of the Amazonian species are seen in the district. They are the bustard quails, button quails & the little button quails. Brown fly-catchers, the grey shrike, olive green birds and various types of mynas are found here.

The rehu, naini, katla, tengra, buail, sauri and barari are the big fish varieties found in the bigger rivers & lakes of the district. Snakes are quite common & crocodiles & alligators are sometimes found in the larger river.

Irrigation Facilities

Tirhut, Tribeni and Done canals are the most prominent canals operating in this district. They get their water supply from the Gandak river at Balmikinager, the northern most part of the district bordering Nepal.

Live Stock

This district depends a lot on livestock for cultivation. The plough cattle are bred locally. There are many fine well-conditioned bullocks seen in the district particularly the cart bullock . Buffaloes are main source of milk . They are generally of small type but in fairly good condition.

Mines & Minerals

The Dun & Sumeswar hills in the extreme north which are the continuation of Shivalik range are formed of ill compacted sandstone. There are beds of Kankar (sandstone) in parts of the district & saltpetre is found almost everywhere.

Rainfall

Rainfall is heavier than most of the districts & is especially heavy in the terai region. The normal annual rainfall is about 56".

Trade & Commerce

The rich forests of the district have opened the doors of a flourishing trade in timber. The district borders Nepal on the north over a long stretch of land. There are some road routes also connecting the district with Nepal. Naturally, therefore, a good bulk of the Indo Nepal trade is carried on through the district. Nepalese rice, timber and spices are imported into India while textiles, petroleum products etc. are exported into Nepal through the district. The chief trade centres are Bagaha, Bettiah, Chanpatia & Narkatiaganj.

3. PLANNING PROCESS ADOPTED FOR DHAP:

The Planning process began with the constitution of a five member team from the district on the behest of State Health Society Bihar. This team consisted of ACMO, DIO, M&E Officer, MOIC (Ramnagar) & BHM (Bagaha-2). This team attended a six day Capacity Building Workshop at Patna, from 7th to 12th September 2009. This workshop was organized by the State Health Society with support from National Health Systems Reasource Centre (NHSRC) & Public Health Resource Network (PHRN).

A decentralized participatory planning process has been followed in development of this District Health Action Plan. The health facilities in the block viz. HSCs, APHCs, PHCs and, FRUs were surveyed using the templates developed at the aforementioned workshop. The inputs from these Situation Analysis & "facility" surveys were taken into account while developing the District Health Action Plan. The findings of the DLHS – 3 have also been used to analyse the present situation in the district.

The District Planning Team (DPT) provided technical oversight and strategic vision for the process of development of District Health Action Plan.

The members of the DPT had also taken the responsibility of contributing to the selected thematic areas such as RCH, Newer initiatives under NRHM, immunization etc. Assessment of overall situation of the District and development of broad framework for planning was done through a series of meetings of the DPT.

The process followed while developing the District Health Action Plans is as follows:

- Extensive District consultations of various interests groups/stakeholders and their feedback.
- Resources availability recommendations of stakeholders at all levels.
- Formation of District level core group to further the planning process.
- Participation of Block level functionaries in the planning process.
- District level consultation processes with workshops, meetings and discussions.
- Feed back & Consultative meetings with various allied Departments.

The major thrust areas in the NRHM namely, Reproductive & Child Health-II, Immunization, Control of Communicable Diseases, Strengthening & Mainstreaming & Establishing the Public Health Standards in the Health System have been taken into account while developing the District Health Action Plan.

4. PRIORITY AREAS AS IDENTIFIED DURING THE PROCESS:

National Rural Health Mission encompasses a wide range of health concerns including the determinants of the good health. Though there is a significant increase in resource allocation for the NRHM, there can never be adequate resources for all the health needs and all that needs to be done for ensuring good health of all the people. It is therefore necessary to Subcentres the areas where appropriate emphasis needs to be given.

Based on the background and the planning process following are the overall priorities of the District:

1. Improving Infrastructure has to be the taken up as there is great gap in infrastructure at all levels.
2. Improving Maternal & Child Health & ensuring complete immunization, Ante natal and Post natal cover.
3. Improving Family Planning Services.
4. Reduction of morbidity / Mortality due to Kalaazar, malaria and TB through effective disease control and surveillence.
5. Increase in the number of facilities as per the population
6. Availability of personnel and their Capacity building
7. Adverse Sex Ratio
8. Improving behaviour change communication.
9. Ensuring edequate supply of drugs particularly at primary level to poorer sections.
10. Ensuring development of effective and sustainalble financing arrangements to protect the interest of marginalized sections.
11. Strengthening the HMIS and the monitoring system especially availability of correct data and its use.
12. Inter-sectoral convergence.
13. Strengthening of Civil Surgeon Office.
14. Quality services at all levels

SPECIFIC PRIORITIES OF THE DISTRICT

1. **Infrastructure**: Increase in the number of SHCs, APHCs, PHCs and Urban Health centres for the slums and urbanized population. Special emphasis on making APHCs functional.
2. **Maternal Health:** Well managed system of institutional deliveries through Delivery huts and Emergency Obstetric Care services, JBSY extended to all poor categories of persons, Blood Storage Units at District Hospital, All PHCs to be developed as FRUs, PHCs to be developed as 24x7 facilities, good referral mechanisms. Ensure complete Ante antal and Post natal coverage.
3. **Neo Natal and Child Health:** Provision of Neonatal services at APHCs, PHCs, Training on IMNCI, addressing Anaemia and Malnutrition. Preparation of School Health Plan.
4. **Family Planning:** Improving the coverage for Spacing methods and NSV
5. **Immunization:** Total coverage for immunization
6. **Adolescent Health:** The focus is on provision of Adolescent Reproductive and Sexual health education through schools and also awareness building on good health practices, responsible family life, and harmful effects of Alcoholism.

7. **National Disease Control Programmes:** Prevention Vector borne diseases especially Kalazar which is very rampant in the district. The control on malaria & TB also remains high on the agenda.
8. **Gender & Equity:** Implementation of PNDT Act 1995 through regular monitoring of Ultrasound Clinics and regular meetings of advisory committee. Increase in BCC/IEC activities for awareness of PNDT Act.
9. **Demand Generation, IEC/BCC:** Nutrition, Health & RCH Education to Adolescents, Behaviour Change in the difficult Populations and for improving the adverse sex ratio. Health Plan for each village through Village Health Committee of the Panchyat.
10. **Programme Management:** Better functioning of the District Health Society and a strengthened Civil Surgeon's Office and establishing BPMU.
11. **Human Resources:** Filling of the vacancies as per the population based norms for the year 2010-11, increased mobility, motivational issues, provision of quarters at all facilities, Availability of well trained ASHAs for each 1000 population
12. **Capacity Building:** Focussed capacity building in Emergency Obstetric Care, Continuous skill building of all personnel as per needs expressed and also the new job responsibilities under NRHM. Training and capacity building of Panchayati Raj Institutions to establish decentralized and participative planning and training of all ASHAs.
13. **Procurement and Logistics:** Construction of a scientific Warehouse for Drugs
14. **Monitoring and Evaluation:** Data validation and computerized data availability upto PHCs with district linkages
15. **Intersectoral Convergence:** Fixing Responsibilities of each sector for their accountability and hence better Intersectoral Coordination and ensure Inter Sectoral convergence with nutrition, Drinking water & sanition programme to derive synergies.
16. **Public-Private Partnership:** Increase in the number of private facilities for accreditation with the Government for providing services

5. GOALS:

The District will strive 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 and will achieve the following goals:

INDICATOR		**Current**		
		W/Champ	**10-11**	**11-12**
Reduction in Infant Mortality Rate (IMR)		80*	50	30
Reduction Maternal Mortality Ratio (MMR)		262	120	100
Reduction in Birth Rate		19.56*	15.5	15
Reduction in Total Fertility Rate		2.69	2.3	2.1
Reduction in Death Rate		5.04*	4.4	4
Increase in Couple Protection Rate		35.3%	65	80
% of Pragnant receiving full ANC		15.3% 32.4%**	75%	90%
Increase % of Women getting IFA tablets		82%* 11%**	95%	100%
Increase Institutional Deliveries		43.3%* 24.9**	70%	80%
Increase Delivery by Skilled Birth Attendants		83.5% 48.7%**	95%	100%
Increase Complete Immunisation of Children (12-23 month of age)		30.2%**	80%	100%
Increase in Annualized NSP CDR (TB)		50 / L*	65 / L	70 / L
Decrease in API of Malaria (NVBDCP)		0.34*	0.2	0.10
Pravelance rate (Leprosy)		.7	0.25	0.1
Sex Ratio		901**	915	925

Note:

- **(*)** means data from District Health Society, Bettiah
- **(**)** means data from DLHS 3
- **(#)** means SRS data
- DNA means Data Not Available

6. SITUATION ANALYSIS:

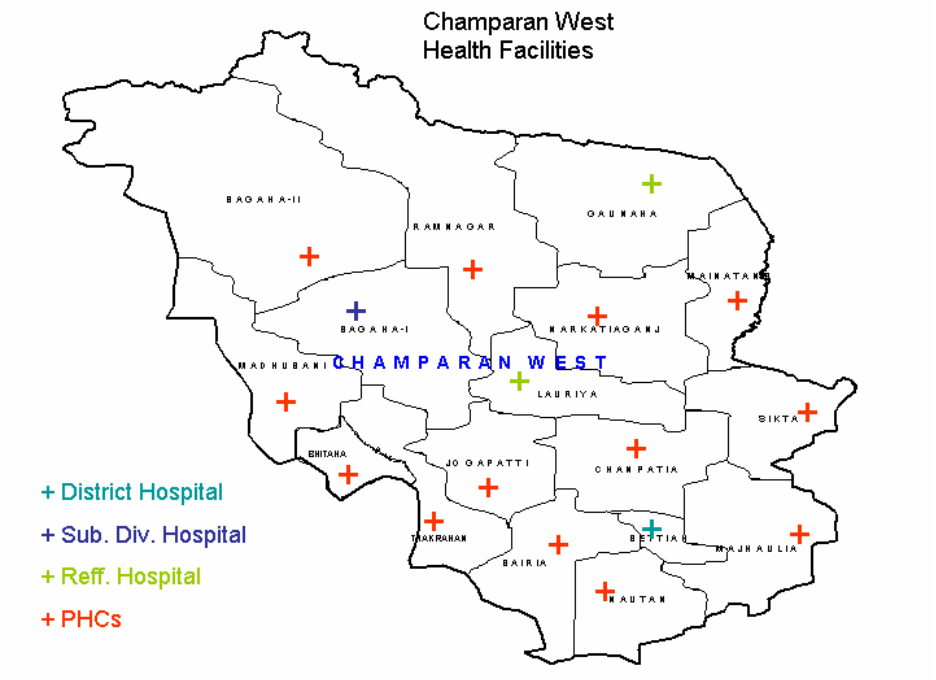
a. DISTRICT PROFILE

No.	Variable	Data
1.	Total area	5225 Sq. Km
2.	Total no. of blocks	18
3.	Total no. of Gram Panchayats	315
4.	No. of villages	2220
5.	No of PHCs	18
6	No of APHCs	30+80 (New)
7.	No of HSCs	369+257 (New)
8.	No of Sub divisional hospitals	2
9.	No of referral hospitals	2
10.	No of Doctors	118
11.	No of ANMs	357
12.	No of Grade A Nurse	20
13.	No of Paramedicals	61
14.	Total population	3759210
15.	Male population	1986766
16.	Female population	1742444
17.	Sex Ratio	901:1000
18.	No of Eligible couples	120256
19.	Children (0-6 years)	1267439
20.	Children (0-1years)	113512
21.	SC population	452705
22.	ST population	67552
23.	BPL population	2112099
24.	No. of primary schools	1689
25.	No. of Anganwadi centers	2980
26.	No. of Anganwadi workers	2914
27.	No of ASHA	3204
28.	No. of electrified villages	562
29	No. of villages having access to safe drinking water	60
30.	No of villages having motorable roads	489

b. Health Profile

Sr No	Block Name	MOIC Name	Std Code	Tel. No.	Mobile No.
1	Bagha-1	Dr. Satynarayan Matho	06251	227130	9470003204
2	Bagha-2	Dr. Nityanand Singh	06251	227160	9470003205
3	Bairiya	Dr. B.N.Sharma	06254	259547	9470003206
4	Bettiah	Dr. Arun Kr. Sinha	06254	245366	9470003207
5	Chanpatia	Dr. Vishnath Prasad	06254	266103	9470003209
6	Gonaha	Dr. Awadhesh Kr Singh	06253	253201	9470003210
7	Jogapatti	Dr. Madan Chandra	06254	224984	9470003220
8	Laoriya	Dr. Surendra Pd. Sharma	06253	251030	9470003211
9	Madhubani	Dr. Anil Kumar	NA	NA	9470003212
10	Mainataand	Dr. Nazir	06253	256450	9470230357
11	Manjholia	Dr. Z. Hasan	06254	282109	9470003214
12	Narkatiyaganj	Dr. Srinath Prasad	06253	244111	9470003215
13	Nautan	Dr. Shankar Rajak	06254	257087	9470003216
14	Ramnagar	Dr. Rajesh Kumar Singh	06255	225440	9470003217
15	Sikta	Dr. Basudeo Pd. Verma	06253	285732	9470003218
16	Thakraha	Dr. A.K. Pandey	NA	NA	9470003219
17	Bhitaha	Dr. Sahrichi Prasad	NA	NA	9470003208

District Hospital: MJK Hospital, Bettiah
Medical Superintendent – Dr. C. B.Singh



Health Facilities in the District

Primary Health Centers/Referral Hospital/Sub-Divisional Hospital/District Hospital

No	Block Name/sub division	Population	PHCs/Referral /SDH/DH Present	PHCs required (After including referral/ DH/SDH)	PHCs proposed
1	BAGAHA-I	376644	PHC -1, Sub div -1	2	0
2	BAGAHA-II	280959	PHC -1	2	0
3	BAIRIYA	188702	PHC -1	1	0
4	BETTIAH	163253	PHC -1, DH-1	0	0
5	CHANPATIYA	289104	PHC -1	2	0
6	GAUNAHA	190404	PHC -1, Ref-1	0	0
7	LAURIYA	245110	PHC -1, Ref-1	0	0
8	MADHUBANI	125547	PHC -1	0	0
9	MAINATAND	210170	PHC -1	1	0
10	MAJHULIYA	299358	PHC -1	2	0
11	NARKATIYAGANJ	353113	PHC -1, Sub div -1	3	Sub Div -1
12	NAUTAN	220735	PHC -1	1	0
13	RAMANGAR	247202	PHC -1	1	0
14	SIKTA	171461	PHC -1	1	0
15	THAKRAHA	124770	PHC -1	0	0
16	YOGAPATI	232191	PHC -1	1	0
17	BHITAHA	50487	PHC -1	0	0
18	PIPRASI	-	PHC-1	0	0
Total		3759210			

Infrastructure

Primary Health Centres/Referral Hospital/Sub-Divisional Hospital/District Hospital: Infrastructure

No	PHC/ Referral Hospital/SDH /DH Name	Population served	Building ownership (Govt/Pan/ Rent)	Building condition (+++/++/#)	Assured running water supply (A/NA/I)	Continuous power supply (A/NA/I)	Toilets (A/NA/I)	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. Of rooms	No. Of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/++/#)
1	BAGAHA-I	376644	Govt	#	NA	A by out Source	NA	NA	NA	NA	NA	NA	NA	NA
2	BAGAHA-II	280959	Govt	#	A	A by out Source	I	A	+++	11	15	A	+++	+++
3	BAIRIYA	188702	Govt	++	A	A by out Source	I	A	+++	14	15	A	+++	+++
4	BETTIAH	163253	Govt	#	A	A by out Source	NA	NA	NA	NA	NA	NA	NA	NA
5	CHANPATIYA	289104	Govt	-	A	A by out Source	I	A	+++	18	15	A	+++	+++
6	GAUNAHA	190404	Govt	++	A	A by out Source	I	A	+++	19	45	A	+++	+++
7	LAURIYA	245110	Govt	+++	A	A by out Source	I	A	+++	16	45	A	+++	+++
8	MADHUBANI	125547	Govt	+++	A	A by out Source	I	A	+++	12	15	A	+++	+++
9	MAINATAND	210170	Govt	+++	A	A by out Source	NA	NA	+++	9	15	NA	NA	NA
10	MAJHULIYA	299358	Govt	-	A	A by out Source	I	A	+++	18	15	A	+++	+++
11	NARKATIYAGANJ	353113	Govt	#	A	A by out Source	I	A	+++	21	25	A	+++	+++
12	NAUTAN	220735	Govt	-	A	A by out Source	I	A	+++	17	15	A	+++	+++
13	RAMANGAR	247202	Govt	+++	A	A by out Source	I	A	+++	15	15	A	+++	+++
14	SIKTA	171461	Govt	#	A	A by out Source	I	A	+++	16	15	A	+++	+++
15	THAKRAHA	124770	Govt	#	A	A by out Source	NA	NA	NA	NA	NA	NA	NA	NA
16	YOGAPATI	232191	Govt	+++	A	A by out Source	I	NA	NA	11	15	NA	NA	NA
17	BHITAHA	50487	Govt	-	A	A by out Source	I	A	-	12	15	A	+++	+++
18	MJK Hospital Bettiah (DH)	--	Govt	++	A	A by out Source	I	A	+	NA	320	A	+	+

ANM(R)- Regular/ ANM(C)- Contractual; Govt- Gov/ Rented-Rent/ Pan –Panchayat or other Dept owned; Good condition +++/ Needs major repairs++/Needs minor repairs-less that Rs10,000-+/ needs new building-#; Water Supply: Available –A/Not available –NA, Intermittently available-I

Human Resources

Sl. No.	PHC /Referral/ SDH/DH Name	Population Served	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses Grade A		Specialists		Storekeeper
			Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	BAGAHA-I	376644	6	3	29	27	1	1	1	1	0	5	0	0	1
2	BAGAHA-II	280959	7	3	32	27	1	0	1	0	0	3	0	0	1
3	BAIRIYA	188702	7	3	26	23	1	0	1	0	0	0	0	0	1
4	BETTIAH	163253	6	3	20	16	1	0	1	1	0	3	0	0	0
5	CHANPATIYA	289104	7	3	32	35	1	0	1	1	0	2	0	0	1
6	GAUNAHA	190404	7	3	35	18	1	0	1	1	0	0	0	0	0
7	LAURIYA	245110	7	3	26	17	1	0	1	0	0	2	0	0	1
8	MADHUBANI	125547	7	3	20	8	1	0	1	0	0	2	0	0	1
9	MAINATAND	210170	7	3	20	11	1	0	1	1	0	0	0	0	1
10	MAJHULIYA	299358	7	3	45	41	1	0	1	1	0	0	0	0	1
11	NARKATIYAGANJ	353113	7	3	37	30	1	0	1	1	0	2	0	0	1
12	NAUTAN	220735	7	3	35	33	1	0	1	0	0	0	0	0	1
13	RAMANGAR	247202	7	3	21	16	1	0	1	1	0	0	0	0	1
14	SIKTA	171461	7	3	20	16	1	0	1	1	0	1	0	0	1
15	THAKRAHA	124770	7	3	19	4	1	0	1	0	0	0	0	0	1
16	YOGAPATI	232191	7	3	23	22	1	0	1	0	0	0	0	0	1
17	BHITAHA	50487	7	3	17	9	1	0	1	0	0	0	0	0	0
18	MJK Hospital Bettiah	--	23	18	0	0	1	0	10	5	37	28	8	8	1
Total		3759210	140	69	457	353	18	1	27	14	37	48	8	8	15

Primary Health Centres/Referral Hospital/Sub-Divisional Hospital/District Hospital: Human Resources

Allopathic (A),Ayush (Ay), Regular (R), Contractual (C)

Allopathic (A),Ayush (Ay), Regular (R), Contractual (C)

Rogi Kalyan Samitis Untied Funds

No	Name of Facility	RKS set up (Y/N)	Number of meetings held	Total Funds	Funds Utilized	No.	Name of the Facility	Funds received	Funds utilized
1	BAGAHA-I	Y	NA	50000.00	50000.00				
2	BAGAHA-II	Y	9	50000.00	50000.00				
3	BAIRIYA	Y	7	50000.00	50000.00				
4	BETTIAH	Y	0	0.00	0.00				
5	CHANPATIYA	Y	10	50000.00	50000.00				
6	GAUNAHA	Y	9	50000.00	50000.00				
7	LAURIYA	Y	8	50000.00	50000.00				
8	MADHUBANI	Y	7	50000.00	50000.00				
9	MAINATAND	Y	5	50000.00	50000.00				
10	MAJHULIYA	Y	10	50000.00	50000.00				
11	NARKATIYAGANJ	Y	10	50000.00	50000.00				
12	NAUTAN	Y	10	50000.00	50000.00				
13	RAMANGAR	Y	10	50000.00	50000.00				
14	SIKTA	Y	9	50000.00	50000.00				
15	THAKRAHA	Y	6	50000.00	50000.00				
16	YOGAPATI	Y	8	50000.00	50000.00				
17	BHITAHA	Y	7	50000.00	50000.00				
18	MJK Hospital Bettiah	Y	10	500000.00	500000.00				

Support Systems to Health facility functioning

No	Facility name	Services available								
		Ambulance	Generator	X- ray	Laboratory services				Canteen	House keeping
		O/I/ NA	O/I/ NA	O/I/ NA	Pathology	Malaria/kalaazar	TB	O/I/ NA	O/I/ NA	
1	BAGAHA-I	O	O	NA	O		1		NA	
2	BAGAHA-II	O	O	O	O		1		NA	
3	BAIRIYA	O	O	NA	O		1		NA	
4	BETTIAH	O	O	NA	O		1		NA	
5	CHANPATIYA	O	O	NA	O		1		NA	
6	GAUNAHA	O	O	NA	O		1		NA	
7	LAURIYA	O	O	NA	O		1		NA	
8	MADHUBANI	O	O	NA	O		1		NA	
9	MAINATAND	O	O	NA	O		1		NA	
10	MAJHULIYA	O	O	NA	O		1		NA	
11	NARKATIYAGANJ	O	O	O	O		1		NA	
12	NAUTAN	O	O	NA	O		1		NA	
13	RAMANGAR	O	O	NA	O	I	1		NA	
14	SIKTA	O	O	NA	O		1		NA	
15	THAKRAHA	O	O	NA	O		1		NA	
16	YOGAPATI	O	O	NA	O		1		NA	
17	BHITAHA	O	O	NA	O		1		NA	
18	MJK HOSPITAL BETTIAH	NA	O	I	O	I	I		O	

