BRIEF HISTORY OF DISTRICT

First Creation of Champarn District : 1866

On 1st of December 1971 Champaran district was split up Into two districts, viz. Purbi Champaran and Paschim Champaran .The headquarter of Purbi Champaran district is at Motihari .Presently Purbi Champaran consists of Six Subdivisions and Twenty Seven Blocks.

Nepal makes its northern boundary, Sitamadhi and Sheohar eastern while Muzaffarpur South and with part of Gopalganj bounds it in western side.

Origin of Name

Flower Champa

The name Champaran owes its origin to Champa-aranya or Champkatanys. Champ Champaka means Magnolia and aranya mess forest. Hence, Champaranya means Forest of Magı (CHAMPA) trees. It is popularly believed that the nomenclature here was made while the vest forest was inhabited by solitary ascetics. It is needless to say that has Purbi means Eastern Side.

Ancient History

The history of Purbi Champaran is a part of parent Champaran district. In the prehistoric period, Champaran constituted a part of the ancient kingdom of Videha .The Aryan Videhas were ordained to settle east of the Gandak or Narayani river. Among the Greatest of the Videha kings was Sirdhwaj

Janak an erudite scholar as well as lord temporal and lord spiritual for his subjects. Yajnavalkya was his chief priest who

codified the Hindu law known as Yajnavalkya Smriti. Both of his wife Gargi and Maitreyi was renowned scholar. It is Gargi who is credited to compose some of mantras. After the fall of Videhan empire Champaran was ceded to oligarrochial republic of Vrijjan confederacy, with OligarPHCal Vaishali as its capital of the Vriggian confederacy Lichohavis were the most powerful and prominent.

For a true imperialist Ajatshatru the emperor of Magadh the power and fame of Vaishali was eyesore. By tact and force he annexed Lichhavis and occupied its capital, Vaishali. He extended his way over the present district of Purbi Champaran which lasted for nearly hundred years. After the Mauryas , the Sungas and the kanvas ruled over Magadh and its vast territories. Archaeological evidences found in Champaran bear testimony of Sunga and Kanva rules here.

The Kushans, who were migrant Turks, overran the entire northern India in the first century AD Probably Champaran was a part of the Kushan empire at that time. Banphar Rajputs in the 3rd century AD got way by the Kushans . Champaran later become a part of the Gupta empire. Alongwith Tirhut, Champaran was possibly annexed by Harsha during whose reign Huen- Tesang, the famous Chines pilgrim, visited India. During 750 to 1155 AD Palas were in the possession of Eastern India and Champaran formed the part of their territories. Towards the close of the 10th century Gangaya Deva of the Kalacheeri dynasty conquered Champaran .He gave way to Vikramaditya of the Chalukya dynasty, who was accompanied by adventures from the Carnatic .It is believed that one of the adventures counted the Saka dynasty of Bangal another, Nanyadeva, founded the Carnatic dynasty of Mithila with its capital at Siaraon on the Indo- Nepal border.

		M.O.I.C				B.H.M	
1	Adapur	Dr. Nagendra pd.	06255	236189	9470003192	Mr. Ashish kr.	9471252390
2	Areraj	Dr. U. K. Mishra	06258	284210	9470003190	Mr. Aditya Ranjan	9470778330
3	Chakia	Dr. Awadhesh kumar	06257	244739	9470003175	Mr.Anil kumar	9472224423
4	Chiraiya	Dr. Majrul Haque	6250	273273	9470003181	Md. N.Azam	9934244794
5	Dhaka	Dr. S.K. Sinha	06250	282685	9470003182	Mrs. Sandhya kr.	9430529840
6	Ghorasahan	Dr. M.P. Gupta	06250	284544	9470003186	Mr. Avinish	9472414040
7	Harsidhi	Dr. P. K. P. Singh	06252	287959	9470003186	Mr. Aditya Ran.	9470778330
8	Kalyanpur	Dr. M.Q. Ali	06257	272068	9470003188	No	
9	Kesaria	Dr. Sri Prakash Tiwari	06257	269784	9470003172	No	
10	Madhuban	Dr. S.K.Jha	06259	274180	9470003185	Mr. Satish kr.	9431474887

11	Mehsi	Dr.K. Sharma	06257	254732	9470003173	Md.Javed Alam	9304730360
12	Motihari	Dr. S.Paswan	06252	240491	9470003184	Mrs. Ayushi ver.	9934449030
13	Chauradano	Dr. Sunil kumar	06255	237350	9470003189	Mr. Rajkumar	9546207703
14	Paharpur	Dr. C. N. Mishra	06258	286838	9470003174	Mr. S.K. Sudhanshu	9279235921
15	Pakridayal	Dr. Veena Das	06259	283043	9470003183	Mr. Chandeshwar	9801210027
16	Patahi	Dr. T.H. Pasa	06259	276593	9470003177	Mr. Manoj kumar	9934429727
17	Ramgarhawa	Dr. Satnarayan Singh	06255	234363	9470003194	Mr. Mintu Kumar	9708293737
18	Raxaul	Dr. Ravi Shankar	06255	223728	9470003196	Mr. S.K. srivastava	9430679771
19	Sugauli	Dr. Shambhu Prasad	06252	280898	9470003178	Mr. R.K. Mishra	9430893754

MEDIEVAL PERIOD

During 1211 and 1226 first Muslim influences was experienced when Ghyasuddin Iwaz the muslim governor of Bangal extended his a way over Tribhukti or Tirhut .It was however, not a complete conquest and he was only able to have Tirhut from

Narsinghdeva a simyaon king, in about 1323 Gnyas- Uddip.Tughiar annexed irabhuk and placed it under Kameshwar Thakur established Sugaon or Thakur dynasty, As Harsinghdeo the last simraon king had taken shelter in Nepal Kameshwar Thakur a Brahmin Rajpandit was installed to regal status. The sugaon dynasty hold Tirabhukti as a tributary province for about a century after the capture of Harsinghdeo . The most famous of the dynasty was Raja Shiva Singh who was adorned by the immortal poet laureate Vidyapati, during the period of Lakshmi Nath Deva Tirabhukti was attached by Sultan Alleuddin Hussain Shah of Bengal and Sikender Lodi of Delhi . A treaty was concluded in 1499 according to which 'Tirahukti , left to Sikandar Lodi subsequently, Sikander Lodi attacked Tirabhukti and made the prince a tributary chief. However, in contravention of the treaty conducted by his father .Nasrat Shah, son of Allauddin Shah attacked Tirbhukti in 1530 annexed the territory, killed the Raja and thus put an end to the Thakur dynasty .

Nasrat Shah appointed his son -in -law as viceroy of Tirhut and the coformard it was governed by Muslim Governor .In 1526 Babar dynosted Sikandar