O- Outsourced/ I- In sourced/ NA- Not available

Health Sub-centres

S.No	Block Name	Population	Sub-centres required	Sub-centers Present	Sub-centers proposed	Further sub-centers required	Status of building		Availability of Land (Y/N)
							Own	Rented	
1	BAGAHA-I	376644	71	34	14	23	56	17	N
2	BAGAHA-II	280959	58	27	28	3	3	25	N
3	BAIRIYA	188702	38	16	11	11			N
4	BETTIAH	163253	27	11	5	11	2	9	N
5	CHANPATIYA	289104	58	27	21	10	2	18	N
6	GAUNAHA	190404	38	20	17	1	3	17	N
7	LAURIYA	245110	47	28	14	5			N
8	MADHUBANI	125547	25	9	12	4			N
9	MAINATAND	210170	42	21	16	5			N
10	MAJHULIYA	299358	58	35	18	5			N
11	NARKATIYAGANJ	353113	73	26	34	13	3	23	N
12	NAUTAN	220735	42	32	9	1			N
13	RAMANGAR	247202	47	21	17	9	4	13	N
14	SIKTA	171461	34	18	6	10			N
15	THAKRAHA	124770	23	9	8	6			N
16	YOGAPATI	232191	46	24	22	0			N
17	BHITAHA	50487	11	11	0	0			N
		3759210	**737**	**369**	**252**	**117**	**73**	**122**	

c. District Indicators (DLHS)

District Indicators, Paschim Champaran, (2001 Census)	
Indicators	**Census 2001**
Population (in thousands)	3043
Decadal Growth Rate (1991-01)	30.4
Sex Ratio*	901
Percent Urban population	10.2
Percent SC population	14.4
Percent ST population	1.3
Female Literacy Rate (7 years and above)	25.9
Male Literacy Rate (7 years and above)	51.9

Population and Household Characteristics, 2007-08				
Background Characteristics	**DLHS - 3**		**DLHS - 2**	
	Total	**Rural**	**Total**	**Rural**
Percent total literate Population (Age 7 +)	53.4	50.4	-	-
Percent literate Male Population (Age 7 +)	66.2	63.7	-	-
Percent literate Female Population (Age 7 +)	41.3	37.7	-	-
Percent girls (age 6-11) attending Schools	98.2	98.0	-	-
Percent boys (age 6-11) attending Schools	98.8	99.0	-	-
Have Electricity connection (%)	11.5	7.0	11.1	7.0
Have Access to toilet facility (%)	12.9	8.2	18.2	13.5
Use piped drinking water (%)	0.6	0.3	14.3	14.3
Use LPG for cooking (%)	3.8	1.1	5.9	3.5
Live in a pucca house (%)	9.0	5.9	15.1	12.1
Own a house (%)	99.0	99.3	-	-
Have a BPL card (%)	28.2	29.1	-	-
Own Agriculture Land (%)	48.2	50.2	-	-
Have a television (%)	7.9	4.7	10.7	7.7
Have a mobile phone (%)	13.5	10.9	-	-
Have a Motorized Vehicle (%)	4.3	3.7	21.3	19.4
Standard of Living Index				
Low (%)	89.2	93.0	80.8	85.0
Medium (%)	6.4	5.3	13.7	12.1
High (%)	4.4	1.7	5.5	2.9
* Number of Females per 1000 Males				

Bihar		**District : Paschim Champaran**		
Indicators	**DLHS - 3**		**DLHS - 2**	
	Total	**Rural**	**Total**	**Rural**
Marriage and Fertility, (Jan 2004 to 2007-08)				

Percentage of girl's marrying before completing 18 years	57.8	58.7	62.9	66.5
Percentage of Births of Order 3 and above	58.7	59.5	57.5	58.6
Sex Ratio at birth	106	110	-	-
Percentage of women age 20-24 reporting birth of order 2 & above	77.3	78.0	-	-
Percentage of births to women during age 15-19 out of total births	96.1	96.4	-	-
Family planning (currently married women, age 15-49)				
Current Use :				
Any Method (%)	32.3	32.0	24.7	24.2
Any Modern method (%)	27.8	27.7	19.7	18.7
Female Sterilization (%)	26.3	26.7	16.0	15.8
Male Sterilization (%)	0.2	0.1	0.9	1.0
IUD (%)	0.0	0.0	0.1	0.1
Pill (%)	0.6	0.6	1.5	1.3
Condom (%)	0.4	0.1	0.5	0.5
Unmet Need for Family Planning:				
Total unmet need (%)	36.9	37.0	36.6	36.2
For spacing (%)	14.3	14.9	17.3	17.4
For limiting (%)	22.6	22.1	19.3	18.8
Maternal Health:				
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	18.7	17.6	-	-
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	32.4	33.0	17.9	16.0
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)[#]	69.7	69.5	26.3	26.4
Institutional births (%)	24.9	23.2	28.7	28.3
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	2.4	2.0	10.3	9.7
Mothers who received post natal care within 48 hours of delivery of their last child (%)	9.5	8.4	-	-
Child Immunization and Vitamin A supplementation:				
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)	30.2	30.6	3.5	3.9
Children (12-23 months) who have received BCG (%)	76.2	77.0	19.3	15.6
Children (12-23 months) who have received 3 doses of Polio Vaccine (%)	39.7	40.1	9.9	5.6
Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	45.3	46.1	9.9	5.6
Children (12-23 months) who have received Measles Vaccine (%)	40.4	41.2	8.0	8.9
[#] It is adjusted according to DLHS-3 definition				

Village (N=45)	
Indicators	**Number**
Villages that have implemented Janani Suraksha Yojana (JSY)	**40**
Villages with Health & Sanitation Committee	**0**
Villages with Rogi Kalyan Samiti (RKS)	**8**
Villages where PRI aware of untied fund by Government	**0**
Health facility within village-ICDS (Anganwadi)	**39**
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-ICDS (Anganwadi)	**2**
Health facility within village- Sub-Centre	**13**
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Sub-Centre	**20**
Health facility within village- PHC	**4**
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-PHC	**26**
Health facility within village- Block PHC	**1**
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Block PHC	**25**
Health facility within village- Govt. Dispensary	**0**
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Government. Dispensary	**20**
Health facility within village- Private Clinic	**4**
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Private Clinic	**24**
Health facility within village- AYUSH Health Facility	**5**
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-AYUSH Health Facility	**20**

Facility Survey			
Indicators	**Number**	**Indicators**	**Number**
Community Health Centre (CHC) N = 2			
Infrastructure :		**Performance :**	
CHC having Personal Computer	0	In-patients admission in last one month	0
CHC having Operation Theatre	0	Referred cases for serious ailments from CHC to higher centre during last one month	0
CHC having Labour Room	0	Deliveries performed in last one month	0
CHC having Blood Storage Facility	0	Blood transfusion done in last one month	0
CHC having large deep freezer	0	Sterilization conducted in last one month	0
CHC prepared a CHC plan for the current year			2
CHC having water supply for 24 hours			0
CHC having Ambulance on road			0

d. District/Sub District Variations:

District Level Variations in Institutional Delivery

Key indicators related to Maternal and Child Health (MCH) and Family Planning clearly show the poor status of RCH in Bihar. However, close examination of data reveals that there exist wide inter-district variations for almost all the key indicators. Listed below is the top five and lowest five performing districts for select key indicators. Data related to institutional delivery suggests that West Champaran has the highest rate of institutional delivery of 43.7%, the same for districts like Purnia and Katihar is 5.3% and 6.1% respectively. Even among the top performing districts, variations are wide and the second best performing district has a differential of more than 10 percentage points. Geographical analysis of these districts indicates that four out of five best performing districts are closer to the state capital. Among the low performers, four out of five districts are located at the periphery and the only nearby district (Samastipur) is extremely flood prone.

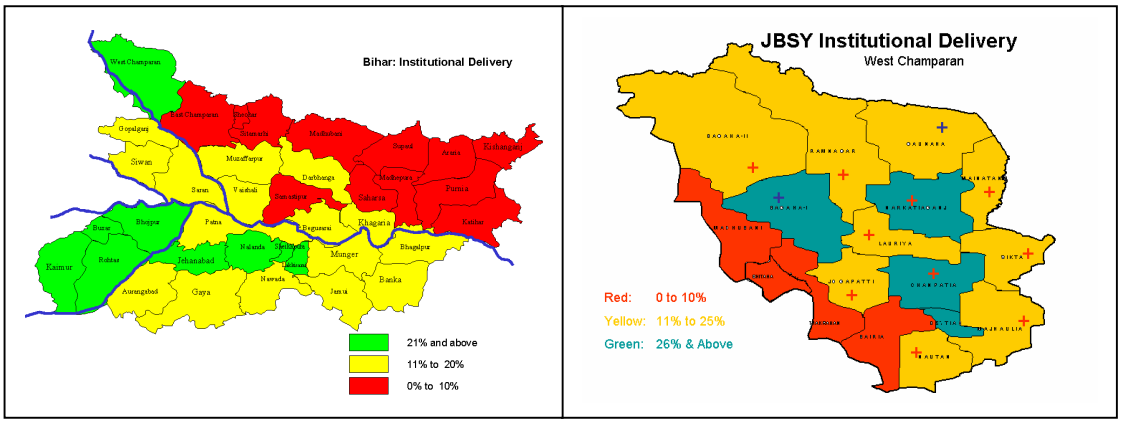
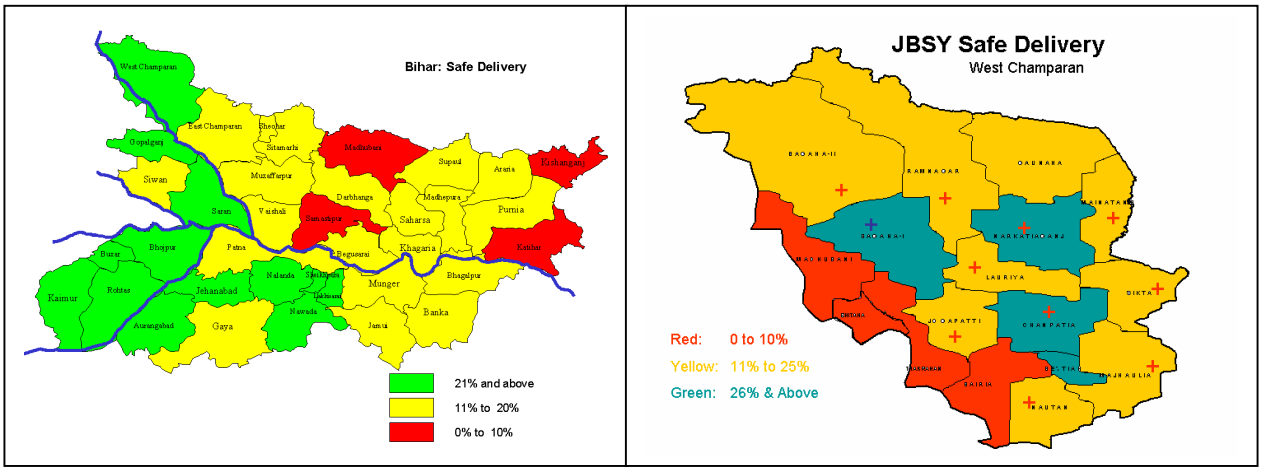


TABLE : DISTRICT LEVEL VARIATIONS IN INSTITUTIONAL DELIVERY				
	Good Performing District	**%**	**Poor Performing District**	**%**
Institutional Delivery	West Champaran	43.7	Purnia	5.3
	Bhojpur	31.9	Katihar	6.1
	Buxar	28.3	Samastipur	6.6
	Jehanabad	26.0	Kishanganj	6.7
	Nalanda	23.2	Araria	6.8

District Level Variations in Safe Delivery

In terms of safe delivery too the top performing districts remain similar to those who featured in as best performing districts for institutional delivery, perhaps indicating that overall delivery services in these districts are relatively better. Among the poor performing districts too, except for one, the districts remain the same as in the previous section. Madhubani, the only district that did not feature in the previous list of poor performing districts for institutional delivery, but ranked here as one of the poor performing districts for safe delivery (9.8%), also shares the geographical characteristics of other districts in this category i.e. peripheral and highly flood prone.

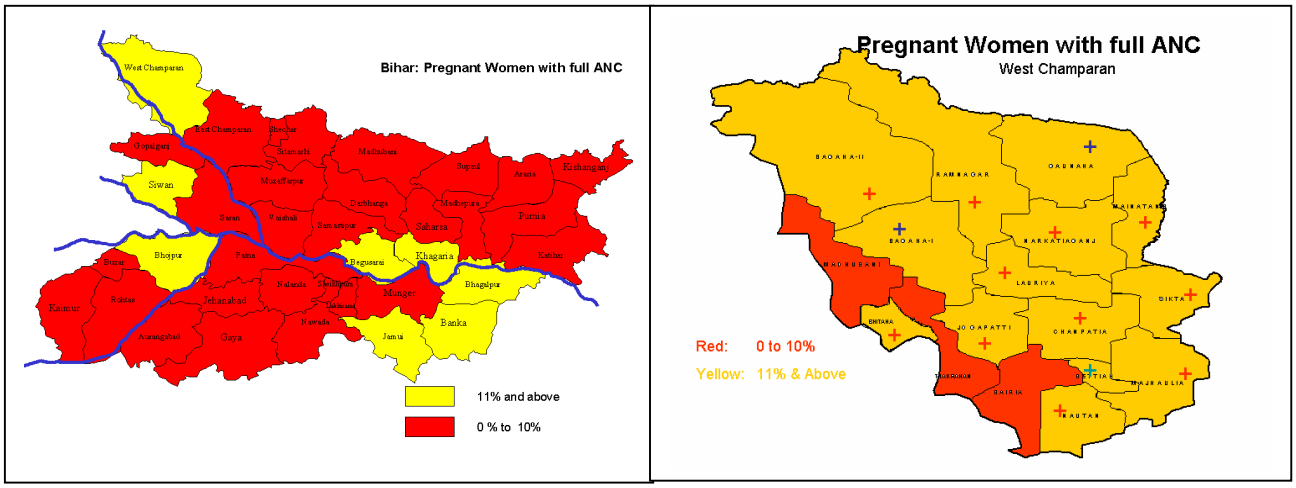
TABLE : DISTRICT LEVEL VARIATIONS IN SAFE DELIVERY				
	Good Performing District	**%**	**Poor Performing District**	**%**
Safe Delivery	West Champaran	48.0	Samastipur	7.6
	Bhojpur	40.1	Katihar	8.0
	Buxar	29.7	Kishanganj	8.2
	Jehanabad	28.0	Madhubani	9.8
	Nalanda	27.1	Araria	10.2



District Level Variations in % of Pregnant Women with full ANC

The general performance in terms of ANC services in the state is abysmally low, reflecting the poor condition of public health services for women in the reproductive age group. Even the best performing district viz West Champaran is at 15.3%, which is low compared to national average. The coverage rate in the low varies between 3.3% to 4.6%.

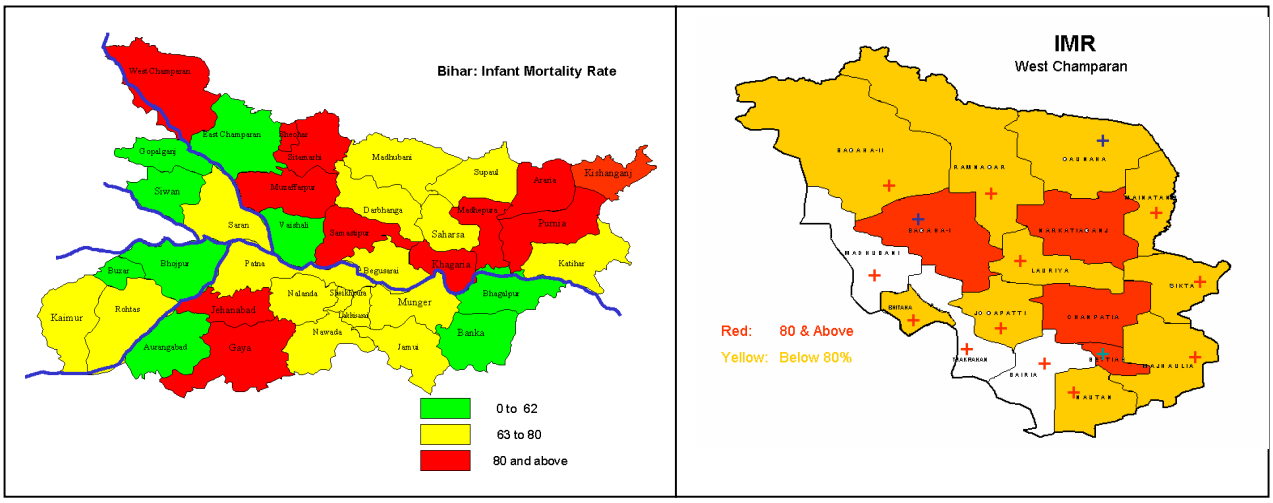
TABLE : DISTRICT LEVEL VARIATIONS IN % OF PREGNANT WOMEN WITH FULL ANC				
	Good Performing District	**%**	**Poor Performing District**	**%**
% of Pregnant Women with full ANC	West Champaran	15.3	Sitamarhi	3.3
	Begusarai	12.5	Samastipur	3.4
	Siwan	11.8	Madhepura	3.8
	Bhojpur	11.1	Purnia	3.9
	Bhagalpur	10.4	Aurangabad	4.6



District Level Variations in IMR

Though the performance of the state in terms of IMR is above the national average, a large proportion of districts continue to report significantly high IMR than the state averages. Geographical analysis suggests that most of these districts such as Kishanganj, Araria, Purnea, Samastipur, and Khagaria with high IMR are either peripheral or highly prone to floods.

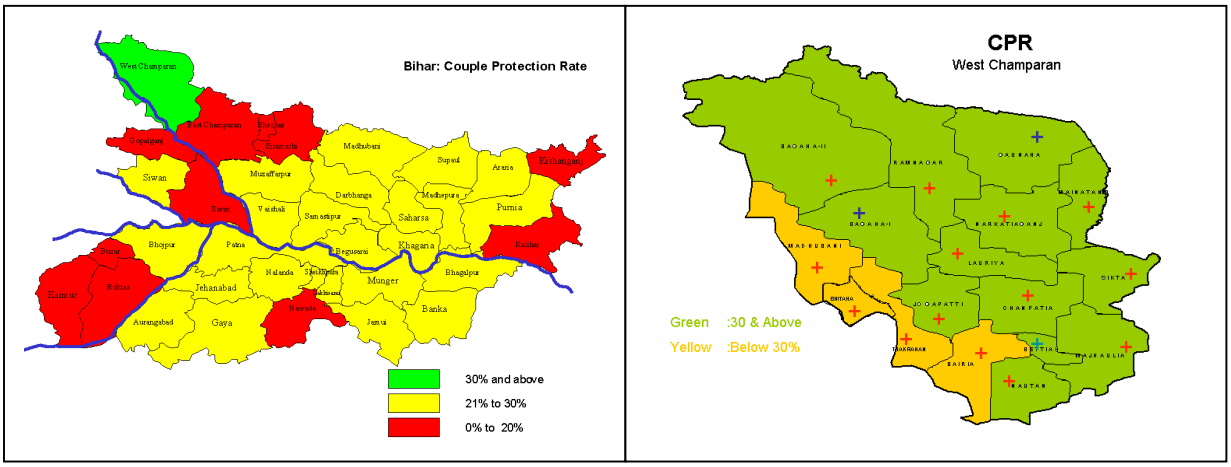
TABLE : DISTRICT LEVEL VARIATIONS IN IMR				
	Good Performing District		**Poor Performing District**	
IMR	Siwan	43	Kishanganj	113
	Vaishali	46	Araria	102
	Gopalganj	53	Purnia	89
	Bhojpur	55	Samastipur	87
	Buxar	55	Champaran West	80



District Level Variations in CPR

Performance indicators for family planning in the state are not very different from those of maternal and child health. The Couple Protection Rate, one of the key indicators for family planning continues to be significantly lower than the national average. Here too, the performance of districts are varied and while districts such as West Champaran, Saharsa, Khagaria, Araria and Darbhanga report CPR in the range of 35.3% to 25.2%, the low performers such as Gopalganj, Kishanganj, Sitamarhi, Katihar and Saran have CPR in the range of 14.5% to 17.5%.

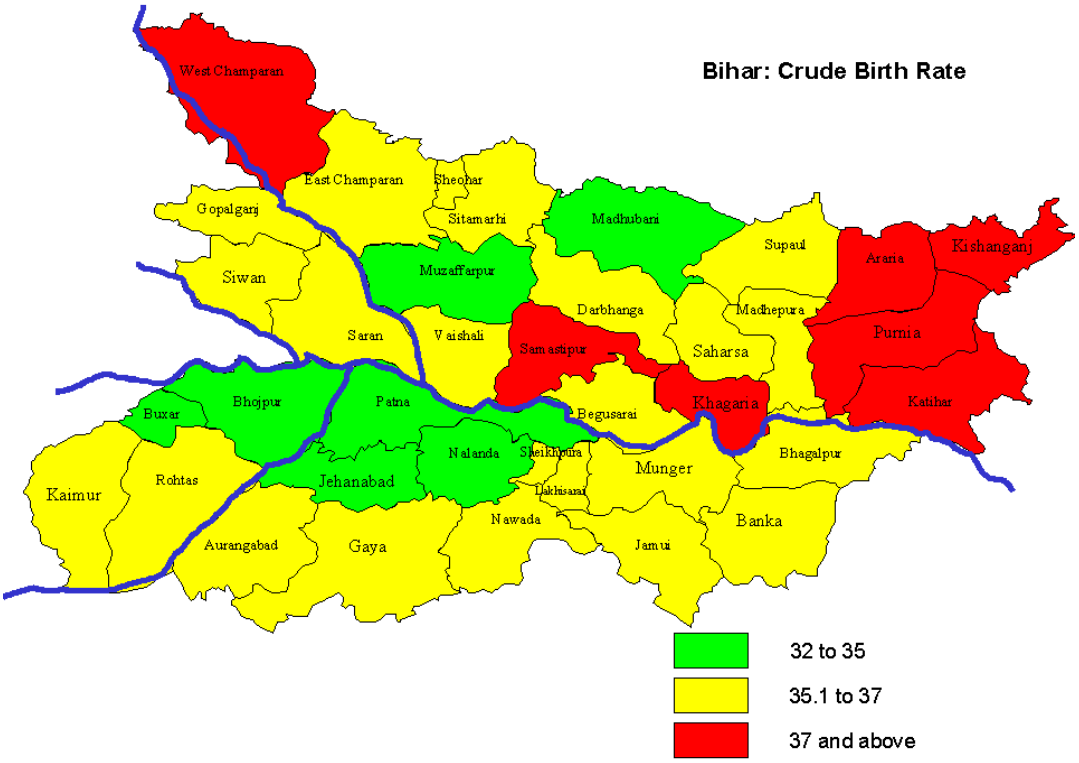
TABLE : DISTRICT LEVEL VARIATIONS IN CPR				
	Good Performing District	**%**	**Poor Performing District**	**%**
CPR	West Champaran	35.3	Gopalganj	14.5
	Saharsa	27.7	Kishanganj	15.5
	Khagaria	26.8	Sitamarhi	16.6
	Araria	26.5	Katihar	17.2
	Darbhanga	25.2	Saran	17.5



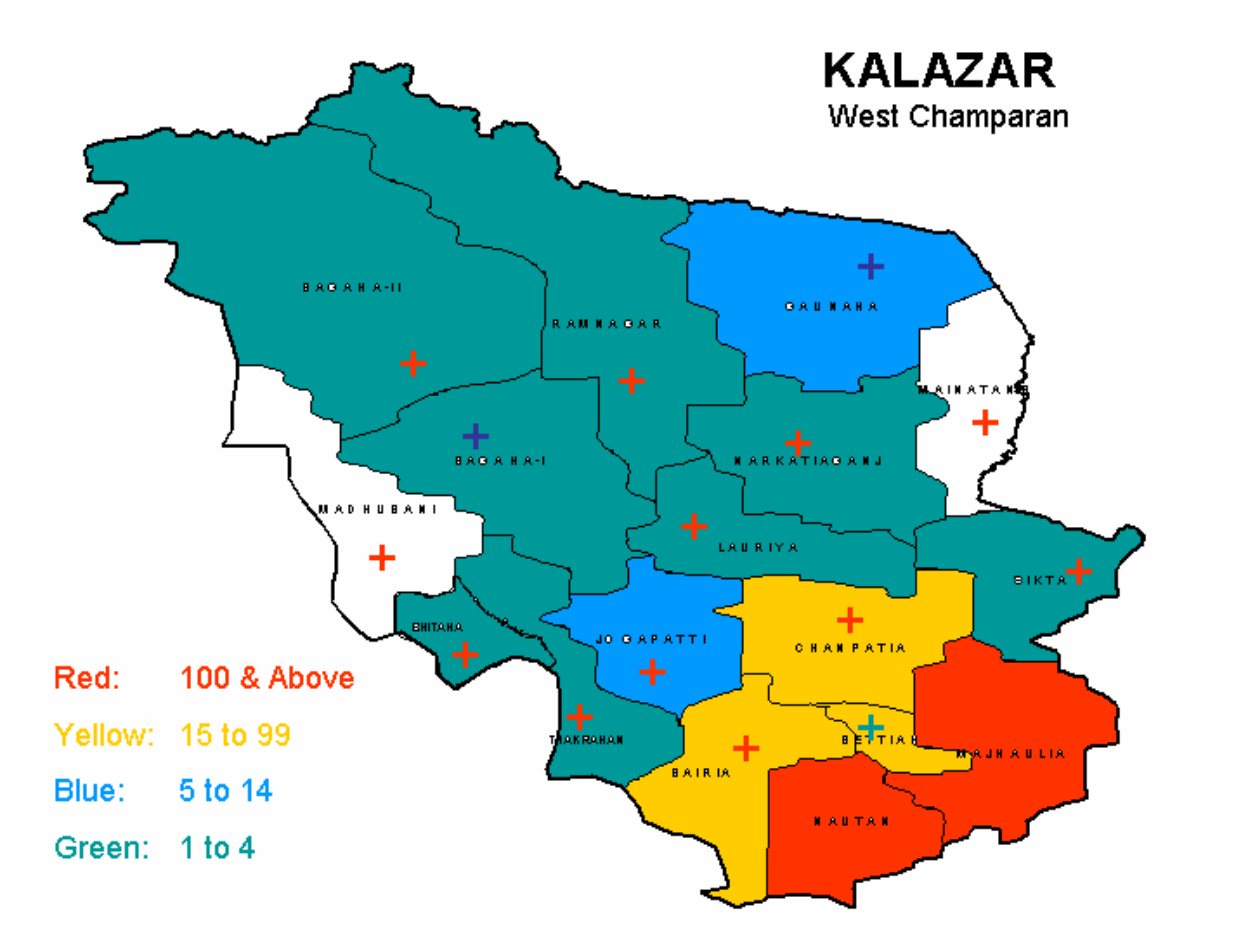
District Level Variations in CBR

The poor state of Family Planning services in the state is also evident in the high Crude Birth Rate. Unlike other indicators discussed previously, the Crude Birth Rate is one of the few indicators for which inter-district variation is relatively less. Across the state, it ranges from a high of 40.7% to a low of 32.6%, for a majority of the districts (22 out of 38), the range is between 35 and 37.

TABLE : DISTRICT LEVEL VARIATIONS IN CBR				
	Good Performing District	**%**	**Poor Performing District**	**%**
CBR	Patna	32.6	West Champaran	40.7
	Madhubani	33.6	Katihar	39.5
	Jehanabad	33.7	Araria	38.8
	Nalanda	34.3	Purnia	38.1
	Muzaffarpur	34.9	Kishanganj	37.4



District Lvel Variation: KALAZAR



Key Indicators of Bihar regarding health																		
S.no.	State/district	% girls marrying below legal age at marriage	% of households with low standard of living	% of households using adequate iodized salt (15ppm)	Birth order 3 and above	% women know all modern method	% husbands know NSV	% women/husbands using any family planning method	% women/husbands using any modern method of family planning	Unmet need for family planning	% women received at least three visits for ANC	% women received full ANC	% of Institutional delivery	% of delivery attended by skilled personne	% of children (age12-23 months) received full immunization	% of children (age12-23 months) did not received any immunization	% women aware of HIV/AIDS	% husbands aware of HIV/AIDS
1	India	28	42.3	29.6	42	49.2	34.4	53	45.7	21.1	50	16.4	40.5	47.6	45.8	19.8	53.6	75.8
2	Bihar	51.5	66.3	29.6	54.4	52.2	35.6	31	27.3	36.7	19.6	5.4	23	29.5	23	49.4	28.8	62.1
3	Champaran –W	63.9	80.8	1.5	57	20.1	3.2	24.6	18.9	37.2	17.5	0.8	28.6	35.8	3.5	74.4	7.7	43

7. SITUATION ANALYSIS: TECHNICAL COMPONENTS

7.1 Infrastructure

7.1.1 - Health Sub Centres

The overall objective is to provide health care that is quality oriented and sensitive to the needs of the community.

The objectives for Sub-Centres are:

i. To provide basic Primary health care to the community.

ii. To achieve and maintain an acceptable standard of quality of care.

iii. To make the services more responsive and sensitive to the needs of the community.

GAPs	1) Sub centres present – 369; Sub centres proposed – 257; Sub centres required – 117 2) The district needs 257 +117= 374 HSCs to start and make functional 3) 61% (189 out of 311) HSCs are on rent and rent is outstanding science 4 years. 4) Building conditions are very poor. Out of 369 existing HSCs, 221 needs new buildings and rest needs major/ minor repairs. 5) All HSCs lacks proper residential facilities, drinking and running water supply, toilets etc according to IPHS. 6) Lands are not available for new buildings 7) Lack of continuous power supply, telephone, transport facility etc at all the HSCs 8) Lack of drugs, equipment's & furniture as per IPHS Norms 9) Non availability of HMIS formats/ registers and stationary 10) Unavailability of labour rooms, clinic rooms, examination rooms, toilets 11) Lack of display boards, visiting schedule of ANM, complain/suggestion box 12) No residential accommodation facility
Issues	1) To increase the number of HSCs (369 to 737) 2) To make functional 257+117 = 374 HSCs 3) Repairing of Old buildings 4) New buildings with residential facilities, clinical rooms, labour rooms, examination rooms, toilets, drinking and running water facility at the appropriate location 5) To assure land availability for proposed and newly proposed HSCs. 6) To assure fund availability for construction of new building and payment of rent. 7) To assure proper power supply for 24 hours at HSCs 8) To assure availability for equipment's, drugs and furniture's according to IPHS norms. 9) To facilitate HSCs with telephone and transport facility for hard to reach areas.
Strategies	**Short Term Strategy:** 1) To optimize the use of existing resources by their repairing and upgrading 2) To hire buildings if required 3) Short term measures to enhance the infrastructure requirements 4) Untied fund for small financial needs **Long Term Strategy:** 1) Development of proposed HSC 2) Sanctioned of further required HSC
Activities	**Short Term:** 1. Allotment of untied fund at each running HSCs. 2. Repairing of existing building and infrastructure. 2. Where repairing is not possible, hire buildings on rent for one year. Advertise it through local news paper. 3. Allotment of Mobile phone at each HSCs. Advertise the number in local news paper 4. Vehicle of APHC should be used for related HSC 5. Solar System for power supply 6. Water supply: Hand pump at each HSCs. 7. Purchase of furniture from untied fund 8. Equipment and Drugs should be made available from PHC/ DHS

	9. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings **Long Term:** 1) Land Availability with support of local community and administration 2) Construction of new buildings (50 in this financial year) according to IPHS norms. Assure completion within one year. 3. Community mobilization for promoting land donations at accessible locations. **Monitoring:** 1. Biannual facility survey of HSCs through local NGOs as per IPHS format 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.	
Budget	1. Untied fund @10,000/- X 369 = 2. For Annual Maintenance & Repair Rs 10000/HSC X 369 = 3. For major repair = 148 HSCs * 20000/- 3. For solar lamp @15,000/- X 369 = 4. New buildings with quarters 50 HSC X 900000/- 5. Upgrading old buildings (Quarters, Toilets etc) 369 X 110000/- (Electricity, Furniture, Mobile, Water connections, Stationeries etc will be implemented from the Untied funds. Outstanding Rent should be paid from untied fund.)	36,90,000/- 36,90,000/- 29,60,000/- 55,35,000/- 4,50,00,000/- 4,05,90,000/- **10,14,65,000/-**

7.1.2 - Additional PHCs

The objectives for Add PHC are:
i. To provide comprehensive primary health care to the community through the Add PHC.
ii. To achieve and maintain an acceptable standard of quality of care.
iii. To make the services more responsive and sensitive to the needs of the community.

GAPs	1. APHCs present – 31; APHCs proposed – 80; APHCs required – 125 2. Out of 31 APHCs, only 16 are having own building 3. Existing 16 buildings are not properly maintained 4. Non payment of rent of 15 APHCs for long period. 5. 120 APHC need new building construction 6. All Existing APHC need Major repair 7. Running water supply is not available 8. Non availability of Labour room. 9. None of the APHC has Power Supply. 10. All Existing APHC require new construction of toilet 11. Lack of equipments, 12. Lack of appropriate furniture 13. Non availability of HMIS formats/registers and stationeries
Issues	1) To increase the number of APHCs (31 to 125) 2) Repairing of Old buildings 3) New buildings with residential facilities, clinical rooms, labour rooms, examination rooms, toilets, drinking and running water facility at the appropriate location

	5) To assure land availability for proposed and newly proposed APHCs. 6) To assure fund availability for construction of new building and payment of rent. 7) To assure proper power supply for 24 hours at APHCs 8) To assure availability for equipment's, drugs and furniture's according to IPHS norms. 9) To facilitate APHCs with telephone and transport facility for hard to reach areas.	
Strategies	**Short Term Strategy:** 1) To optimize the use of existing resources by their repairing and upgrading 2) To hire buildings if required 3) Short term measures to enhance the infrastructure requirements 4) Untied fund for small financial needs **Long Term Strategy:** 1) Development of proposed APHC 2) Sanctioned of further required APHC	
Activities	**A. Strengthening 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 the month of April-10. 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 **C. 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. **D. Monitoring**: D.1 Biannual facility survey of APHCs through local NGOs as per IPHS format D.2 Regular monitoring of APHCs facilities through PHC level supervisors in IPHS format. D.3 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. D.4 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. D.5 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.	
Budget	1. Untied fund @25,000/- X 31 = 2. For Annual Maintenance & Repair Rs 10,000 X31 = 3. For major repair = 16 x 25000/- 3. For Generator (Outsourced) @15,000/- X 31 X12 = 4. New buildings with quarters 20 APHC X 15,00,000/- 5. Upgrading old buildings (Quarters, Toilets etc) 16 X 1,10,000/- (Electricity, Furniture, Mobile, Water connections, Stationeries etc will be implemented from the Untied funds. Outstanding Rent should be paid from untied fund.)	7,75,000/- 3,10,000/- 4,00,000/- 55,80,000/- 3,00,00,000/- 17,60,000/- **3,88,05,000/-**

7.1.2 – Primary Health Centres

The objectives of IPHS for PHCs are:

i. To provide comprehensive primary health care to the community through the Primary Health Centers.
ii. To achieve and maintain an acceptable standard of quality of care.
iii. To make the services more responsive and sensitive to the needs of the community.

GAPs	1. The district altogether needs 36 PHCs but there are only 18 functioning PHC. 18 PHC are required to be formed. 2. All 18 PHCs are having own building 3. All 17 PHCs are running with only six bed facility. Delivery : 4. At present only 16 PHC's is conducting delivery.0020 at an average of 5 deliveries per day Out of which only 06 PHC having an average of 10 deliveries per day. Family Planning 5. Only 6 PHC's are conducting at an average of 7 Family Planning Operation per day. 6. OPD / Minor operation/ Emergency are 150 OPD per day in each PHC. 7. This huge workload is not being addressed with only six beds inadequate facility. 8. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms 9. 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. 10. Lack of equipments as per IPHS norms and also underutilized equipments. 11. Lack of appropriate furniture 12. Non availability of HMIS formats/registers and stationeries Operation of RKS: 13. Lack in uniform process of RKS operation. 14. Lack of community participation in the functioning of RKS. 15. Lack of facilities/ basic amenities in the PHC buildings
Issues	1. Available facilities are not compatible with the services supposed to be delivered at PHCs. 2. Quality of services 3. Community participation.
Strategies	1. Up gradation of PHCs into 30 bedded facilities. 2. ISO certification of selected PHCs in the district. 3. Strengthening of BMU 4. Ensuring community participation. 5. Strengthening of Infrastructure and operationalization of construction works 6. Monitoring
Activities	1.1.Need based (Service delivery)Estimation of cost for up gradation of PHCs 1.2. Preparation of priority list of interventions to deliver services. 2.1. Selection of any two PHCs for ISO certification in first phase. 2.2. Sending the recommendation for the certification with existing services and facility detail. 3.1. Ensuring regular monthly meeting of RKS. 3.2. Appointment of Block Health Managers in rest of the vacant place & Accountants in all institutions. 3.3. Training to the RKS signatories for account operation. 3.4. Trainings of BHM and accountants on their responsibilities.

	4.1.Meeting with community representatives on erecting boundary, beautification etc, 4.2. Nukkad Nataks on Citizen's charter of HSCs as per IPHS 1.1 Monthly meetings of VHSCs, Mothers committees	
Budget	**Activity/ Items**	**2010-11**
	Upgrading PHC	
	Building for new PHC (5)	0/-
	New Building for 5 existing PHC	1,20,00,000/-
	Furniture	18,00,000/-
	Equipment	1,00,00,000/-
	Vehicle / Ambulance	1,00,00,000/-
	Recurring cost for existing PHCs	55,00,000/-
	Recurring costs of additional PHCs	0/-
	Repair of building for PHCs	5,20,00,000/-
	Sub Total	**9,13,00,000/-**
	Untied Fund and Annual Maintenance	
	Untied Fund of Rs 100000/PHC	18,00,000/-
	Annual Maintenance grant of Rs 150000/PHC	27,00,000/-
	Annual Fund to give facilities to the patients of Rs 100000/PHC	18,00,000/-
	Sub Total	**63,00,000/-**
	Total	**9,76,00,000/-**

S.No.	Indicators	Present Status (09-10)	% Availability	Availability as per DLHS 3	%age Availability
1	PHC having Residential Quarter for Medical Officer	16 (Repairable)	90.00	9	50.00
2	PHC having separate Labour Room	15	83.33	11	61.00
3	PHC having Personal Computer	18	100	1	5.60
4	PHC having Normal Delivery Kit	16	88.9	10	55.50
5	PHC having Large Deep Freezer	6	33.33	4	22.22
6	PHC having regular water supply	14	80.00	12	66.7
7	PHC having Neonatal Warmer (Incubator)	0	0	0	0.00
8	PHC having Operation Theatre with Boyles Apparatus	4	22.22	2	11.00
9	PHC having Operation Theatre with anaesthetic medicine	6	33.33	4	22.2

7.1.3 - Sub divisional / Referral Hospital

GAPs	The district has been requiring 2 sub divisional Hospital but there is only 1 functioning. The district has 2 Referral Hospital but there are not functioning. Both Referral Hospital have own building but not adequate space. Require additional building **Delivery** : At present normal delivery is 15, caesarean or other operation Conducting per day **Family Planning** Family Planning Operation 12 per day. OPD / Minor operation/ Emergency is 250 per day This huge workload is not being addressed with only 30 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 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 underutilized 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 existing buildings
Issues	1. Available facilities are not compatible with the services supposed to be delivered at Referral 2. Quality of services 3. Community participation.
Strategies	1. Up gradation of Referral into 100 bedded facilities. 2. ISO certification of selected Referral in the district. 3. Strengthening of BMU 4. Ensuring community participation. 5. Strengthening of Infrastructure and operationalization of construction works 6. Monitoring
Activities	1.Need based (Service delivery)Estimation of cost for up gradation of Referral 2. Preparation of priority list of interventions to deliver services. 1. Selection of any one Referral 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 these institutions 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, **3A.Strengtheing of Sub div./Referral hospital having own buildings** A.1Rennovation of building. 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 **3B. Construction of new of Sub div./Referral hospital** B1. Preparation of priority list of Sub div. /Referral hospital according to IPHS population and location norms. B2. Community mobilization for promoting land donations at accessible locations. B3. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed of Sub div./Referral hospital 4.2 Monitoring of renovation/construction works through RKS members. 4.3 Training of Members of RKS committees/ Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of RKS committees on construction work.	
Budget	**Activity/ Items**	**2010-11**
	Upgrading FRUs / Su Div. Hospitals	
	New Building	1,20,00,000/-
	Furniture	10,00,000/-
	Equipment	1,00,00,000/-
	Vehicle / Ambulance	1,00,00,000/-
	Recurring cost for existing FRUs	55,00,000/-
	Repair of building	20,00,000/-
	Sub Total	**4,05,00,000/-**
	Untied Fund and Annual Maintenance	
	Untied Fund of Rs 500000/ FRU & Sub Div. Hosp. (4)	20,00,000/-
	Annual Maintenance grant of Rs 500000/ FRU & Sub Div. (4)	20,00,000/-
	Annual Fund to give facilities to the patients of Rs 100000 / FRU & Sub Div. (4)	4,00,000/-
	Sub Total	**44,00,000/-**
	Total	**4,49,00,000/-**

7.1.4 Untied Funds and Incentive Fund for the Village Level Committees

Situation Analysis/ Current Status

NRHM has placed a lot of stress on Community involvement and formation of Village Health & Sanitation Committees (VHSC) in each village. These committees are responsible for the health of the village. In District West Champaran these committees have been formed but need strengthening to improve their functioning. The selection of ASHA, her working, progress of the village is part of the responsibilities of the Gram Panchayat. Rs 10000 to all Village Level Committee was provided under NRHM.

In W. Champaran there are 170 villages with population less than 500. There are 1267 villages with population between 2001 and 5000. There are 386 villages with population more than 5000.

Objectives

1. Strengthening the Village Level Committees through financial support

Strategies

1. Provision of annual Untied funds of Rs 10000 each year to the villages up to a population of 1500

Activities

1. Provision of Annual Untied funds of Rs 10000 each year to the village's up to a population of 1500. Villages with more than 1500 population up to 3000 will get twice the funds. Villages with population more than 3000 will get three times the funds.

This untied fund is to be used for household surveys, health camps, sanitation drives, revolving fund etc;

2. Orientation of the ANMs for the utilization of the Untied Funds and she in turn will orient the Village Level committee.
3. Monthly meetings of the VLC for reviewing the funds and activities. This is to be facilitated by the ANMs
4. Monthly review at the PHC level regarding the VLC functioning and utilization of funds.

Support required

1. State should ensure the orientation procedure for the VLC
2. Funds to be transferred on time to the ANMs
3. PRIs to ensure proper usage and accounts

Timeline

	2010-11
Untied Fund of Rs 10000 / unit for Pop 2000 / unit x 170 units	x
Orientation and reorientation of the VHWSC	x
Provision of Rs 5000 as permanent advance for incentives to ASHA	x
Monthly meetings of the VHWSC	x
Review of the VHWSC functioning at PHC level	x

Budget

Activity / Item	**2010-11**
Untied Fund of Rs 10000 / unit 1500 / unit x 170units	18.6
Untied Fund of Rs 20000 / unit 3000 / unit x 1000 units	200.0
Untied Fund of Rs 30000 / unit 5000 / unit x 80 units	24.0
Total	**242.6**

7.2. Human Resource Plan	
Situation Analysis/ Current Status	HSCs 1. Only one ANM is posted at one HSC. 2. Total HSC = 369 3. Total ANM = 447 4. Total HW = 5. Lack of Male and Female Health Workers and volunteers at HSC 6. Lack of Skilled ANM and HW 7. Below standard record keeping and reporting APHCs 1. Out of 31 APHCs have 62 doctor is required but only 10 doctors posted, 2. Out of 120 grade A Nurse only 20 grade A Nurse has been appointed , but they are deputed at PHC or district Hospital 3. Out of 145 Male Health Worker only 25 have been posted. PHCs 1. Doctors: Existing 18 PHC district have 217 sanctioned post of regular doctor only 69 are working and in respect of 83 contractual doctor appointments only 49 are working. 2. Grade A Nurse: Out of 18 sanctioned posts only 2 are working. 3. ANM: - Out of 126 sanctioned posts only 97 are working. 4. Lab Technician: - Out of 18 sanctioned posts only 1 are working. 5. Pharmacist: - Out of 36 sanctioned posts only 9 are working. 6. Block Extension Educator: - out of 18 sanctioned posts only 5 are working. 7. Health Educator: - Out of 16 sanctioned posts only 5 are working. 8. L.H.V:- Out of 30 sanctioned posts only 23 are working. 9. Out of 18 BHM & Accountant only 11 BHMs & 18 Accountant are placed at present. Sub-Divisional / Referral Hospitals 1. Doctors : Lack of Obstetrician & Gynaecologist, Anaesthetist 2. Lack of Grade A Nurse, O.T Assistant, Ward Boys, Sweeper, Chaowkidar, Ophthalmic Assistant District Hospital 1. Doctors: Only 18 doctors ; Sanctioned 23; Standard 77 2. Paramedical: Only 28 Nurses; Sanctioned 37; Standard is 200-250 3. No lab technician; Sanctioned 1 4. Pharmacist: Only 3; Sanctioned 6; Standard 10 5. Dresser: Only 2; Sanctioned 4 6. Other Staffs are also insufficient and not according to the norms of IPHS
Objectives	To equip health system with adequate manpower especially as per IPHS to meet the NRHM goals.
Strategies & Activities	1. Rational placement of Specialists and trained staff 2. Recruitment of staff on contract where vacancies 3. Approval of staff for new facilities including Urban facilities 4. Motivational measures to retain staff 5. Rs 10000 per month as hardcore allowances to all the doctors
Support required	1. The State must approve and give sanctions for the necessary personnel for each facility before actually starting the facilities. 2. Contractual staff should be allowed recruitment as and when required. Permission from State should not be taken each time.

	Total requirements	Current Status	Add. Req. - Contractual
Doctors	177	118	59
Specialist Doctors	40	0	40
ANM	914	353	561
Health worker Male	71	117	46
Laboratory Technician	18	1	17
Pharmacist / Dresser	27	14	13
Storekeeper	19	15	04
Grade A Nurse	157	39	118

Budget for Contractual Staff

Activity / Item	Unit Cost (per year) in lacs	2010-11	2010-11
Doctors	3.60 / yr	59	**212.40**
Doctors (Specialist)	4.8 / yr	40	**192.00**
ANM	1.20 / yr	561	**673.20**
Health worker Male	1.20 / yr	46	**55.20**
Laboratory Technician	1.20 / yr	17	**20.40**
Pharmacist / Dresser	0.96 / yr	13	**12.48**
Storekeeper	0.96 / yr	04	**03.84**
Grade A Nurse	1.5 / yr	118	**177.00**
		Total	**1346.52**

7.3. MATERNAL HEALTH

Situation Analysis/ Current Status

Indicator	No.			
No of Pregnant women	120256			
Maternal Deaths	2 As per C.S.O. report			
ANC registration	No. 62873		50%	
Full ANC coverage	DNA		15.3% (DLHS02)	
Full ANC coverage (3 ANC)	DNA			
Institutional Deliveries (In the last reporting year)	53586		82.2%	
Deliveries by skilled birth attendants	36842		84.5%	
Home deliveries (Total No.): 10576	Skilled		Unskilled	
	No.	%	No.	%
	6518	61.6	4058	38.4
No. of pregnancy related complications referred to FRU level	DNA			

Source: Data from C.S. Office Nov-09 Report

GAPs & ISSUES:

1. Mothers registered in the first trimester when they were pregnant with last live birth / still birth (%): 18.7*
2. Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%): 32.4*
3. Increase community awareness about need and benefits of ANC, Institutional delivery and PNC;
4. Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%): 69.7*
5. Institutional births (%): 24.9*
6. Delivery at home assisted by a doctor/nurse /LHV/ANM (%): 2.4*
7. Mothers who received post natal care within 48 hours of delivery of their last child (%): 9.5*

Objectives

1. 100% pregnant women to be given two doses of TT
2. 90% pregnant women to consume 100 IFA tablets by 2011
3. 70% Institutional deliveries by 2011
4. 90% deliveries by trained /Skilled Birth Attendant by 2011
5. 95% women to get improved Postnatal care by 2011
6. Increase safe abortion services from current level to 80 % by 2011

Strategies

1. Provision of quality Antenatal and Postpartum Care to pregnant women
2. Increase in Institutional deliveries
3. Quality services and free medicines to all the deliveries in the health facilities.
4. Availability of safe abortion services at all CHCs and PHCs
5. Increased coverage under Janani Bal Suraksha Yojna & Janani Suvidha Yojna.
6. Strengthening the Maternal, Child Health and Nutrition (MCHN) days
7. Improved behaviour practices in the community
8. Referral Transport
9. EmOC at PHCs
10. Organizing RCH Camps.

Activities

1. Increase availability of ANC services through reinforced network of frontline ANC service providers
2. Strengthen supervisory network to support network of frontline ANC service providers
3. Ensure delivery of ANC services through strengthening of health sub-centres, APHCs and PHCs

	4. Ensure timely and adequate supply of essential equipment and consumables with frontline ANC providers (ANMS and LHVs) and health facilities (HSCs, APHCs and PHCs) 5. Build capacity of frontline ANC service providers (ANMs and LHVs) 6. Form inter-sectoral collaboration to increase awareness, reach and utilization of ANC services 7. Promote institutional delivery through reinforced network of APHCs, PHCs/Referral Hospitals, Sub-divisional Hospitals and District Hospitals 8. Promote institutional delivery by involving private sector/NGO providers of EmOC in un-served and under-served areas 9. Ensure safe delivery at home 10. Revamp existing referral system for emergency deliveries 11. Form inter-sectoral collaboration to increase awareness regarding safe delivery and referral; 12. The specific strategies to achieve this objective have been discussed in the previous two objectives 13. Identification of all pregnancies through house-to-house visits by ANMs, AWWs and ASHAs 14. Fixed Maternal, Child Health and Nutrition days • Once a week ANC clinic by contract LMO at all PHCs and CHCs • Development of a microplan for ANMs in a participatory manner • Wide publicity regarding the MCHN day by AWWs and ASHAs and their services • A day before the MCHN day the AWW and the ASHA should visit the homes of the pregnant women needing services and motivate them to attend the MCHN day • Registration of all pregnancies • Each pregnant woman to have at least 3 ANCs, 2 TT injections and 100 IFA tablets • Nutrition and Health Education session with the mothers 15. Postnatal Care • The AWW along with ANM will use IMNCI protocols and visit neonates and mothers at least thrice in first week after delivery and in total 5 times within one month of delivery. They will use modified IMNCI charts to identify problems, counsel and refer if necessary 16. Provision of Weighing machines to all Sub centres and AWCs 17. Establishing Delivery Huts for all the Sub centres along with provision of additional ANMs in all these Delivery huts for 24 hour deliveries. 18. Availability of IFA tablets • ASHAs to be developed as depot holders for IFA tablets • ASHA to ensure that all pregnant women take 100 IFA tablets 19. Training of personnel for Safe motherhood and Emergency Obstetric Care (Details in Component on Capacity building) 20. Developing the CHCs and PHCs for quality services and IPHS standards (Details in Component Up gradation of CHCs & PHCs and IPHS Standards) a. Availability of Blood Bank at the District Hospital b. Certification of the Blood Storage Centres 21. Improving the services at the Sub centres (Details in Component on Up gradation of Sub centres and IPHS)

	22. Behaviour Change Communication (BCC) efforts for awareness and good practices in the community (Details in Component on IEC) 23. Increasing the Janani Suraksha Yojna coverage • Wide publicity of the scheme (Details in Component on BCC …) • Availability of advance funds with the ANMs • Timely payments to the beneficiary • Starting of Janani Bal Suraksha Yojana Helpline in each block through Rogi Kalyan Samitis • Increase in the No. of Private Health Providers in Urban Areas for JSY. 24. Training of TBAs focussing on their involvement in MCHN days, motivating clients for registration, ANC, institutional deliveries, safe deliveries, post natal care, care of the newborn & infant, prevention and cure of anaemia and family planning 25. Safe Abortion: • Provision of MTP kits and necessary equipment and consumables at all PHCs • Training of the MOs in MTP • Wide publicity regarding the MTP services and the dangers of unsafe abortions • Encourage private and NGO sectors to establish quality MTP services. • Promote use of medical abortion in public and private institutions: disseminate guidelines for use of RU-486 with Mesoprestol 26. Development of a proper referral system with referral cards and arrangement of referral facilities to the complicated deliveries at all PHCs.
State support	1. Ensuring availability of personnel especially specialists and Public Health Nurses for the 24 hour APHCs, PHCs and two ANMs at the sub centres 2. Ensuring availability of formats and funds with the ANM for JSY and timely payments 3. Certification of PHCs as MTP centres 4. The State should closely monitor the progress of all the activities

Budget	**Activity / Item**	**2010-11**
	Consultancy for support for developing Microplan for MCHN days	1,00,000/-
	Adult Weighing machines @ Rs 1200 per machine x 2980 AWCs & Maintenance	35,76,000/-
	40 Delivery Huts @ Rs 1,00,000 /hut	40,00,000/-
	Recurring cost of 40 Delivery Huts @ Rs 1,50,000 per year	60,00,000/-
	Blood Storage Unit @ Rs 5 lakhs per unit	10,00,000/-
	Referral Cards @ Rs 3 per card x 1,00,000	3,00,000/-
	MTP kits @ Rs 15000 Per kit at GH & PHCs/APHCs	10,00,000/-
	JBSY beneficiaries @ Rs 2000/person X 80000	16,00,00,000/-
	RCH Camps @ Rs 200000 per camp x 48	96,00,000/-
	Hiring of vehicle for referral at everyPHC/APHC @15000x48x 12month	86,40,000/-
	Total	**19,42,16,000/-**

Recurring Costs per Delivery Hut for one year

S.No	Head	Unit	Unit Cost	Amount
1.	O.C	1 year	50000	50000
2.	Material and supply	1 year	70000	60000
3.	Motor Vehicles	12 mths	2000	24000
4.	Honorarium for TBA	12 mths	500	6000
	Total			**1,50,000**

7.4. NEWBORN & CHILD HEALTH

Situation Analysis/ Current Status	**Breast Feeding** 1. Children breastfed within one hour of birth (%): 9.8* 2. Children (age 6 months above) exclusively breastfed (%): 6.9* 3. Children (6-24 months) who received solid or semisolid food and still being breastfed (%): 80.7* **Immunization:** 1. Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%): 30.2* 2. Children (12-23 months) who have received BCG (%): 76.2* 3. Children (12-23 months) who have received 3 doses of Polio Vaccine (%): 39.7* 4. Children (12-23 months) who have received 3 doses of DPT Vaccine (%): 45.3* 5. Children (12-23 months) who have received Measles Vaccine (%): 40.4* 6. Children (9-35 months) who have received at least one dose of Vitamin A (%): 27.3* 7. Children (above 21 months) who have received three doses of Vitamin A (%): 1.6* **Diarrhoea** 1. Children with Diarrhoea in the last two weeks who received ORS (%): 13.9* 2. Children with Diarrhoea in the last two weeks who were given treatment (%): 58.8 3. Children with acute respiratory infection/fever in the last two weeks who were given treatment (%): 62.1 4. Children had check-up within 24 hours after delivery (based on last live birth) (%): 9.9 5. Children had check-up within 10 days after delivery (based on last live birth) (%): 9.2 *DRLS
Objectives	1. Reduction in IMR 2. Increased proportion of women who are exclusively breastfed for 6 months to 100% 3. Increased in Complete Immunization to 100% 4. Increased use of ORS in diarrhoea to 100% 5. Increased in the Treatment of 100% cases of Pneumonia in children 6. Increase in the utilization of services to 100% 7. To strengthen school health services.
Strategies	1. Promote immediate and exclusive breastfeeding and complementary feeding for children 2. Improving feeding practices for the infants and children including breast feeding 3. Increase timely and quality immunisation service and provision of micronutrients for children in the age group of 0-12 months 4. Eradication of Poliomyelitis 5. Increase early detection and care services for sick neonates in select districts through the IMNCI strategy in select districts 6. Improve curative care services for children less than three years of age for minor ARI and diarrheal. 7. Promotion of health seeking behaviour for sick children 8. Community based management of Childhood illnesses 9. Improving newborn care at the household level and availability of Newborn services in all PHCs & hospitals 10. Enhancing the coverage of Immunization 11. Zero Polio cases and quality surveillance for Polio cases 12. Preparation of operational plan and guidelines for School Health. 13. Regular Monitoring and supervision.
Activities	1. Use mass media (particularly radio) to promote breastfeeding immediately after birth (colostrums feeding) and exclusively till 6 months of age. 2. Increase community awareness about correct breastfeeding practices through

	traditional media. 3. Improving feeding practices for the infants and children including breast feeding • Education of the families for provision of proper food and weaning • Educate the mothers on early and exclusive breast feeding and also giving Colostrums • Introduction of semi-solids and solids at 6 months age with frequent feeding • Administration of Micronutrients – Vitamin A as part of Routine immunization, IFA and Vitamin A to the children who are anaemic and malnourished • Growth Monitoring by ANM/AWW and Health Staff for early detection of Malnutrition. 4. Conduct fixed day and fixed-site immunisation sessions according to district micro plans. 5. Build capacity of immunisation service providers to ensure quality of immunization services 6. Form inter-sectoral collaboration to increase awareness, reach and utilization of immunisation services 7. Strengthen Supervision and monitoring of immunization services 8. Promotion of health seeking behaviour for sick children and Community based management of Childhood illnesses • Training of LHV, AWW and ANM on IMNCI including referral • BCC activities by ASHA, AWW and ANM regarding the use of ORS and increased intake of fluids and the type of food to be given • Availability of ORS through ORS depots with ASHA • Identification of the nearest referral centre and also Transport arrangements for emergencies with the PRIs and community leaders with display of the referral centre and relevant telephone numbers in a prominent place in the village 9. As per Intensified Pulse Polio Immunisation Campaign (IPPI) based on ongoing Supplementary Immunisation Activities (SIAs). 10. Build state IMNCI training pool • (Re)train health and ICDS staff in IMNCI protocols • Ensure implementation of IMNCI clinical work following training • Upgrade the capacity of PHC/FRUs to delivery quality paediatric services • Involvement of private facilities to accept emergency referrals for BPL children • Raise awareness about early recognition of childhood illnesses, home-based care and care-seeking 11. Improving newborn care at the household level a. Adaptation of the home based care package of services and scheduling of visits of all neonates by ASHA/AWW/ANM on the 1st, 2nd, 7th, 14th and 28th day of birth. b. In case of suspicion of sickness the ASHA /AWW must inform the ANM and the ANM must visit the Neonate c. Referral of the Neonate in case of any symptoms of infection, fever and hypothermia, dehydration, diarrhoea etc; d. Supply of medicine kit and diagnosis and treatment protocols (chart booklets) for implementation of the IMNCI strategy e. Strengthening the neonatal services and Child care services in District hospital, Sub-Divisional Hospitals and all PHCs : This will be done in phases

	f. In all of these units, newborn corners would be established and staff trained in management of sick newborns and immediate management of newborns. g. The equipment required for establishing a newborn corner would include Newborn Resuscitation trolley, Ambubag and masks (newborn sizes), Laryngoscopes, Phototherapy units, Room warmers, Inverters for power back-up, Centralized oxygen and Pedal suctions h. Training of staff in Newborn Care, IMNCI and IMCI (MOs, Nurses, ANM, AWW, ASHA) including the management of sick children and severely malnourished children. i. Availability of Paediatricians in all the General hospitals and Referral hospitals. j. Ensuring adequate and free supply of drugs for management of Childhood illnesses. 12. Strengthening the Fixed Maternal and Child health days • Developing a Microplan in joint consultation with AWW • Organize Mother and Child protection sessions twice a week to cover each village and hamlet at least once a month • Tracking of Left-outs and dropouts by ASHA, AWW and contacting them a day before the session • Information of the dropouts to be given by ANM to AWW and ASHA to ensure their attendance • Wide publicity regarding the MCHN days 13. Strengthening Immunization 14. School Health Programme • Preparation and dissemination of guidelines for School Health • Monthly visit by Deputy Civil Surgeon (School Health). • Coordination and convergence with education department. • Training to School Teachers on Health Activities.	
Support required	1. Availability of trained staff including Paediatricians 2. Technical Support for training of the personnel 3. Timely availability of vaccines, drugs and equipment 4. Good cooperation with the ICDS, Edu. Dept. and PRIs	
Budget	**Activity / Item**	**2010-11**
	Newborn Corner furnished with equipment @ Rs 5 lakh per facility	10,00,000/-
	Provision of Invertors @ 50000 x 48	24,00,000/-
	Examination table, chair, stool, table, other equipment @ Rs. 5000 x 3200 AWCs	1,60,00,000/-
	Infant Weighing Machines @ Rs. 1200/ AWCx 3200	38,40,000/-
	Referral cards @ Rs 4 x 100000	4,00,000/-
	Free availability of medicines	1,00,00,000/-
	Monitoring of School Health Activities @ 10000 pm x 12 months	1,20,000/-
	Training of Teachers @ 500 x 5000 teachers	25,00,000/-
	Supply of Medicines, glasses, hearing aids	50,00,000/-
	Total	**4,12,60,000/-**
	Training on IMNCI and IMCI of LHV/ASHA/AWW/ANM/MOs on the home based Care package and management at facilities	Component on training
	Supply of Diagnosis and treatment protocols (chart booklets) for IMNCI & IMCI strategy	
	Supply of medicine kit for IMNCI	State

7.5. FAMILY PLANNING

Situation Analysis/ Current Status

Indicators	No. or Rate
Eligible Couple	120256
Couple Protection Rate	62%
Female Sterilization operations in 2009 till Dec-09	4719
Vasectomies in 2009 till Dec-09	122
Couples using temporary method in 2009 till Dec-09	67485

The awareness regarding contraceptive methods is high except for the emergency contraception. This is because of inadequate IEC carried out for Emergency Contraception. .

- Current Use of Any method (%): 32.3*
- Any modern method (%): 27.8*
- Female sterilization (%): 26.3*
- Male sterilization (%): 0.2*
- IUD (%): 0.0*
- Pill (%): 0.6*
- Condom (%): 0.4*

In temporary methods commonest use is of Condom, which has a high failure rate. Use of Copper –T is low. The community prefers female sterilization since there is gender imbalance and limited male involvement. Women also do not have decision-making power.

- Total unmet need for Family Planning (%): 36.9*

The reasons for the low use of permanent methods and Copper -T are due to inadequate motivation of the clients, inadequate manpower, limited skills of the ANMs for IUD insertion and also their irregular availability. The rejection rate is high since proper screening is not done before prescribing any spacing method.
Copper T-380 – 10 year Copper T has been recently introduced but there is very little awareness regarding its availability. There is a need to promote this 10 yr Copper T
Some socio-cultural groups have low acceptance for Family Planning.
Promotion efforts for Vasectomy have been very infrequent and only 122 men have undergone Vasectomy.
The current number of trained providers for sterilization services is insufficient.

Objectives

1. Reduction in Total fertility Rate from 2.5 to 2.4
2. Increase in Contraceptive Prevalence Rate to 70 %
3. Decrease in the Unmet need for modern Family Planning methods to 0%
4. Increase in the awareness levels of Emergency Contraception from 60% to 80%

Strategies

1. Training of MOs in NSV & Female Sterilization.
2. Raise awareness and demand for Family Planning services among women, men and adolescents
3. Availability of all methods and equipments at all places
4. Increase access to and utilization of Family Planning services (spacing and terminal methods)
5. Increasing access to terminal methods of Family Planning
6. Promotion of NSV
7. Increased awareness for Emergency Contraception and 10 yr Copper T
8. Decreasing the Unmet Need for Family Planning

	9. Expanding the range of Providers 10. Increasing Access to Emergency Contraception and spacing methods through Social marketing & Training of ANMs for IUD Insertions. 11. IEC/BCC activities for Family Planning Methods.
Activities	1. Extensive campaign using multiple channels to raise awareness and demand for Family Planning 2. Broad inter-sectoral collaboration to promote small family norm, late marriage and childbearing 3. Promotion of Family Planning Services at community level through peer educators (satisfied acceptor 4. Each APHC and PHC will have one MO trained in any sterilization method. • All the PHC will have at least one MO posted who can be trained for abdominal Tubectomy. This method does not require a postgraduate degree or expensive equipment. • Similarly MOs will be trained for NSV • Specialists from District hospitals and CHCs will be trained in Laparoscopic Tubal Ligation. • At PHCs, one medical officer will be trained in NSV • Each PHC will be a static centre for the provision of sterilization services on regular basis. The Static centres will be developed as pleasant places, clean, good ambience with TV, music, good waiting space and clean beds and toilets. 5. Provide quality Family Planning Services through expanded network of health facilities and frontline health workers 6. Increase availability of contraceptives through Social Marketing and community-based distribution of contraceptives 7. Increase utilization of Family Planning services through provision of incentives to acceptors and private providers of FP services. **8.** About 4 -7 PHCs come under the catchments area of PHCs and the camps will be organized on fixed days in each of the PHCs. • Equipments and supplies will be provided at PHCs and PHCs for conducting sterilization services. • A systemic effort will be made to assess the needs of all facilities, including staff in position and their training needs, the availability of electricity and water, Operation theatre facilities for District hospitals/PHCs/APHCs, Inventory of equipment, consumables and waste disposal facilities and the condition, location and ownership of the building. • At least three functional Laparoscopes will be made available per team, as will the equipment and training necessary to provide IUD and emergency contraception services. The existing Laparoscopes need to be replaced. For effective coverage 4 teams are required with minimum three Laparoscopes for each team. **3.** Training in Spacing methods, Emergency Contraceptives and interpersonal communication for dissemination of information related to the contraceptives in an effective manner. • Supply of Emergency Contraceptives to all facilities • Access for the quality IUD insertion improved at all the 117 sub centres.

	• All the ANMs at 117 sub centres will be given a practical hands on training on insertion of IUD • IUD 380-A will be used due to its long retention period and can be used as an alternative for sterilization. **4.** IEC / BCC • Awareness on the various methods of contraception for making informed choices • Discussed in the Component on IEC • Increasing male involvement in family planning through use of condoms for safe sex and also in Vasectomy. • BCC activities to focus on men for Vasectomy. **5**. Inter Sectoral convergence • A detailed action plan will be produced in co-ordination with the ICDS department for involvement of the AWWs and their role in increasing access to contraceptive services. • Staff of ISM department will be trained in communication and non-clinical methods to promote and increase the availability of FP methods. • Engaging the private sector and provide incentives and training to encourage them to provide quality family planning services • Training private lady doctors in IUD insertion and promoting the provider will help to expand coverage of these services increase the total use of IUCD. • Training for the private sector will be provided as above, and approved, monitored providers will be promoted and eligible for discounted supplies. • Accreditation of private hospitals and clinics for sterilization and NSV • Creating an enabling environment for increasing acceptance of contraceptive services Innovative schemes will be developed for reaching out to younger men, women, newly married couples and resistant communities. **6.** Role of ASHAs: • Training for provide counselling and services for non-clinical FP methods such as pills, condoms and others. • Act as depot holders for the supplies of pills and condoms by the ANMs for free distribution • Procurement of pills and condoms from social marketing agencies and provide these contraceptives at the subsidized rate • Provide referral services for methods available at medical facilities Assist in community mobilization and sensitisation. **7.** Formation of District implementation team consisting of DC, CS, District MEIO, Distt NSV trainer • One day Workshop with elected representatives, Media, NGOs, departments for sensitisation and implementation strategy, fixing pre-camp, camp and post-camp responsibilities • Development of a Microplan in one day Block level workshops • NSV camp every quarter in all hospitals initially and then PHCs and APHCs • IEC for NSV • Trained personnel • Follow-up after NSV camp on fixed days after a week and after 3 months for Semen analysis

	• Access to non-clinical contraceptives increased in all the villages • AWWs and ASHAs as Depot holders
Support required	• Availability of a team of master trainers/ANM tutors and RFPTC trainers for follow up of trained LHVs and ANMs after one month and six months of training and provide supportive feedback to the service providers • A training cell will be created in the medical college for the training of the medical officers in the area of various sterilization methods • Availability of equipment, supplies and personnel

Timeline

	2010-11
Training of MOs for NSV	20 MOs
Training of MOs for Minilap	10 MOs
Training of Specialists for Laparoscopic Sterilization	6 MOs
Development of Static Centre at General hospital	Dist & Sub div
Sterilization Camps (Persons)	25000
NSV Camps	24
Accreditation of private institutions for sterilization	10
Supply of Copper T – 380	25000
Emergency Contraception	3000

Budget

Activity / Item	**2010-11**
NSV camps @ Rs. 250000 per camps x 12	3000000
Sterilization Camps @ 1000 & 650 for 25000 cases	24000000
Copper T-380 @ Rs 50 / piece x 25000	1250000
Emergency Contraception @ Rs10/2 tabs	15000
Development Static Centres @ Rs 2 lakh	400000
NSV Equipment @ Rs 10000 x 20	200000
Laparoscopes @ Rs 3.00 lakhs x 2	600000
IEC activities for NSV for per 2 camps	137200
Total	**29602200**

Detailed Calculations

Calculations per Case of NSV

S.No	Head	Unit Cost
	Payment of NSV per Case	**1500**

Requirements for organizing one Camp per month (60 cases/camp)

S.No	Head	Unit	Unit Cost	Amount
1.	District Workshop	1	10000	10000
2.	Block workshops	1	7000	7000
3.	IEC activities @ per 2 camps			140000
4.	TA to Acceptor for Semen Analysis	60	50	3000
5.	Payment to NSV Advocate/motivator, Drugs & Dressings	60	1500	90000
	Total			**250000**

Budget for IEC activities for NSV for per 2 camps

S.No	Head	Unit	Unit Cost	Amount
1.	Hand Bills	100000	0.25	25000
2.	NSV booklets	10000	2.5	25000
3.	Banners	250	60	15000
4.	Posters	10000	4	40000
5.	DA for Driver & 2 persons	36 Mandays	100	7200
6.	Electronic Media Publicity for 15 days			10000
7.	Wall writing & publicity			5000
8.	Other Innovative activities			10000
9.	**Total**			**137200**

Budget for Vasectomy sterilization per case

S.No	Head	Unit Cost (BPL)	Unit Cost (Non-BPL)
	Payment of Tubectomy Case	**1000**	**650**

Budget for sterilization camps benefiting 20000 cases

S.No	Head	Unit	Unit Cost	Amount
1.	Per Case BPL @ Rs 1000	20000	1000	20000000
2.	Per Case Non-BPL @ Rs 650	5000	650	3250000
3.	IEC activities			250000
4.	Other activities and Office Expenses			500000
	Total			**24000000**

7.6. Strengthening Immunization

Situation Analysis/ Current Status

Immunization:

1. Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%): 30.2*
2. Children (12-23 months) who have received BCG (%): 76.2*
3. Children (12-23 months) who have received 3 doses of Polio Vaccine (%): 39.7*
4. Children (12-23 months) who have received 3 doses of DPT Vaccine (%): 45.3*
5. Children (12-23 months) who have received Measles Vaccine (%): 40.4*
6. Children (9-35 months) who have received at least one dose of Vitamin A (%): 27.3*
7. Children (above 21 months) who have received three doses of Vitamin A (%): 1.6*

Objectives/ Milestones/ Benchmarks

Reduction in the IMR to 49
100 % Complete Immunization of children (12-23 month of age)
100 % BCG vaccination of children (12-23 month of age)
100% DPT 3 vaccination of children (12-23 month of age)
100% Polio 3 vaccination of children (12-23 month of age)
90% Measles vaccination of children (12-23 month of age)
100% Vitamin A vaccination of children (12-23 month of age)

Strategies

1. Strengthening the District Family Welfare Office
2. Enhancing the coverage of Immunization
3. Alternative Vaccine delivery
4. Effective Cold Chain Maintenance
5. Zero Polio cases and quality surveillance for Polio cases
6. Close Monitoring of the progress

Activities

1. Strengthening the District Family Welfare Office
   - Support for the mobility District Family Welfare Officer (@ Rs.3000 per month towards cost of POL) for supervision and monitoring of immunization services and MCHN Days
   - One computer assistant for the District Family Welfare Office will be provided for data compilation, analysis and reporting @ Rs 15000 per month.
2. Training for effective Immunization

   Training for all the health personnel will be given including ANMs, LHVs, MPWs, Cold chain handlers and statistical assistants for managing and analyzing data at the district.
3. Alternative vaccine delivery system (mobility support to PHCs for vaccine delivery)

   a. For Alternative vaccine delivery, Rs. 50 to the ANM will be given per session. It is proposed to hold one session per week per Sub centre.

   b. Mobility support (hiring of vehicle) is for vaccine delivery from PHC to MCHN days site where the immunization sessions are held for 8 days in a month
4. Incentive for Mobilization of children by Social Mobilizers
   - Rs.100 per month will be given to Social Mobilizers for each village for mobilization of children to the immunization session site. This money will be provided to ASHA wherever possible but if there is no ASHA then it will be given to someone nominated from the village by the PRIs.
6. Contingency fund for each block
   - Rs. 1000 / month per block will be given as contingency fund for communication.
7. Disposal of AD Syringes
   - For proper disposal of AD syringes after vaccination, hub cutters will be provided by Govt. of India to cut out the needles (hub) from the syringes. Plastic syringes will be separated out and will be treated as plastic waste. Regarding the disposal of needles, Pits will be formed at PHCs as per CPCB guidelines. For construction of the pits at

	PHCs a sum of Rs. 2000/ PHC has been provisioned. 8. Outbreak investigation • Rapid Action Team for epidemics will be formed • Dissemination of guidelines • Training of Rapid Action Team for investigating outbreaks who will in turn orient the ANMs during Sector meetings 9. Adverse effect following Immunization (AEFI) Surveillance: • Standard Guidelines have been developed at national level and will be disseminated to the district officials and block levels in Review meetings. 10. IEC & Social Mobilization Plans Discussed in details in the Component on IEC 11. Cold Chain • Repairs of the cold chain equipment (@ 750/- per PHC & CHC will be given each year • For minor repairs, Rs. 10,000 will be given per year. • Electricity & POL for Genset & preventive maintenance (Running Cost) of Walk in Coolers (WICs) & Walk in Refrigerators (WIF) () @ 15000/equipment per two months plus Rs. 1000 per machine for POL for Genset. • Payment of electricity bills for continuous maintenance of cold chain for the PHCs @ 300 per month PHCs (vaccine distribution centres) has been budgeted under this head. • POL & maintenance of vaccine delivery van • @ Rs. 3000/month for maintenance and POL for Vaccine delivery van for regular supply of vaccine to the PHCs.
Support required	State to ensure the following: • Regular supply of vaccines and **Autodestruct syringes** • Reporting and Monitoring formats • Monitoring charts • Cold Chain Modules and monitoring formats • Temperature record books • Polythene bags to keep vaccine vials inside vaccine carrier • Polythene for the vaccines to avoid labels being damaged • Training of Cold Chain handlers • Training of Mid level managers

Budget	**Activity**	**2010-11**
	Mobility support for alternative vaccine delivery Rs. 50 per session for 1 planned sessions per week at each Sub centre village for 12 months = Rs. 50x1 sessionsx4 weeks/mthx12 monthsx 369HSCs	8.86
	Vehicle for distribution of vaccines in remote areas @ Rs 800 per PHC for 1 times per week x 4 weeks x 12 months x 18 PHCs	6.91
	Mobility Support Mop up campaign @ Rs 10000 per PHC (Including travel, vaccine delivery, IEC) x 6 rounds/ year x PHCs	10.80
	Mobilization of Children by Social Mobilizers @ Rs. 200/ per month x 12monthx 6400 Mobilizers (ASHA + AWW + ANM)	153.77
	Contingency fund for each block @ Rs.1000/month x 18 blocks x 12 months	2.16
	Pit Formation for **disposal of AD Syringes** and broken vials (@ Rs. 2000 per pit per Sub centre and APHC (369 + 31)	8.00
	Printing of Immunisation cards @1.50 per card x 100000 cards each year	1.5

	Maintenance of Cold Chain Equipments (funds for major repair) (@ Rs.750 per PHC per month and Rs 10,000 annual for minor repairs	**2.28**
	POL & maintenance for Vaccine delivery van at district level @ Rs.15000/month x 12 mths	1.8
	Provision of Generator at PHC 18 x 15000/- x 12 months	31.40
	Honorarium of One computer assistant in DIO Office 15000/- x 12 months	1.80
	Total	**229.28**

7.7. ADOLESCENT HEALTH

Situation Analysis	Sex Ratio	901
	Percent total literate Population (Age 7 +)	53.4
	Percent literate Male Population (Age 7 +)	66.2
	Percent literate Female Population (Age 7 +)	41.3
	Percent girls (age 6-11) attending Schools	98.2
	Percent boys (age 6-11) attending Schools	98.8
	Percentage of girl's marrying before completing 18 years	57.8
	Percentage of Births of Order 3 and above	58.7
	Sex Ratio at birth	106
	Percentage of women age 20-24 reporting birth of order 2 & above	77.3
	Percentage of births to women during age 15-19 out of total births	96.1

Objectives

1. Improve sex ratio 901 -> 950
2. Increase the knowledge levels of Adolescents on RH and HIV/AIDS
3. Enhance the access of RH services to all the Adolescents
4. Improvement in the levels of Anaemia to 50% by 2012

Strategies

1. Raise awareness and knowledge among adolescents about Reproductive Health and Family Planning services with emphasis on late marriage and childbearing.
2. Improve micronutrient service for adolescents primarily to reduce anaemia.
3. Awareness amongst all the adolescents regarding Reproductive health and HIV/AIDS.
2. Provision of Adolescent Friendly Health & counselling services

Activities

The Adolescent Health package will consist of the following activities:

- Create conducive environment to promote adolescent health needs among health service providers and community at large.
- Targeted BCC campaign using multiple channels to raise awareness about safe reproductive health practices and Family Planning among adolescents.
- Partnerships with key stakeholders and major networks to promote safe reproductive health practices and Family Planning among adolescents.
- Provide RTI/STI curative services for adolescents through expanded network of health facilities and frontline health workers

	1. Targeted BCC campaign using multiple channels to promote good nutritional practices and micronutrients such as Iron Folic Acid and Iodine among adolescents. 2. Increase availability and distribution of micronutrient Workshop to develop an understanding regarding the Adolescent health and to finalize the operational Plan. 3. Supplements to adolescents at grassroots level primarily through health and education networks 4. Provision of Adolescent friendly health services at PHCs, CHCs, FRUs and district hospitals in a phased manner. Training of the MOs, ANMs on the needs of this group, vulnerabilities and how to make the services Adolescent friendly. 5. Adolescent Health Clinics will be conducted at least twice in a month by the MO to provide Clinical services**,** Nutrition advice, Detection and treatment of anaemia, Easy and confidential access to medical termination of pregnancy, Antenatal care and advice regarding child birth, RTIs/STIs detection and treatment, HIV detection and counselling, Treatment of psychosomatic problems, De-addiction and other health concerns 6. Awareness building amongst the PRIs, Women's groups, ASHA, AWWs 7. Provision of IFA tablets to all Adolescents, deworming every 6 months, Vitamin A administration and Inj. TT. 8. Carrying out the services at the fixed MCHN days. 9. Involvement of NGOs for Environment building. One NGO per Block will be selected. NGO will select the counsellor in the villages. 10. Involvement of ASHAs as counsellor and one Male & Female person of all the villages, and training of all the health personnel in the Sub centres, PHCs and CHC in the block 11. There will be equal number of Male and Female counsellors and will alternate between two PHCs – one week the male counsellor is in one PHC and the female counsellor in the other and they switch PHCs in the next week so that both the boys and girls benefit. 12. The counsellor will be • Facilitating group meetings • Organizing Counselling session once per week at the PHCs with wide publicity regarding the days of the sessions. • Collecting data and information regarding the problems of Adolescents 13. Close monitoring of the under 18 marriages, pregnancies, prevalence of RTI/STDs.	
Budget	**Activity**	**2010-11**
	Awareness generation @ Rs 2000 per village	40.0
	Workshop of all the partners	2.0
	Training a district pool of Master trainers	1
	Training of Councillors at every CHC/PHC/@ 10000/batch x 25	2.5
	Orientation & Reorientation Health personnel	0.25
	Counselling sessions @ Rs 1000/per month/per APHC/ PHC	3.0
	Counselling Clinics renovation, furnishing and Misc expenses @ Rs 10000 x all APHCs/PHCs	2.5
	Joint Evaluation by an agency & Govt	1
	Total	**52.25**

7.8. National Disease Control Programme

7.8.1. RNTCP

Situation Analysis/ Current Status	1. Lack of proper monitoring and supervision at TU and District Level 2. Proper counselling of patients by the DOTS provider and by the STS is not being done. 3. Schedule of Follow-up is not being maintained 4. Regular intake of drugs is not being ensured • Issues related to Ensure Quality of DOTS 1. Lack of dispensing medication properly as per technical guidelines in district. ANMs providing DOTS at HSCs do not visit Centre on DOTS day. 2. Regular intake of Drugs is not being conducted by DOTS providers 3. Delay in initiation of Treatment of NSP Patient within a weak 4. Follow-up sputum smear microscopy examination at the end of Intensive Phase and at the end of the treatment is not done in many cases. • Provide Quality DMC services 1. Microscopes of many DMCs are defective or dysfunctional 2. Proper space with electricity connection for keeping microscopes and proper water supply in the DMCs is not available 3. Poor maintenance of microscopes 4. Irregular supply of Lab consumables i.e., Slides, sputum containers and chemicals HR Issues 1. Lack of staffs i.e., Lab Technician(LT), STS, STLS, TBHV and other Staffs 2. Operational Issues: Lack of coordination between ASHA, AWW and ANMs.
Objectives	Increase Cure-rate*(56 %(DTO) to 85%) Increase Case-detection [29 %(DTO) to 70%]
Strategies	1. Detection of New cases 2. House to House visit for detection of any cases 3. IEC for awareness regarding the symptoms and effects of TB. 4. Prompt treatment to all cases 5. Rehabilitation of the disabled persons 6. Distribution of Medicine kit and rubber shoes 7. Honorarium to ASHA for giving DOTs
Activities	1. Effective monitoring and supervision to ensure the follow-up sputum smear examinations done according to guidelines 2. Ensure that every dose of medication is observed during the intensive phase of treatment and at least one dose per week in the continuation phase. 3. Ensure return of empty blister packs during weekly collection of drugs 4. Participation of ASHAs and AWWs for providing DOTS so as to reach services close to the patients for decrease default rate. 5. Ensure proper counselling of the patient by the health workers. 6. Organizing awareness campaign and community meetings to aware people about the TB and DOTS. 7. Sensitization of MOTCs/MOs at the Peripheral health facilities to ensure every TB suspect undergo Sputum Smear examination (at least 2% of Total New OPD patient) 8. Sensitization of all Lab Technician for Correct Sputum Smear Microscopy(5%-15% positivity is expected among patients examined for diagnosis) 9. Ensuring 3 sputum smear examinations for TB patients. 10. . . . Participation of ASHA and Community Volunteers to provide effective DOTS. 11. Incentive to ASHA and Volunteers for timely Sputum smear microscopy Collection and

	follow-up. 12. Initiation of treatment of New Smear Positive (NSP) patients within a weak of diagnosis. To control spared of infection in Group. 13. Proper Monitoring/Supervision to ensure regular and interrupted DOTS as per guidelines. 14. Proper counselling of patients by the DOTS provider and supervisory staffs. 15. Maintenance/ Replacement of defective Binocular microscopes. 16. Establishment of new DMC as per need and repairing/renovation of closed DMCs with proper electricity connection and water supply. 17. Refreshment training of Lab Staffs specially Lab Technician for maintenance of microscopes. 18. Ensure regular and adequate supply of laboratory consumables to DMCs from |District TB Centre(DTC) 19. Recruitment of Counsellor at PHC level 20. Active participation of community specially ASHA and AWW. 21. Capacity building of ASHA 22. Remuneration to ASHA/Community volunteer for providing DOTS will be paid timely. 23. New recruitment for lacks in staffs i.e., Lab Technician, STS, STLS, TBHV and other staffs.	
Support required	Availability of regular supply of drugs	
Timeline		
Budget	**Activity / Item**	**2010-11**
	Salary to Contractual Staff	
	Honorarium	
	IEC for information on the disease to be spread all over the rural outposts through posters and instructional booklets.	
	Training	
	Total	

7.8.2. LEPROSY

Situation Analysis/ Current Status

Balance Cases at beginning of year		New cases detected in year (April 08 to Nov 08)		Cases Discharged in year		Balance Cases at end of year		Per 10,000 Population		Proportion of Deformity Ratio among cases
PB	MB	PB	MB	RFT	O.D	PB	MB	PR	NCDR	
0	5	1	4	4	0	1	5	.66		1

The Nodal Officer for monitoring the Leprosy programme is the District TB Officer.

Objectives

Eradication of Leprosy

Strategies & Activities

8. Detection of New cases
9. House to House visit for detection of any cases
10. IEC for awareness regarding the symptoms and effects of Leprosy
11. Prompt treatment to all cases
12. Rehabilitation of the disabled persons
13. Distribution of Medicine kit and rubber shoes
14. Honorarium to ASHA for giving MDT

Support required

Availability of regular supply of drugs

Timeline

2010-11
House to house detection
Wide publicity
Rigorous follow-up

Budget

Activity / Item	**2010-11**
Salary to Contractual Staff	1.2
Honorarium	0.5
IEC for information on the disease to be spread all over the rural outposts through posters and instructional booklets.	1.00
Training	.5
Total	**3.2**

7.8.3. NATIONAL MALARIA CONTROL PROGRAMME

Situation Analysis / Current Status

Issues	No.	%
Total Blood Slides Examined (BSE)	112815	
Total Positive Cases: Plasmodium Vivax (Pv): Plasmodium Falciparum (Pf):	287	
Slide Positivity Rate (SPR)		.25
Annual Parasite Index (API)		0.30
Slide Positive plasmodium falciparum Rate (PFR)	DNA	
Deaths:	0	

In Bihar disease surveillance for Malaria was introduced during 1960-61 under National Malaria Eradication Programme.

Now the programme is known as National Vector Borne Disease Control programme. Under this District malaria Working Committee has been constituted and representatives from various departments are there but there is very little help from these departments.

The mosquito density of Aonpheles Culifacies was found mainly from May to October whereas Anopheles Aegepti and Anopheles Stephensai were found throughout the year with a peak from April to Nov.

The main bottlenecks are related to shortage of manpower especially for the remote areas. There are 22 posts of MPHS (LHV) and only 10 are in position. There are 29 posts of MPHS (M) and only 12 are in position.

Also there is lack of skills for taking blood slides, record keeping and there is lack of motivation.

Objectives

Reduction in SPR, API, PFR death rate

Strategies

1. Provision of additional Manpower
2. Training of personnel
3. Strengthening of Malaria clinics
4. Addressing Disease outbreak
5. Health education
6. Involvement of Private sector
7. Innovative methods of Mosquito control

Activities

1. Provision of additional Manpower
   - The posts of MPW Male and the MPHS need to be filled up
   - Hiring of personnel till regular staff in place
2. Training of personnel

   The MOs, Laboratory Technicians, MPHWs and MPHS, ANMs, ASHAs will be trained in various techniques relating to the job
3. Strengthening of Malaria clinics
   - Provision of Proper equipment and reagents – Fogging machines, sprayers,
   - Provision of Jeep, Truck,
4. Addressing Disease outbreak
   - District Outbreak teams will be created at the district headquarter
   - In the team MO, LT, one MPHW, one field worker
   - Provision of mobility, Lab equipments, spray equipment
5. Health education to the community through the ANMs, AWW, ASHAs, RMPs,

	Ayush personnel 6. Involvement of Private sector: The private practitioners will be closely involved **7.** Innovative methods of Mosquito control: Promotion of Gambusia fish needs to be done at every facility. The Civil Surgeon's office should have a hatchery and at each CHC level storage tank full of Gambusia, which can be easily distributed by any of the personnel.
Support required	• Availability of supplies • Filling up of vacancies • Supply of health Education material • Regular Supply of Gambusia fish

Timeline

Activity / Item	**2010-11**
Hiring Contractual Staff	x
Purchase of Jeep and Trucks	x
Fogging & Spraying	x
Hoardings	4 CHCs 1 GH 12 PHCs
Hatcheries for Gambusia Fish	3 CHCs & 1GH,
IEC activities	X

Budget

Activity / Item	**2010-11**
Salary Contractual staff	48.21
Travel expenses @ Rs 6000 per month x 12 months	0.72
Office expenses @ Rs 5000 per month x 12	0.60
Jeep and maintenance	6.00
Trucks – 3 and maintenance	24.00
4 small Fogging machines for each PHC @ Rs 1.00 lakh and one at District HQ Pulse Fog Machines @ Rs.8.00 lakh per unit and maintenance	31
Training	13.55
Misc @ Rs 1Lakh per GH and Rs 20000 per CHC, and for PHC Rs 10000	3.8
Board hoarding: ten 8'x 12' at 10 sites initially at the CHCs and General hospitals @ Rs 25,000 / -	2.5
Board hoarding: twenty 5'x3' at 120 sites initially at the PHCs@ Rs 10,000 / -	2
POL @ Rs 120,000 / - per vehicle jeep and truck for 12 months x 4	4.8
Hatchery in all CHCs for Gambusia fish @ Rs 1.00 lakh per CHC, General Hospitals and Civil surgeon's office Rs 50,000 for PHC	5
Total	**142.18**

Training

	Personnel	Unit Cost	Units	Amount
	DTO	State		
	MO	15580	50	779000
	LT	6000	2	12000
	MPH	1925	20	38500
	MPW	2875	48	138000
	ANM	2875	100	287500
	ASHA	500	200	100000
				1355000

Salaries of Contractual Staff

	Personnel	Unit Cost	Units	Months	Amount
1	MPHW Male	7000	21	12	1764000
2	MPHS Male	10000	18	12	2160000
3	Spray and Fogging staff	4000	4	12	192000
4	LT	6500	2	12	156000
5	Data Entry Operator	6000	1	12	72000
6	Accountant	1250	1	12	15000
7	Driver	4500	1	12	54000
	Total				**4821000**

7.8.4. KALA AZAR:	
Situation Analysis/ Current Status	1. Poor coverage of DDT spray; **2.** Poor condition of Sprayer, pump and nozzles etc; **3.** Less time spent on spraying DDT; **4.** Inadequate stock of DDT; **5.** Poor rate of case detection of Kalazar; **6.** Poor treatment facility in endemic areas **7.** Lack of monitoring and supervision mechanism; **8.** Lack of appropriate BCC & Community Mobilization. **9.** Faulty payment plan **10.** Poor Case detection & Cure rate
Objectives	To control Kalazar in all the blocks of the districts
Strategies & Activities	1. Identification of endemic areas (hot spots) of Kalaazar in the PHC areas and preparation of micro plan based on the findings. 2. To increase the coverage of DDT spray in the endemic zone, there should be proper monitoring by the supervisors, capacity building of the sprayer, supervisors and other healthcare professionals. Monitoring of the spraying squad by MOIC. 3. Regular checking of the spraying pumps for better functioning and timely replacement of the faulty pieces. 4. Adequate training module for capacity building of the sprayer to ensure that very corner of the house is properly sprayed & all the eatables are properly covered with plastics before spray. 5. Ensure adequate Stock of DDT through proper & timely indenting to improve the quality of spray. 6. Case detection rate should be increased with appropriate diagnostic test. RK 39 diagnostic kit to be made available at all PHCs and APHCs. 7. Cure rate can be increased by regular supply of drugs; 8. Appropriate fund allocation for the payment of the spraying of DDT. 9. Intensive BCC in the hot spot areas before the sprayings of DDT to mobilize community support around the program.
Support required	Ensured timely supply of DDT

Budget:

Salary Contractual staff	48.21
Travel expenses @ Rs 6000 per month x 12 months	0.72
Office expenses @ Rs 5000 per month x 12	0.60
Jeep and maintenance	6.00
Trucks – 3 and maintenance	24.00
4 small Fogging machines for each PHC @ Rs 1.00 lakh and one at District HQ Pulse Fog Machines @ Rs.8.00 lakh per unit and maintenance	31
Training	13.55
Misc @ Rs 1Lakh per GH and Rs 20000 per CHC, and for PHC Rs 10000	3.8
Board hoarding: ten 8'x 12' at 10 sites initially at the CHCs and General hospitals @ Rs 25,000/-	2.5
Board hoarding: twenty 5'x3' at 120 sites initially at the PHCs@ Rs 10,000/-	2
POL @ Rs 120,000/- per vehicle jeep and truck for 12 months x 4	4.8
BCC around Kalaazar	7
Procurement of power sprayers 10 pieces	2
Total	**146.18**

7.8.5. OTHER VECTOR BORNE DISEASES

Situation Analysis/ Current Status

Other VBDs	No.
Kalazaar	00
Dengue	00
Lymphatic Filariasis	00
Japanese Encephalitis	00
Others	

Objectives

Decrease in incidence of Dengue to nil
Prevention of JE, Chikingunya and other new infections

Strategies

1. Reduction of vector density
2. Mosquito-man contact reduction
3. Community awareness

Activities

1. Reduction of vector density
    - Identification of breeding sites
    - Fogging and spraying
    - Covering of any breeding sites
2. Mosquito-man contact reduction
    - Use of Insecticide coated mosquito nets
    - Promotion of the mosquito nets
3. Preparedness for new infections
    - Increase in Manpower
    - Training of personnel for identification of new infections
    - Preparation of Laboratories in the district and State to diagnose the new diseases
    - Preparedness of dealing with the epidemic outbreak
4. Community awareness as part of the IEC for Malaria and IDSP

- Group meetings
- Pamphlets/ handbills
- Public announcements

Support required

Support from State Laboratory and the NICD for diagnosing Dengue, Chikingunya, JE etc;
Support from District Administration, PRIs, WCD, PHEd,

Timeline

One jeep for Entomologist (already covered in malaria budget)
One truck for shifting manpower and drums/equipment (in malaria budget)

Budget

Activity / Item	**2010-11**
Budgeted in Malaria	
IEC and awareness to the people	1.0
Unforeseen expenses	0.5
	1.5

7.8.6. BLINDNESS CONTROL PROGRAMME

Situation Analysis/ Current Status

Indicators	No.
Total Cataract surgery performed	4202
Cataract surgery with IOL	4185
School going children screened	34660
Children detected with refractive error	5206
Children provided with free corrective spectacles	
Village having no Register	0

Eye Care is being provided through the Civil Hospital, There are 5 Ophthalmic Assistants in the district posted at BPHCs. General Hospitals and CHCs don't have Ophthalmologists. The norm for GOI is 1 eye surgeon for a population of one lakh. Hence in this district at least 9 Eye Surgeons are required. The norm for Ophthalmologist to Ophthalmic Assistant is 1: 3-4

Data is not available regarding this from Private sector.

The numbers of surgeries need to be at least triple to tackle the blindness due to Cataract.

There is no Eye Bank or Eye donation centre in District West Champaran. The nearest Eye Bank is at Patna.

Objectives

1. Reduction in the Prevalence Rate of blindness to 0.5 %
2. Decrease in the Prevalence Rate of Childhood blindness to 0.6 % per 1000 children by 2011
3. Usage of IOL in 95% of Cataract operations

Strategies

1. Provision of high quality Eye Care
2. Expansion of coverage
3. Reduce the backlog of blindness
4. Development of institutional capacity for eye care services

Activities

1. Determining the prevalence of Cataract through a study by an external agency.
    - One time house-to-house survey for study of prevalence of vision defects and Cataract of entire population leading to referrals and appropriate case management including cataract surgeries
2. Increasing the number of Ophthalmologists either by hiring or through involvement of Private Sector.
3. Training in IOL to Ophthalmologists
4. Training of Paramedical staff and Teachers, NGOs, Patwaris and AWW for screening of school children and IEC activities.
5. AMC for all equipment will be done.
6. Equipment
    - Repair of Synaptophore and Operating Microscope
    - Purchase of Ophthalmic Chair, Slit Lamp, Operating Microscope, Synaptophore, A Scan biometry, Keratometer, Direct and Indirect Ophthalmoscope
7. Construction of Eye Unit in Hospitals and later CHCs
8. Supply of basic Eye medicines like eye drops, eye ointments and consumables for Primary Eye Care in PHCs/CHCs.

	Eye Care centre	Vision Centre	Screening
	Eye Surgeon	Primary Eye Care	Identify Blind
	Treatment of eye conditions and follow-up	Vision Test	Maintain Blind Register
	Training	Screening Eye Camps	Motivator
	Supervision	Referral for surgery	Referral

9. All PHCs and CHCs to be developed for vision screening and basic eye care
10. Blind Register to be filled up by the AWW, together with PRIs
11. Eye Camps with the involvement of Private sector and NGOs
12. School Eye Screening sessions
13. IEC activities

Support required	Procurement of latest equipment for hospitals by GOI Timely Repair of equipment
Timeline	**2010-11** Health Mela Development of CHCs as Vision Centres Development of General Hospital as Eye Unit School Screening Cataract Camps

Budget	**Activity / Item**	**2010- 11**
	Health Mela	1.00
	IEC	0.50
	School Eye Screening	0.40
	Blind Register	0.70
	Observance of Eye Donations	0.15
	Cataract Camps @ Rs 50000 per camp x 10	5.00
	NGO and Eye Bank @ Rs 750 / IOL x 300, 30 cases for Corneal transplant	3.00
	POL for Eye Camps @ Rs 5000 / camp x10	0.50
	Survey of Factory workers / Roadways	0.10
	Training of School teachers @ Rs 100 / head x 200	0.20
	Training of PRIs @ Rs 100 / head x 200	0.20
	Repair and purchase of equipment and maintenance	12.00
	Total	**23.75**

7.8.7. Integrated Disease Surveillance Programme	
Situation Analysis/ Current Status	The **programs with major surveillance components** include: • The National Anti-Malaria Control Program • National Leprosy Elimination Program • Revised National Tuberculosis Control Program • Nutritional Surveillance • National AIDS Control Program • National Polio Surveillance Program as part of the Polio eradication initiative • National Programme for Control of Blindness (Sentinel Surveillance) Surveillance activities of all these vertical programs of Malaria, Tuberculosis, Polio, and HIV are functioning independently leading to duplication of Surveillance efforts. Surveillance has been ineffective due to ▪ There are a number of parallel systems existing under various programs which are not integrated. ▪ The existing programs do not cover non-communicable diseases. ▪ Medical colleges and large tertiary hospitals in the private sector are not under the reporting system as well as for utilization of laboratory facilities. ▪ The laboratory infrastructure and maintenance is very poor ▪ Presently, surveillance is sometimes reduced to routine data gathering with sporadic response systems thereby leading to slow response to Epidemics, ▪ Information technology has not been used fully for information and to analyze and sort data so as to predict epidemics based on trends of the reported data. In response to these issues the Integrated Disease Surveillance Programme was launched in Bihar in 2005 to provide essential data to monitor progress of on going disease control programs and help in optimizing the allocation of resources IDSP includes 15 diseases/ conditions (Malaria, Acute diarrhoeal disease-Cholera, Typhoid, Jaundice, Tuberculosis, Acute Respiratory Infection, Measles, Polio, Road Traffic Accidents, Plague, Yellow Fever, Meningoencephalitis /respiratory distress, etc., HIV, HCB, HCV)) and 5 state specific diseases (Thyroid diseases, Cutaneous Leishmaniosis, Acid Peptic Diseases, Rheumatic Heart Diseases). ▪ Establishing of District Surveillance unit ▪ Up gradation of 2 PSU Labs ▪ Water testing labs are in place ▪ V-Sat has been installed but training is required ▪ Rapid response teams have been established at District levels. ▪ DSUs (District Surveillance Units) has been established in all districts ▪ 1 Data entry operators and 1 Data Entry Manager have been appointed on contract. ▪ 1 Computer has been installed the software provided by GOI has not been received ▪ Regional Lab has been proposed fro specialized test
Objectives	1. Improving the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors. 2. Establishing a decentralized state based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the country at the state and national level. **3.** Improving the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over

	time and evaluate control strategies.	
Strategies	1. Strengthening data quality, analysis and links to action; 2. Improving the laboratories 3. Training of all the stakeholders in disease surveillance and action 4. Coordinating and decentralizing surveillance activities 5. Intersectoral Coordination and involvement of communities and the private sector	
Activities	1. Strengthening of the District Surveillance Unit (DSU), established under the project, • Training of the Unit Incharge for epidemiology – {DMO) • Hiring of Administrative Assistant • Training of contract staff on disease surveillance and data analysis and use of IT • Providing support for collection and transport of specimens to laboratory networks • Provision of computers and accessories • WEN connectivity to be operationalized • Provision of software of GOI 2. Setting up of Peripheral Surveillance Units at Bagha. 3. Sensitizing the Community for • Notifying the nearest health facility of a disease or health condition selected for community-based surveillance • Supporting health workers during case or outbreak investigations • Using feedback from health workers to take action, including health education and coordination of community participation. • Meetings with the SHGs, school teachers, Numberdar and Chowkidars for sensitisation and prompt reporting of cases 4. Improvement in the Laboratories at the district and at PHCs through provision of equipment and consumables	
Support required	Timely trainings for the Nodal persons Government Order for involvement of teachers in Disease Surveillance	
Budget	**Activity / Item**	**2010-11**
	Renovation of Labs at 3 PHCs and general hospitals@ Rs 25,000	1
	Renovation of Lab at District @ Rs 150,000 and maintenance	1.50
	Equipment for Lab at PSU at PHC and general hospitals @ Rs 50,000	2.5
	Equipment for Lab at District @ Rs 5,00,000	5
	Computer and Accessories at PHC and general hospitals @500000	0
	Computer and Accessories at DSU @ 630000	6.30
	Office Equipment for PSU at CHC and general hospitals @ Rs 10,000 per unit	0.5
	Office Equipment for DSU @ Rs 10,000	0.10
	Software for DSU@ Rs 350000	3.5
	Furnishing of Lab at PSU at CHCs and general hospitals @ Rs 10,000	0.5
	Furnishing of Lab at DSU @ Rs 60,000	0.60
	Material and supplies at Lab at PSU at CHCs and general hospitals @ Rs 10,000	0.5
	Material and supplies at Lab at DSU @ Rs 75,000	0.75
	Contract Staff at District level @ 200000 / yr for 4 staff	2.00
	IEC activities	1.00
	Training and retraining	1.86
	WEN connectivity	0.50

	Operational costs at PSU for Surveillance @ Rs 15000 / year x 5	0.75
	Operational costs at DSU for Surveillance @ Rs 130000 / year	1.30
	Total	**30.16**

Detailed Budget for Trainings

Personnel	**Unit Cost**	**Units**	**Amount**
MPW	900	70	63000
Lab Assistant at CHCs and Hosp	1000	6	6000
Lab Assistant at Distt	3500	2	7000
MOs	2000	40	80000
DST 4 members	7500	4	30000
		Total	**186000**

7.8.8. Iodine Deficiency Disorders

Situation Analysis/ Current Status

Iodine is one of the essential micronutrients. Minimum requirement is 150 microgram per day. The main source of Iodine is from soil and water. Iodine is taken from food grown in iodine rich soil. At present there is a depletion of Iodine in the soil due to which there is a deficiency of Iodine. Deficiency result in a variety of disorders ranging from Abortion, stillbirths, Goitre, impaired mental function, retarded growth.

In Haryana the National Iodine Deficiency Programme is being implemented since 1986. There is a ban on the sale on non Iodized salt in Haryana.

In district West Champaran no case of Iodine deficiency disorders has been identified**.**

Objectives

Prevention of Iodine Deficiency diseases

Consumption of Iodized salt by 100% families

Strategies

1. Supply / monitor quality of Iodized salt
2. Assessment of the magnitude of the problem
3. Laboratory Monitoring of Iodized salt and urine samples

Health Education

Activities

1. Supply / monitor quality of Iodized salt
   - Monitoring is done through Food Inspectors who collect two samples of salt per month per district and send it to a laboratory.
   - The Health workers have been supplied with Kits to test samples at least five per month.
   - Review is done in the monthly meetings
   - Monitoring through School health programme – Testing of samples and awareness
   - Supply of Testing kits to AWCs, Schools, SHGs
2. Assessment of the magnitude of the problem & done by the Central Survey team
3. Laboratory Monitoring of Iodized salt and urine samples

   The samples are collected by MPHW and sent for analysis.
4. Health Education: An IEC strategy is essential to promote the consumption of Iodized salt through AWWs, PRIs, NGOs, ASHA, SHGs etc; Demonstration of Iodized salt by school children through testing, Rallies, sensitisation of shopkeepers.
5. Testing of salt at shops and homes

Support required

1. Regular Supply of Testing Kits
2. Regular Supply of Iodized salt

Regular supply of IEC material

Timeline

2010-11

- Widespread awareness regarding the consumption of Iodized salt
- Testing of Salt samples in each AWC by AWW, ANM, ASHA
- Awareness in schools and SHGs
- Testing and strict enforcement of Iodized salt in all the village shops

Budget

Activity / Item	**2010-11**
Large Village meetings for awareness on IDD and consumption of Iodized salt	2.00
Programme in schools – 1689 Primary, Upper Primary, Secondary- Govt and Private by School health team	6.00
Awareness programme with the SHGs and shopkeepers @ Rs 500 per village x 2220 villages	11.10
Total	**19.10**

7.9. Gender and Equity

Situation Analysis / Current Status

2007-08

Sex Ratio : 901*

Background Characteristics	DLHS - 3		DLHS - 2	
	Total	**Rural**	**Total**	**Rural**
Percent total literate Population (Age 7 +)	53.4	50.4	-	-
Percent literate Male Population (Age 7 +)	66.2	63.7	-	-
Percent literate Female Population (Age 7 +)	41.3	37.7	-	-
Percent girls (age 6-11) attending Schools	98.2	98.0	-	-
Percent boys (age 6-11) attending Schools	98.8	99.0	-	-

	DLHS - 3		DLHS - 2	
	Total	**Rural**	**Total**	**Rural**
Marriage and Fertility, (Jan 2004 to 2007-08)				
Percentage of girl's marrying before completing 18 years	57.8	58.7	62.9	66.5
Percentage of Births of Order 3 and above	58.7	59.5	57.5	58.6
Sex Ratio at birth	106	110	-	-
Percentage of women age 20-24 reporting birth of order 2 & above	77.3	78.0	-	-
Percentage of births to women during age 15-19 out of total births	96.1	96.4	-	-

Objectives

1. Empowering women
2. Increasing male involvement in RCH activities
3. Addressing adverse Sex Ratio
4. Sensitizing the personnel on issues of Gender
5. Implementation of PNDT Act 1995.

Strategies & Activities

1. Addressing Adverse Sex ratio
   - Workshops with private providers, IMA members, Religious leaders, Caste leaders, PRIs, MLAs
   - Early registration of pregnancies through TBAs, ASHAs, AWWs, Numberdar and Chowkidar and any of these to get Rs 50 per case for early registration of pregnancy
   - Rallies in all schools and colleges and generating discussions in schools and colleges through debates
   - Regular advertisements in the newspapers
   - Swearing-in-ceremonies at the time of marriages regarding female foeticide
   - Regular meetings of the Appropriate Authorities
   - Registration of all Ultrasonography machines
   - Review of the monthly format to be filled by the Ultrasonography machines providers
2. Increasing male involvement in family planning
   - Use of condoms for safe sex
   - Vasectomy and NSV are safer and easier to perform in primary health centres than Tubectomy.
   - BCC activities to focus on men for Vasectomy.

	Service delivery sites for male methods by training health providers in NSV and conventional vasectomy will be expanded so that each CHC and Block PHC in the district has at least a provider trained in NSV. • Demand for male contraceptive methods, men's reproductive health services through designing and implementing male-focused BCC activities. 3. A Research Study on the effect on bachelors in District West Champaran due to the shortage of girls and also the ill effects in Society. 4. Gender sensitization training will be provided for all health providers in the APHC/PHC and integrated into all other training activities so that they will have greater awareness of factors that influence women's decision making and thereby help them respond better to the needs of women and support her in exercising her choice. 5. Increasing the age of marriage • IEC activities for the harmful effects of early marriage • Registration of marriages • All the printing press people who print wedding cards should send one card to the Civil Surgeon's office 6. Health card would be provided to all girl children up to the age of 18 years. 7. Improving the Literacy status and promotion of education up to 10th standard. The Panchayats shall be granted incentives for ensuring 100 percent enrolments of girls in the age group of 6-14 years in schools. 8. Treatment of anaemia in girls and also improving their nutritional status through Supplementary food at the AWCs 9. Reporting of Gender Based Violence cases by all the departments 10. Promotion of Samoohic Vivahs 11. Affidavit in court should be given regarding the dowry given to prevent false cases. 12. Implementation of PNDT Act in the District by proper and routine check up of Ultrasound Clinics in the district.
Support required	Strict enforcement of the PCPNDT Act Support from other departments as mentioned under intersectoral convergence

udget	**Activity / Item**	**2010-11**
	Workshops with private providers, IMA members, Religious leaders, Caste leaders, PRIs, MLAs in every block and Gram Panchayat and with SHGs	2.00
	Incentive for Early registration of pregnancies @ Rs 50 per case x 20000 pregnancies	10.00
	Rallies in all schools and colleges and generating discussions in schools and colleges through debates	2.00
	Regular advertisements in the newspapers	1.20
	Health Card for Girl Child @ Rs 2 /card x 10,000 cards	0.20
	Price for the panchyats for three best sex ratio in the district @ 100000, @ 50000 & @ 20000	1.7
	Price for the panchayat where the girls age group 6-14 years 100% enrolment in the schools @ 20000	1.0
	Monitoring and meetings of advisory committee	1.0
	Computer and other asseverates	.50
	Total	**19.6**

7.10. Demand Generation, IEC/BCC	
Status	There is lack of awareness and good practices amongst the community due to which they neither avail the services nor take any positive action. There is lack of awareness regarding the services, schemes including the Fixed Health days. The following issues need special focus: • Spacing methods, ideal interval between births, no scalpel vasectomy, information about FP facilities and MTP facilities available at different levels • Importance of 3 visits for ANC, advantages of institutional delivery, Post natal care, availability of skilled birth attendants, balanced diet during pregnancy, anaemia, misgivings about IFA, kitchen garden • Importance of complete immunization, disadvantages of drop outs, nutritional requirements of infants and children, malnutrition, exclusive breastfeeding • Problems of adolescents, drugs addiction, malnutrition, problems of sexuality, age at marriage, tendency to take risks in sexual matters • DOTS programme for TB, location of microscopy centres, cardinal symptoms of TB, • High risk behaviour in the community in relation to water born diseases, heart diseases and lung diseases, and HIV / AIDS, STDs • Evil of drugs addiction affecting adolescents, • High prevalence of RTIs, including STDs, • Issues of malaria spread and prevention and also other diseases • JSY, Fixed Health days , availability of services The personnel have had no training on Interpersonal communication.
Objective	Widespread awareness regarding the good health practices Knowledge on the schemes, Availability of services
Strategy	1. Information Dissemination through various media, 2. Interpersonal Communication 3. Promoting Behaviour change
Activity	1. Awareness on • Fixed MCHN days • JSY • Services available 2. Designing of BCC messages on exclusive breast feeding and complimentary feeding, ANC, Delivery by SBA, timely referral, PNC, FP, Care of the Newborn, Gender, hygiene, sanitation, use of toilets, male involvement in the local language 3. Consistent and appropriate messages on electronic media – TV, radio 4. Use of the Folk media, Advertisements, hoardings on highways and at prominent sites 5. Training of ASHA / AWW / ANM on Interpersonal communication and Counselling on various issues related to maternal and Child health 6. Display of the referral centres and relevant telephone numbers in a prominent place in the village 7. Promoting inter-personal communication by health and nutrition functionaries during the Fixed health & Nutrition days 8. Orientation and training of all frontline government functionaries and elected representatives 9. Integration of these messages within the school curriculum 10. Kit for the newly married and during first pregnancy to be given at the time of marriage and during pregnancy

	11. Mothers meeting to be held in each village every month to address the above mentioned issues and for community action 12. Kishore Kishori groups to be formed in each village and issues relevant to be addressed in the meetings every month 13. Meetings of adult males to be held in each village to discuss issues related to males in each village every month and for community action. 14. Village Contact Drives with the whole staff remaining at the village and providing services, drugs , one to one counselling and talks with the Village Health & Water Sanitation Committee and the Mother's groups 15. Developing Nirdeshika for holding Fixed Health & Nutrition days to be distributed to all MOs, ANMs, AWWS, LS, PRIs, 16. Monthly Swasthya Darpan describing all the forthcoming activities and also what happened in the month along with achievements 17. Bal Nutrition Melas 4 times at each Sub centre 18. Wall writings 19. Pamphlets for various issues packed in an envelope 20.	
State Support	State to give guidelines for the good practices and also training module on BCC	
Budget	**Activities**	**2010-11**
	Finalizing the messages	0.50
	Advertisements	2.0
	TV spots	1.0
	Folk Media shows @ Rs 1000 / village	3.76
	Hoardings @ Rs 10000 / hoarding x 100 hoardings	10.0
	Display boards @ Rs 2000 / board x 160 Display boards	1.8
	Pamphlets @ Rs 5 / pamphlets x 100000 pamphlets	5.0
	Nirdeshika for Fixed Health Nutrition days @ Rs 20 / Nirdeshika	0.8
	Swasthya Darpan @ Rs.20 / copy / month	4.8
	Bal Nutrition Melas @ Rs 300 x 4 times x No of SCs	1.41
	Opinion leaders workshops @ Rs 300 / person x 100	1.2
	Wall writings @ Rs 500 x 376 villages	1.88
	Total	**34.15**

7.11. Program Management

Situation Analysis/ Current Status	The District Health Society have formed been registered in West Champaran. The Society is reconstructed and with these following members and the Deputy Commissioner as the Governing board President. The members are all the Programme Officers, Education, SDM, IMA president, ICDS, PWD. The Governing body meetings are held monthly under the chairmanship of the Deputy Commissioner. Although the DHS formed and meetings conducted regularly but still they are not focused on health issues and need proper training on planning and management.	
Objectives / Milestones/ Benchmarks	District Health Society to make functional and empower to plan, implement and monitor the progress of the health status and services in the district.	
Strategies	1. Capacity building of the members of the District Health Society regarding the programme, their role, various schemes and mechanisms for monitoring and regular reviews. 2. Establishing Monitoring mechanisms 3. Regular meetings of Society.	
Activities	1. Orientation Workshop of the members of the District Health Society on strategic management, financial management & GOI / GOB Guidelines. 2. Monthly Review and planning meetings. 3. Improving the Review and planning meetings through a holistic review of all the programmes under NRHM and proper planning. 4. Formation of a monitoring Committee from all departments. 5. Development of a Checklist for the Monitoring Committee. 6. Arrangements for travel of the Monitoring Committee 7. Sharing of the findings of the committee during the Field visits in each Review Meeting with follow-up of the recommendations.	
Support required	1. Technical and financial assistance needs to be imparted for orientation and integration of societies. 2. A GO should be taken out that at the district level each department should monitor the meetings closely and ensure follow-up of the recommendations. 3. Instructions & directions from GOB for proper functioning of the societies and monitoring committee. 4. Funds to maintain society office & staff.	
Budget **In Lakhs**	**Activity / Item**	**2010-11**
	Orientation Workshop	0.5
	Monthly Meetings	0.12
	Mobility for Monitoring	0.50
	Total	**1.12**

District Programme Management Unit	
Status	In NRHM a large number of activities have been introduced with very definite outcomes. The cornerstone for smooth and successful implementation of NRHM depends on the management capacity of District Programme officials. The officials in the districts looking after various programmes are overworked and there is immense pressure on the personnel. There is also lack of capacities for planning, implementing and monitoring. The decisions are too centralized and there is little delegation of powers. In order to strengthen the district PMU, three skilled personnel i.e. Programme Manager, Accounts Manager and M&E Officer have being provided in each district. These personnel are there for providing the basic support for programme implementation and monitoring at district level under DHS. The District Programme Manager is responsible for all programmes and projects in district under the umbrella of NRHM and the District Accounts Manager (DAM) is responsible for the finance and accounting function of District RCH Society including grants received from the state society and donors, disbursement of funds to the implementing agencies, preparation of submission of monthly/ quarterly/ annual SOE, ensuring adherence to laid down accounting standards, ensure timely submission of UCs, periodic internal audit and conduct of external audit and implementation of computerised FMS. The District Nodel Monitoring and Evaluation Officer (M&E Officer) has to work in close consultation with district officials, facilitate working of District RCH Society, maintain records, create and maintain district resource database for the health sector, inventory management, procurement and logistics, planning and monitoring & evaluation, HMIS, data collection and reporting at district level. There is a need for providing more support to the Civil Surgeon office for better implementation especially in light of the increased volume of work in NRHM, monitoring and reporting especially in the areas of Maternal and Child Health, Civil works, Behaviour change and accounting right from the level of the Sub centre. The Civil surgeon's office is located in the premises of the only General hospital in the district. The office of all the Deputy Civil Surgeons is also in hospital premises.
Objectives	Strengthened District Programme Management Unit
Strategies	1. Support to the Civil Surgeon for proper implementation of NRHM. 2. Capacity building of the personnel 3. Development of total clarity at the district and the block levels amongst all the district officials and Consultants about all activities 4. Provision of infrastructure for the personnel 5. Training of District Officials and MOs for management 6. Use of management principles for implementation of District NRHM 7. Streamlining Financial management 8. Strengthening the Civil Surgeon's office 9. Strengthening the Block Management Units 10. Convergence of various sectors

Activities	1. **Support to the Civil Surgeon** for proper implementation of NRHM through proper involvement of DPMU and more consultants for support to civil surgeon for data analysis, trends, timely reports and preparation of documents for the day-to-day implementation of the district plans so that the Civil Surgeon and the other district officers: • Finalizing the TOR and the selection process • Selection of consultants, one each for Maternal Health, Civil Works, Child health, Behaviour change. If properly qualified and experienced persons are not available then District Facilitators to be hired which may be retired persons. **2. Capacity building of the personnel** • Joint Orientation of the District Officers and the consultants • Induction training of the DPM and consultants • Training on Management of NRHM for all the officials • Review meetings of the District Management Unit to be used for orientation of the consultants 3. **Development of total clarity in the Orientation workshops** and review meetings at the district and the block levels amongst all the district officials and Consultants about the following set of activities: • Disease Control • Disease Surveillance • Maternal & Child Health • Accounts and Finance Management • Human Resources & Training • Procurement, Stores & Logistics • Administration & Planning • Access to Technical Support • Monitoring & MIS • Referral, Transport and Communication Systems • Infrastructure Development and Maintenance Division • Gender, IEC & Community Mobilization including the cultural background of the Meos • Block Resource Group • Block Level Health Mission • Coordination with Community Organizations, PRIs Quality of Care systems 4. **Provision of infrastructure for officers**, DPM, DAM, M&E Officer and the consultant of the District Project Management Unit. 5. Provision of office space with furniture and computer facilities, photocopy machine, printer, Mobile phones, digital camera, fax, etc;

	6. Use of Management principles for implementation of District NRHM 1. Development of a detailed Operational manual for implementation of the NRHM activities in the first month of approval of the District Action Plan including the responsibilities, review mechanisms, monitoring, reporting and the time frame. This will be developed in participatory consultative workshops at the district level and block levels. 2. Financial management training of the officials and the Accounts persons 3. Provision of Rs. 500000 as Untied funds at the district level under the jurisdiction of the Civil Surgeon 7. **Strengthening the Block Management Unit**: The Block Management units need to be established and strengthened through the provision of : • Block Programme Managers (BPM), Block Accounts Managers (BAM) and Data Operators (DO) for each block. These will be hired on contract. For the post of BPM and the BAM retired persons may also be considered. • Office setup will be given to these persons • Accountants on contract for each PHC since under NRHM Sub centres have received Rs 10,000 also the village committees will get Rs 10,000 each, besides the funds for the PHCs. • Provision of Computer system, printer, Digital Camera with date and time, furniture **8. Convergence of various sectors at district level** • Provision of Convergence fund for workshops, meetings, joint outreach and monitoring with each Civil Surgeon 9. **Monitoring the Physical and Financial progress** by the officials as well as independent agencies 10. **Yearly Auditing** of accounts
Support from state	1. State should ensure delegation of powers and effective decentralization. 2. State to provide support in training for the officials and consultants. 3. State level review of the DPMU on a regular basis. 4. Development of clear-cut guidelines for the roles of the DPMs, DAM and District Nodal M&E Officer. 5. Developing the capacities of the Civil Surgeons and other district officials to utilize the capacities of the DPM, DAM and M&E Officer fully. 6. Each of the state officers Incharge of each of the programmes should develop total clarity by attending the Orientation workshops and review meetings at the district and the block levels for all activities. 7. If qualified persons for the posts of DPM, DAM are not available then State should allow the appointment of facilitators or Coordinators or retired qualified persons by the District Health Society.
Time Frame	2010-11 • Selection of District level consultants, their capacity building and infrastructure • Development of an operational Manual 2010-11 • Selection of Block Management Units and provision of adequate infrastructure and office automation • Capacity building up of District and Block level Management Units • Training of personnel

	• Reorientation of personnel

Budget in Lakhs

Activity	**Year 2009-10**
Honorarium DPM,DAM, M&E Officer and Consultants	31,80,000/-
Travel Costs for DPMU @ Rs 10,000/ per month x 12 mths	1,20,000/-
Infrastructure costs, Furniture, computer systems, fax, UPS, Printer, Digital Camera	10,00,000/-
Workshops for development of the operational Manual at district and Block levels	1,00,000/-
Untied Fund	5,00,000/-
Joint Orientation of Officials and DPM, DAM, M&E Officer	1,00,000/-
Management training workshop of Officials at SHS / PHRN Patna @ 10,000/- X (18 BHM + 18 BA)	3,60,000/-
Personnel for BPMU	1,72,80,000/-
Training of DPM and Consultants	50,000/-
Review meetings @ Rs 1000/ per month x 12 months	1,20,000/-
Office Expenses @ Rs 10,000/month x 12 months for district	1,20,000/-
Annual Maintenance Contract for the equipment	50,000/-
Travel costs for BPMU @ Rs 5000 per month per block	10,80,000/-
Monitoring of the progress by independent agencies	1,00,000/-
Hiring of vehicles at block level @ Rs 800x 5 days /mth x 18 PHCs x 12 mths	8,64,000/-
Office expenses for Blocks @ Rs 5000 x 18 blocks x 12	10,80,000/-
Total	**2,61,04,000/-**

Detailed calculation of Budget for Personnel at DPMU for one year

S.No	Details	Units	Unit Cost	Amount for 12 months
	Personnel at District level			
	District Programme manager	1	50000	600000
	District Accounts Manager	1	45000	540000
	District Data Assistant	1	45000	540000
	Consultant for Maternal Health	1	25000	300000
	Consultant for Child Health	1	25000	300000
	Consultant for Civil Works	1	25000	300000
	Consultant for HMIS	1	25000	300000
	Consultant for Behaviour Change	1	25000	300000
	Sub Total			**3180000**
	Personnel at Block level			
	Block Programme manager	18	25000	5400000
	Block Accounts Manager	18	20000	4320000
	Block ASHA Coordinator	18	20000	4320000
	Data Operator	18	15000	3240000
	Subtotal			**17280000**
	Hiring of vehicles at block level @ Rs 800x 5 Days x 18 blocks x12 months	18	4000	**864000**
	Office Automation with Furniture, Computer system, Camera, Printer, etc	18 for BPMU 1 for DPM 1 for DAM	50000	**1000000**

7.12. CAPACITY BUILDING

Trainings	
Status	Training is an essential part of human development. Although the personnel have the basic skills necessary for carrying out their duties there is a need to upgrade the skills as well as to keep pace with the new developments under NRHM. There is a skill gap for managing safe deliveries, Abortions, Newborn Care, managing Childhood illnesses, Obstetric and Paediatric emergencies, morbidity and epidemics. There is no system for continuing education of the personnel. The management skills are also lacking resulting in poor management of programmes including financial management. Most of the personnel are unable to use computers and internet. The trainings are carried out by the SIHFW along with the Regional training centres and the district training centres. There is a shortage of staff and also rapid turnover. The specialists leave very rapidly since the payment to the specialists is very low as compared to Delhi and Punjab. The staffs who have received trainings are not placed in the facilities where they can utilize their skills. The monitoring of the trainings is not done hence the quality of trainings is in question. Also there is no monitoring of the work output of the personnel for which they have received the trainings. 2177 ASHAs have been trained. Some of the skill birth attendants are already trained and rest are required training in plan period
Objective	Reduction in the MMR and IMR Fully skilled personnel at all levels in the Health sector, ICDS, PRIs, NGOs and private sector for provision of services
Strategy	1. Development of training plan and methodology for all the personnel on various issues of RCH to reduce the Maternal and Neonatal mortality, meeting the unmet needs, building Gender perspective, good programme management and managing various components of NRHM 2. Ensuring the quality of trainings
Activity	**1. Capacity building for the reduction in Maternal and Neonatal mortality** • TBA training for 15 days in the concept of clean deliveries, danger signs, early referral, Newborn care and family planning, communication, • MTP training on MVA to all PHC MOs for 15 days. In 2010-11, 10 Lady MOs will be trained. Refresher trainings on MVA to be given • Training in Obstetric management & skills for operationalization of 24x7 PHCs for 16 weeks • Training in skilled Birth attendants (ANM for 21 days & LHV, SN for 14 days) • IMNCI training to ANM/LHV, SN, MO, CDPO for 8 days in the area covering the 24 x 7 PHCs • Integrated skill training for Urban Medical Officers for 12 days at MJK Medical College • Training on Blood transfusion for MOs and Lab Technicians for CEmOC centres with Blood storage facilities for 3 days • Training in Life saving / Anaesthesia for EmOC at FRUs for MOs for 18 weeks • Integrated skill training of all SN

	• Integrated skill training for ANMs • Training of ASHAs • Training in management of newborns and sick children at Medical College of the MOs, SN, • Training in BCC for MOs, LHVs, ANMs • Training of Ayush personnel on issues of RCH and reporting for 3 days **2. Capacity building to meet the unmet needs** • Training on NSV for MOs for 5 days • Training for Laparoscopic Sterilization for Surgeons, Gynaecologists, SN, OT attendants for 12 days • Skill up gradation of ANMs & LHVs for 5 days • Orientation on contraceptive devices for MOs of Govt facilities as well as private facilities **3. Training on Medico-legal aspects** **4. Capacity building for Gender equality** • Orientation on Gender equality & PCPNDT Act for DCs, CSs, doctors both Govt and private, members of District Appropriate authority NGOs **5. Capacity building for good programme management** • Professional Development course for District Programme Managers, Senior district officials, SMOs for 10 weeks • Management Development course for MOs for 5 days • General and Financial rules (G & FR) for the district officials, MOs, clerical staff for 3 days • Financial management training for Accounts Officers, Accountants for 3 days • Computer training to all the MOs, Clerical staff, accounts personnel **6. Capacity building for managing the other components of NRHM** **RNTCP** • Reorientation Training of DOT providers for 1 day • Orientation of MOs on revised Paediatric & PWBs under Paediatric management for 1 day • Training of newly appointed MOs (1) under RNTCP – MO TU, M/Garh for 10 days Convergence for Sanitation and hygiene under NRHM • One day orientations of VHWSCs for total sanitation **Disease Control Programme** – Blindness Control, Malaria, IDSP, IDDM • MPW • LT training PRIs • Training on NRHM and their roles of the members of the Zila Parishad, Panchayat Samitis, Gram Panchayat members, VHWSCs for 1 day NGOs • Training in BCC • Training of Field NGOs Private Sector Training on Family Planning issues, PCPNDT Act, Reporting **7. Ensuring the quality of trainings** • A district quality training team will be formed to ensure the organization of trainings as per schedule, arrangements and monitoring the quality of all the trainings on the basis of checklists to be developed by the state. • They will ensure the availability of trainers and the staff at the District Training Centre. • The team will also monitor the work output of the trained personnel and give recommendations regarding improvements in the training and the future requirements. • A list of Resource persons will be developed from the State for specialized issues.
State	• SIHFW to develop the training calendar and organize the trainings as per schedule

Support	• Medical colleges to be prepared for providing trainings on EmOC, MTP, Neonatal Care • Monitoring by the State the quality of trainings and the work output through the development of a format and checklist • Placement of the personnel trained in various specialized issues at the right facilities • Ensuring staff at the District training centre	
Timeline	**Activity**	**2010-11**
	SBA training for 20 MOs x 2 batches for 14 days	20
	MVA MTP training to all PHC MOs for 14 days x 15 MOs x 5 batches	15
	Training on Blood transfusion for MOs and Lab Technicians for EmOC centres with Blood storage facilities for 3 days	1MO 1LT
	Training in Obstetric management & skills for 24x7 PHCs for 16 weeks	2 MOs/2 SN
	Training in skilled Birth attendants for 14 days for LHV & SNs and for 21 days for ANMs x 9 batches for ANMs and 4 batches for LHV/SNs	52
	IMNCI training to ANM/LHV, SN, ASHA for 8 days x 9 batches	225
	IMNCI training to MOs x 1 batch	22
	Integrated skill training for Urban MOs for 12 days at MJK Medical College	5 MOs
	Integrated skill training of all SN	10 SNs
	Integrated skill training for ANMs	20ANMs
	Integrated skill training for MOs	5 MOs
	Training of MOs, SN in Mgt of Newborns & sick children at Medical College	2 MOs 2 SN
	Training in BCC for MOs, LHVs, ANMs, x 5 days	12 MOs, 5 LHVs 25 ANMs
	Training on NSV for MOs at NSV camps	4 MOs
	Training on Minilap x 12 days x 15 persons	15
	Training for Laparoscopic Sterilization for MOs x 12 days	15
	Orientation on contraceptive devices for MOs - Govt and private facilities	150
	Training on Medico-legal aspects to MOs,	30 MOs & SMOs
	Training on IUD for MOs x 5 batches	4
	Training on IUD for SN/ANMs/LHV x 20 batches	100
	Orientation on PCPNDT Act for DCs, CSs, doctors both Govt and private, members of District Appropriate authority NGOs in a workshop	x
	Training of NGOs in BCC @ Rs 300 per person x 6 days	20 persons
	Professional Development course for District Programme Managers, Block Programme Managers, Senior district officials, SMOs for 10 weeks	Mgrs 5. Distt Officials 4, SMO 3
	Training in Life saving/Anaesthesia for EmOC at FRUs for MOs for 18 weeks	0
	Training of ASHAs	Discussed in the respective chapters
	Disease Control Programme – Blindness Control, malaria, IDSP, IDDM, RNTCP	
	Training for **Urban Health** Centres	
Budget	**Activity**	**2010-11**
	SBA training for 20 MOs x 9715 x 2 batches for 14 days	.2

	MVA MTP training to all PHC MOs for 14 days x 15 MOs x 21630 x 5 batches	1.52
	Training on Blood transfusion for MOs and Lab Technicians for EmOC centres with Blood storage facilities for 3 days	-
	Training in Obstetric management & skills for 24x7 PHCs for 16 weeks	-
	Training in skilled Birth attendants for 14 days for LHV & SNs and for 21 days for ANMs x @ 41855 x 9 batches for ANMs and @ 28170 x 4 batches for LHV/SNs	4.9
	IMNCI training to ANM/LHV, SN, ASHA for 8 days x 105650 x10 batches	10.57
	IMNCI training to MOs x 117900 x 1 batch	1.18
	Integrated skill training for Urban MOs for 12 days at Medical College	
	Integrated skill training of all SN @ 4200 x 10 persons	.42
	Integrated skill training for ANMs @ 2100 x 20 persons	.42
	Integrated skill training for MOs @ x 3700 x 5 persons	.19
	Training of MOs, SN in Mgt of Newborns & sick children at Medical College	-
	Training in BCC for MOs, LHVs, ANMs, MOs: Rs 500/MO x 5 days LHVs & ANMs x 200 x5 days	.36
	Training on NSV for MOs at NSV camps	-
	Training on Minilap x 12 days x 15 persons	-
	Training for Laparoscopic Sterilization for MOs x 12 days @21630x5 batch	1.52
	Orientation on contraceptive devices for MOs - Govt and private facilities	-
	Training on Medico-legal aspects to MOs,	-
	Training on IUD for MOs x @11713x 5 batches	.50
	Training on IUD for SN/ANMs/LHV x @9556 x 20 batches	1.92
	Orientation on PCPNDT Act for DCs, CSs, doctors both Govt and private, members of District Appropriate authority NGOs in a workshop	-
	Training of NGOs in BCC @ Rs 300 per person x 6 days	.36
	Professional Development course for District Programme Managers, Block Programme Managers, Senior district officials, SMOs for 10 weeks	-
	Training in Life saving/Anaesthesia for EmOC at FRUs for MOs for 18 weeks	-
	Training of ASHAs @ 38194 x 8 batches	3.06
	Block training Facilitator @ 51321 x 1 batch	.52
	Total	**27.64**

7.13. Procurement and Logistics

Situation Analysis/ Current Status	In district West Champaran is no proper Warehouse. There are rooms in which drugs are stored but it is not a scientific Warehouse. Most of the drugs are supplied by the State but some drugs are locally procured. Inventory Management is not very scientific and the records are not computerized. There is no system of wastage control, replacements, transfer of stocks from one centre to the other. Record Keeping is done manually. There is 15 storekeepers in the District is different PHCs and District Hospitals. But they are not trained about storekeeping. Requirements are also not made scientifically.	
Objective	Development of a Scientific Warehouse system.	
Strategies	1. Developing a Warehouse 2. Capacity building of the personnel for stores and also record keeping 3. Computerization of all the stocks	
Activities	1. Construction of a scientific Warehouse 2. Procurement of software and computer hardware for the Warehouse from TNMSC 3. Proper Equipment and hardware 4. Availability of Pharmacist, Assistant Pharmacist, Packers 5. Training of personnel 6. Appointment of an agency for Operationalization of the Scientific Warehouse	
Support required	State to develop a scientific and transparent Procurement, Logistics and Warehousing system with quality control	
Budget	**Activity / Item**	**2010-11**
	Construction of Warehouse	25.00
	Software	0.25
	Computer system with UPS, Printer, Scanner,	0.70
	Equipment & Hardware	10
	Pharmacist @ Rs 9000 / mth	0
	Assistant Pharmacist @ Rs 5000 / mth	0
	Packers -2 @ Rs 4000 / mthx2	0
	Security Staff @ Rs 6000 / mth	0
	Training of personnel	0

	Consultancy to agency for Operationalization of the Warehouse	2.00
	Total	**37.95**

7.14. Monitoring and Evaluation

Situation Analysis/ Current Status	Monitoring is an important aspect of the programme but it is not happening effectively and regularly. Each officer and the MOIC, MO, BHM at PHCs are supposed to make regular visits and monitor the progress and check on the activities and also the data provided by the ANMs. The reports have to be submitted and discussed in the monthly review meetings at the entire forum. The District Health Society is not monitoring the progress and neither are the committees at the Block and Gram Panchayat levels. No proper Check-lists exist for monitoring. Also analysis is not done of the visits and any data collected No Verbal Autopsies (Maternal, Neo-natal, Infant & Child Death audits) are carried out any levels. The Role & Functioning of the Sub centre level Committee, PHC level Committee, RKS at PHC and VLC need to be clearly defined. There is no system of concurrent Evaluation by independent agencies so that the district officials are aware regarding the progress and the lacunae.	
Objectives	Effective Monitoring and Evaluation system	
Strategies	1. Developing the system for visits, reporting and review 2. Developing a system of Concurrent Evaluation	
Activities	1. Fixing the dates for visits, review meetings and reports 2. Development of Checklist for Monitoring 3. Software for the checklist and entry of the findings in the checklist 4. MOIC, MOs & BHM to make at least 5% facility visits and also of the villages 5. Quality assessment of all health institutions. 6. Maternal Mortality Audit by MO and by involving LW / AWW for reporting of maternal deaths, 7. Mobility for monitoring at all levels and with the use of district monitors	
Support required	Appointment of Agencies for Concurrent Evaluation Monitoring by State from time to time State officials to attend Review meetings	
Budget	**Activity / Item**	**2010-11**
	Review meetings @ Rs 1000 / - x facilities x 12 mths	2,88,000 / -
	Mobility support for Deputy C.S. (Immunization and Family Welfare) for Monitoring for POL	60,000 / -
	Mobility support for monitoring MCHN days @ Rs. 800 X 5 days X 4 monitors X 12 months	1,92,000 / -
	Quality assessment of all health institutions each year @ Rs 2000 / inst	50,000 / -
	Trainings of all the committee members	1,00,000 / -
	Maternal, Child death Audit @ Rs 1000 / death	3,00,000 / -
	Total	**9,90,000/-**

7.15. Inter-Sectoral Convergence

7.15...1 Partnership with AYUSH department

Under Ayush there are:
12 Government Ayurvedic Dispensaries and one Ayurvedic Special Centre
10 General Homeopathic Dispensaries

Issues / Areas	Areas of cooperation	Areas of convergent action
Curative ; Patient care, Surveillance referral	Traditional treatment Notification of diseases outbreak	For outreach and coverage of areas not covered by MOs Joint training in Surveillance Joint meetings
Preventive; Immunization, Promotive and Prophylaxis services	Traditional treatment to increase the immunity IEC for prevention	Joint planning for BCC
Specific issues in Implementation of national programmes - Maternal care - Child care - Adolescent health - School Health - Malaria - Leprosy - IDD - Tuberculosis - IDSP - HIV / AIDS - Water borne diseases	Participation in Pulse Polio, Family Welfare, school health, Malaria, Skin diseases Participation in all national programmes	To cooperate the health dept and participate in programmes. Joint Review and joint planning Joint participation and monitoring Participation in MCHN days Provision of medicine kits DOTS providers Diseases Surveillance

7.15.2 ICDS projects

Issues / Areas	Areas of cooperation	Areas of convergent action
Maternal and child health care, complete immunization Anaemia and Malnutrition	• Fixed MCHN days • Joint CNAA • Data Validation • Common sectors • Out reach to children and pregnant women	• Training for counselling clients, • Provision of spacing methods including oral pills, condoms, LAM and SDM and community mobilization. • Convergence of services at the grassroots would ensure increasing the access to and demand for services • Provision of Examination table and Infant weighing machine to all AWCs • Joint sector meetings, block and district meetings • DDCs • DOTS providers • Diseases Surveillance

Rural Development Department

Issues / Areas	Areas of cooperation	Areas of convergent action
1. 90% of BPL houses in rural areas are without latrines and 64% of APL houses, in rural areas are without latrines. Only 44% households were covered. School Sanitation and IEC are important components of Total Sanitation Campaign. The performance is relatively poor on sanitation 2. Roads, Maintenance of buildings, Electricity and water supply are the domain of the rural development.	Formation of a Core group at the gram Panchayat level for joint action Support in total sanitation campaign	Joint action for electricity and water, Latrines in Ayush facilities also. Roads to be developed trill the health facilities Maintenance of buildings through joint reviews and plans DOTS providers Diseases Surveillance

Public Health department

Issues / Areas	Areas of cooperation	Areas of convergent action
Provision of safe drinking water. Presently there are 782 Hand pumps and 717well used for drinking water	Safe Water supply to all households and all health facilities Ensuring the proper drainage of stagnant water	Provision of GLRs, tanks Periodic Chlorination Health facilities Proper drains to be built near hand pumps Covering all open drains and puddles of water. Notification of diseases in villages Diseases Surveillance

PRIs

Issues / Areas	Areas of cooperation	Areas of convergent action
The PRIs have been envisaged to play a very important role in NRHM At the village level they are part of the VLC. \ At the Gram Panchayat level they are part of the Gram Panchayat health committee. Similarly at the Block and the District they are part of the Block and District health mission. At the Sub centre the Sarpanch is the joint signatory to the bank account for the operation of the Untied funds of Rs 10000. In the Gram Panchayat meetings held twice each month the PRIs review the activities of the health department along with the ICDS	Motivating the community Availability of personnel and services Participation in the MCHN days Giving importance to issues of health in the Gram Panchayat meetings	Joint plans Joint review and monitoring Mobilization of the community for action on health care issues, safe drinking water and sanitation. Advocacy at village, Gram panchayat, block and district level.

Education Department

Issues / Areas	Areas of cooperation	Areas of convergent action
Literacy rate of females is 25.9%. Malnutrition and anaemia management in school going children Prevention and control of drug addiction in adolescent Family life education	In Pulse Polio campaign School health programme Member of Village, health and Water Sanitation Committee Proper implementation of mid day meal program Support in various IEC campaigns organised by health dept.	IEC activities School health Education Screening of children for health problems, vision defects DOTS provider Motivating Community members Diseases Surveillance

7.15. Inter Sectoral Convergence	
Situation Analysis/ Current Status	Health is a social responsibility and is not the domain of the health department only. Unfortunately the total responsibility has fallen on the health department. The various departments have been involved in the Pulse Polio campaign which has led to the massive mobilization and success of the campaign. The District Health Society has been formed consisting of members of various departments. Block health societies will be formed and also at the sector, and village level. At the Gram Panchayat level under the Sarpanch Gram Panchayat committees have been formed consisting of various sectors. The Village health and Water Sanitation Committees also consist of various sectors and the community. In reality these committees need to be strengthened since they are not functional. All the various sectors are working separately although for the same cause. Hence there is a lot of duplication and wastage of resources. Although orders have been issued for convergence but other sectors do not participate readily. The forum of the fixed health day each week has a lot of potential and has not been used properly.
Objectives	1.Providing Primary and basic quality health care services at the village level 2.Providing quality RCH services 3.Optimal utilization of RCH services by community especially women 4.Empowering women to facilitate them to seek and demand quality RCH services.
Strategies	1. Strengthening the various Committees and Societies 2. Strengthening the MCHN days 3. Joint action for various issues
Activities	1. Joint workshops for Planning and Review at all levels • Orientation programmes • Monthly meetings 2. Strengthening the MCHN days • Wide participation of all the sectors in preparation of the community and in the actual activities, in health education • Each Wednesday during Immunization sessions joint orientations by all sectors and problem solving for each of the sectors 3. Joint Action for Sanitation, provision of safe water, provision of services and personnel at facilities 4. Joint review at the Gram Panchayat meetings

	5. Joint efforts for education of the girls, improving the sex ratio, raising age of marriage, improving the nutritional status, identifying the correct BPL families, income generation. 6. Realignment of the Health and the ICDS sectors for common data and common work boundaries. 7. ASHA to participate in all the meetings of the ICDS held between the 20th to 22nd of each month. 8. At the CHC level monthly meetings are organized. This should be jointly organized with the ICDS 9. At the monthly meetings of the Civil Surgeon the officers of all the departments should come 10. Annual action Plans to be developed jointly through meetings at the village, Gram Panchayat, Sector and culminating in Block workshops and District workshops	
Support required	Govt orders for inter-sectoral coordination with clear roles and responsibilities and If the various sectors do not attend the meetings then the decisions will be taken and will be binding for all the sectors. Strict follow-up at the State level for ensuring coordination.	
Timeline	**2010-11** Formation of Block Committees Orientation of Committee members at all levels Joint Community action Joint Annual Action Plan Sector Alignment Strengthening the Gram Panchayat meetings and Gram Sabhas	
Budget	**Activity / Item**	**2010-11**
	Meetings of the Block Committees @ Rs 2000 /meeting x 18 blocks x 12 months	4,32,000/-
	Meetings of the Village groups @ Rs 100 per village x 2220 villages x 12 months	26,64,000/-
	Joint monitoring at the sector level Hiring of vehicle @ RS 1000/ day x 5 days/month x 12 sectors x 12 months	72,000/-
	Joint monitoring at the block level Hiring of vehicle @ RS 1000/ day x 5 days/month x 18 blocks x 12 months	10,80,000/-
	Yearly joint Planning Workshops at the Block level for development of the Action Plans @ Rs 10,000/- per block x 18 blocks	1,80,000/-
	Yearly joint Planning Workshops at the District level for development of the Action Plans @ Rs 20000	20,000/-
	Yearly joint Workshops to consolidate the findings at the block levels at the District level for development of the Action Plans @ Rs 20000	20,000/-
	Total	**44,68,000/-**

7.16. Public Private Partnerships	
Situation Analysis/ Current Status	The private sector includes NGOs, Private Practitioners, Trade and Industry Organisations, Corporate Social Responsibility Initiatives. The private sector is the major provider of curative health services in the country. 43% of the total IUD clients obtain their services from the private sector. Engaging with it to provide family planning services has the potential to significantly expand the coverage of quality services. Public-private partnerships can stimulate and meet demand and have a synergistic impact of the RCH. To ensure efficient services of good quality from the private and public sectors, robust monitoring and regulatory mechanisms need to be developed so that the private sector can come forward and cooperate in all the National programmes and also in sharing its resources. There is no policy on Public Private Partnership in Haryana Unless there are incentives for the private sector to venture into this area, its involvement is unlikely.
Objectives	1. Increasing the coverage of the health services and also increasing the accessibility for health services 2. Widening the scope of the services to be provided to the clients
Strategies	Incentives and training to encourage private providers to provide sterilization services
Activities	**1. Accreditation of facilities for specialized treatment** **2. Provision of fixed payments for clients** • Developing the clinical skills of private doctors will be developed in vasectomy, abdominal tubectomy and laparoscopy. Training private lady doctors in IUD insertion and promoting the provider will help to expand coverage of these services increase the total use of IUCD. **3. Hiring of Specialists for providing services** • Gynaecologist @ Rs 1500 per visit • Anaesthetists @ Rs 1000 per visit • Paediatrician @ Rs 500 per visit **4. Encouraging the use of public facilities by private doctors on a fee-sharing basis** Private doctors will be allowed to use public facilities on a fee sharing basis, e.g. in the evening when PHC / APHC s are normally closed. This will optimise the utilization of the existing infrastructure of public health facilities and make services more accessible, especially to day labourers. • Local private doctors will be identified and invited to participate through consultative meetings, and assist in drawing up a partnership action plan • A detailed plan will be developed in consultation with the private sector for determining the amount and mode of payment, the regulation and monitoring frameworks necessary, and safeguards to ensure equity of access. • Training for the private sector will be provided as above, and approved, monitored providers will be promoted and eligible for discounted supplies 5. **Arogya Kosh** to continue 6. **PPP- Various Schemes under RNTCP**
Support required	1. State to agree for allowing the private sector to use facilities 2. State to develop the Public Private Policy 3. Finalization of Incentives for the Private sector for various services 4. Private providers should get payment on a monthly basis

Budget	Activity / Item	2010-11
	Arogya Kosh	3,00,000/-
	Hiring of specialists-2 @ 30000 pm	7,20,000/-
	Training of NGO personnel and the Private sector @ Rs 500 for 2 days per person x 40 persons	40,000/-
	Workshop for involvement of the Private sector	50,000/-
	Total	**11,10,000/-**

7.17. Bio-Medical Waste Management	
Situation Analysis / Current Status	As per the Bio-Medical Waste Rules, 1998, indiscriminate disposal of hospital waste was to be stopped with handling of Waste without any adverse effects on the health and environment. In response to this the Government has taken steps to ensure the proper disposal of Biomedical waste from all Nursing homes, hospitals, Pathological labs and Blood Banks. The District Health Officer is the Nodal Person in each district for ensuring the proper disposal of Biomedical Waste. Trainings to the personnel for sensitizing them have been imparted, Pits have been dug, Separate Colour Bins/containers and Segregation of Waste is taking place though has to be done more systematically. Proper Supervision is lacking. GOI has sanctioned a Plasma Pyrolysis Plant. Plasma Pyrolysis is a state-of-the-art technology for safe disposal of medical waste. It is an environment friendly technology, which converts organic waste into commercially useful by-products in a safe and reliable manner. The plant will soon be installed and training will be imparted to two persons from the district.
Objectives	1. Stopping the indiscriminate disposal of hospital Waste from all the facilities by 2009-10 2. Ensuring proper handling and disposal of Biomedical Waste in each Facility
Strategies	1. Capacity Building of personnel 2. Proper equipment for the disposal and disposal as per guidelines 3. Strict monitoring and Supervision
Activities	1. Review of the efforts made for the Biomedical Waste Interventions 2. Development of Microplan for each facility in District & Block workshops 3. Capacity Building of personnel • One day reorientation workshops for District & Block levels • Training to two persons for Plasma Pyrolysis Plant. The company persons will impart this training. • Biomedical Waste management to be part of each training in RCH and IDSP 4. Proper equipment for the disposal • Plasma Pyrolysis Plant to be installed • Installation of the Separate Colour Bins/containers and Plastic Bags for the bins 5. Segregation of Waste as per guidelines 6. Partnering with Private providers for waste disposal 7. Proper Supervision and Monitoring • Formation of a Supervisory Committee in each facility by the MOs and the Supervisors

Budget	**Activity**	**2010-11**
	Orientation and reorientation for Biomedical Waste Management at District and Block levels	1,50,000/-
	Consumables	1,00,000/-
	Maintenance of the Plasma Pyrolysis plant	3,50,000/-
	Payment for incinerators@ Rs. 8 per bed 12 mths x 1000 beds	96,000/-
	Total	**6,96,000/-**

7.18. Financing RKS

Situation Analysis/ Current Status	For sustainability and needs based care, health financing is the key. Rogi Kalyan Samity has been formed in each of the PHCs and District Hospital. These are hospital autonomous societies which are allowed to take user fees for services provided at the facilities. Formation of these RKS has resulted in great satisfaction amongst the patients and also the staffs since now funds are available with the facilities to care for the people. No trainings have been given for the skill building of the Incharges of these facilities. There is no standardized reporting format and information regarding these RKS is available.	
Objectives	Availability of sufficient funds for meeting the needs of the patients	
Strategies	1. Generation of funds from User charges 2. Donations from individuals 3. Efficient management of the RKS 4. Provision of Seed money to each RKS	
Activities	1. Generation of funds from User charges: User charges are taken for Registration, IPD, Laboratory investigations from persons who can afford to pay. 2. Donations from individuals: Donations are to be generated from individuals. For the betterment of hospitals, equipment, additions to the buildings, etc 3. Efficient management of the RKS: Training will have to be given for efficient management and utilization of the funds for activities that generate funds. Computerization of data and all the parameters need to be carried out preferably through customized software. Trainings can be organized with the help of SIHFW Rajasthan who have developed modules and conducted trainings for the management of these Societies. **4.** Provision of Seed money to each RKS of Rs 100000 each year for repair, purchase of new equipment, additions, alterations, etc. **5.** Development of customized software and training of staff for the use of this software **6.** Regular filling of formats	
Support required	1. Timely meetings of Rogi Kalyan Samitis **2.** Trainings on the management of the RKS	
Budget	**Activity**	**2010- 11**
	Provision of Seed money @ Rs 1 lakh per PHC for RKS	18,00,000/-
	Training of the Incharges and second in command @ Rs 1000 per person x 1 day	18,000/-
	Total	**18,18,000/-**

7.19. Community Health Action		
Situation Analysis/ Current Status	Constitution of Village Health and Sanitation Committees (VHSC) has not yet been done and now these committees are the part of Village Level Committees formed by the PRIs. The cooption of these PRIs committees has to take place. Simultaneously, these committees need to have their own bank account jointly managed by ASHA & one PRI member or President of the VHSC. Thus none of these committees have account as yet and subsequently no activities have been carried out and no untied fund for VHSC has been utilised.	
Objectives	Ensuring availability of quality health services to the community Motivating the community for good health seeking behaviour	
Strategies	Formation and Strengthening the VLC and the Gram Panchayat meetings Monitoring the progress of the Village health Action Plan and also the village morbidity and mortality	
Activities	1. Facilitation of the process with the support of an external agency 2. Trainings of the VLC 3. Regular meetings of the committee, once a month, shall be held. 4. Regular meetings of the SMS Groups with linking with the SHGs and formation of Emergency Fund through the collections. Also developing a micro plan for the SMS Groups. 5. Local Gram Panchayat shall review the functioning of VHSC Based on village plans; sub-centre action plan shall be formulated. 6. Tour plan of ANM to be shared with local Gram Panchayat 7. Verbal autopsy of Maternal and Child deaths by the members for each mortality 8. Organization of Health Camps in every Sub Health Centre feeder area 9. Organization of a Public hearing in every cluster (PHC area) within a block 10. Formation of Block level team for holding health camps and public hearings. 11. District level team to support household survey and survey of health facilities	
Support required	1. Zila Pramukh and the District Collector to ensure that meetings of Gram Panchayats are held and to review what issues of health are being discussed**.** 2. State officials to provide the capacity building of the District officials for village health action 3. State to develop the training module for the members of VHSC and also the TOTs 4. District Authorities have to ensure the monthly meetings of VLCs and SMS Groups.	
Timeline	**2010-11** Formation of the PRIs' committees as VHSC; Opening of Bank account of all such committees formed; Disbursement of untied fund meant for VHSCs. Training of Village Level Committees Preparation of Village health action Plans Public hearing in every cluster Health camps Strengthening the Block health committee	
Budget	**Activity / Item**	**2010-11**
	Training of the VHSC @ Rs 200 per person x 15 persons/Committee x 2220 villages	66,60,000/-

	Meetings of the VHSC @ Rs 200 per village x 2220 villages x 12 months	53,28,000/-
	Total	**1,19,88,000/-**

7.20. ASHA – Accredited Social Health Activist & MAMTA		
Situation Analysis	No. of AWC = 3300 No. of ASHA = 3204 GAP = 180 Trained ASHA = 2691 513 (43 old+470 new) ASHA needs Training Reorientation (2nd Phase) Training not given Total Mamta Required = 56 in MJK Hospital + 9 in Sub-Divisional Hospital +126 in PHCs Total Present = 29 in MJK Hospital + 9 in Sub-Divisional Hospital	
Objectives	1. To select remaining 513 ASHA & 153 Mamta 2. To give training to remaining 513 ASHA 3. Reorientation training to ASHA	
Strategies	1. Selection and capacity building of ASHA & Mamta 2. Constant mentoring, monitoring and supportive supervision by district Mentoring group	
Activities	1. Strengthening of the existing ASHAs through support by the ANMs and their involvement in all activities. 2. Reorientation of existing ASHAs 3. Selection of new ASHAs to have one ASHA in all the villages and in urban slums 4. Selection of New Mamta. 5. Training of all remaining ASHAs who have not received any training regarding the related other modules. 6. Provision of a kit to ASHAs 7. Formation of a District ASHA Mentoring group to support efforts of ASHA and problem solving 8. Review and Planning at the Monthly sector meetings 9. Periodic review of the work of ASHAs through Concurrent Evaluation by an independent agency	
Budget	**Activity / Item**	**2010-11**
	Kit @ Rs 2000 x 3204 ASHA	64,08,000/-
	Reorientation @ Rs 1400 x 3204 ASHA	44,56,600/-
	Training to New & Remaining ASHA Rs 1400 x 513	7,18,200/-
	Trainer's Cost 400/day X 7 days X 87 batches of 40 ASHA	2,43,600/-
	Expenses for the District mentoring group – meetings, travel @ Rs 5000 per month x 12 months	60,000/-
	Incentive for Mamta Avg. Rs. 100/ X 365 days X 230 Mamta	83,95,000/-
	Total	**2,02,81,400/-**

7.21. Mobile Medical Units		
Situation Analysis/ Current Status	There is no any mobile dispensary is available in Bettiah Hospital. As per the NRHM guideline there is no Mobile medical unit exist.	
Objectives/	Meeting the unmet health needs of the people residing in difficult and underserved areas, through provision of healthcare at their doorstep	
Strategies	Operationalizing a Medical Mobile Unit (MMU)	
Activities	1. Joint meeting of the District Health Society and the Rogi Kalyan Samiti (RKS) to decide the appropriate modality for Operationalization of the MMU. 2. Formation of a Monitoring Committee 3. The RKS will operate for long-term sustainability of the intervention. 4. Staff will be hired on contract by the RKS. 5. Need Analysis to be carried out for determining the areas of MMU. 6. Development of a monthly roster for operationalizing MMU 7. MMU with essential accessories, basic laboratory facilities, semi-auto analyser and generator etc. 8. Wide publicity before the arrival of the MMU 9. Periodic Review.	
Support required	Govt Order from the State for exemption of the Regular Staff from providing services in the MMU, Funds for purchase of MMU and its maintenance. Manpower	
Budget	**Activity / Item**	**2010-11**
	Hiring staff	19.20
	Orientation of the staff	0.10
	Joint Workshop for finalizing modalities	0.10
	Cost of Vehicle, equipment and accessories	30.00
	Recurring Cost of Drivers, Drugs, supplies, Mobile phones, POL, Maintenance	5.80
	Total	**55.20**

Detailed Calculations

Budget for Vehicles, Equipment and Accessories

S.No	Head	Unit Cost
1.	Cost of Vehicle for staff to MMU	5,00,000
2.	Cost of Vehicle for carrying A / V aids, equipment etc	20,00,000
3.	Prefabricated tents & Furniture	2,90,000
4.	Equipment	2,00,000
5.	Mobile Phone (one for each Driver)	10,000
	Total	**30.0**

Budget of Personnel

S.No	Head	Unit	Unit Cost	Amount
1.	Emoluments to MOs -1	12 mths	30000	360000
2.	Emoluments to Specialists –2 (Part time)	12 mths	40000	960000
3.	Lab Technician	12 mths	10000	120000
4.	Pharmacist	12 mths	10000	120000
5.	Nurse x 4	12 mths	7500	360000
	Total			**1920000**

Budget for Recurring Expenses

S.No	Head	Unit	Unit Cost	Amount
1.	Salary of Drivers –2	12 mths	7500	180000
2.	Drugs			268000
3.	POL & Maintenance of Vehicles			100000
4.	Maintenance of equipment			20000
5.	Mobile Phone bill -2	12 mths	500	12000
	Total			**5.8**

a.	**Vitamin A Program**	
Situation Analysis	No. Of PHCs = 18 Total Number of sites = 3400 Total Number of Vaccinators for Training = 3400	
Strategies	Two rounds of Vit. A 1st : April 2009 (1st Week) 2nd : October 2009 (1st Week)	
Budget	Cost of DCC level Orientation @ 4000/-	4000/-
	Cost of PHC level Orientation @ 2100/- x 18	37800/-
	Cost of PHC level Vaccinator's Training @ 1675/- x 65 batches	108875/-
	Vaccinator for Site 3400 @ 100/- each	340000/-
	Mobility Fund 1000/- x 18 PHC + 1500/- x 1 District	19500/-
	Contingencies 1000/- x 18	18000/-
	13 Supervisors for Urban Ares @ 250/-	3250/-
	Sub Total (For 1 round)	531425/-
	Total (For 2 rounds)	**1062850/-**

18. BUDGET AT-A-GLANCE (In Rs.)		
	Components	2010-11
1	Infrastructure	
	1. HSCs	10,14,65,000.00
	2. APHCs	3,88,05,000.00
	3. PHCs	9,76,00,000.00
	4. FRUs	4,49,00,000.00
	5. Untied fund	2,42,60,000.00
2	Human Resources	13,46,52,000.00
3	Maternal Health	19,42,16,000.00
4	Neo Natal and Child Health	4,12,60,000.00
5	Family Planning	2,96,02,200.00
6	Immunization	2,29,28,000.00
7	Adolescent Health	52,25,000.00
8	National Disease Control Programmes (RNTCP, KALAZAR)	
	1. RNTCP	0.00
	2. Leprosy	3,20,000.00
	3. Malaria	1,42,18,000.00
	4. Kalaazar	1,46,18,000.00
	5. Other Vector Born Diseases	1,50,000.00
	6. Blindness Control Program	23,75,000.00
	7. Integrated Disease Surveillance Programme	30,16,000.00
	8. Iodine Deficiency Disorders	19,10,000.00
9	Gender & Equity	19,60,000.00
10	Demand Generation, IEC/BCC	34,15,000.00
11	Programme Management	2,62,16,000.00
12	Capacity Building	27,64,000.00
13	Procurement and Logistics	37,95,000.00
14	Monitoring and Evaluation	9,90,000.00
15	Inter-sectoral Convergence	44,68,000.00
16	Public-Private Partnership	11,10,000.00
17	Bio-Medical Waste Management	6,96,000.00
18	Financing RKS	18,18,000.00
19	Community Health Action	1,19,88,000.00
20	ASHA & Mamta	2,02,81,400.00
21	Mobile Medical Units	55,20,000.00
22	Vitamin A Program	10,62,850.00
	Grand total	85,76,04,450.00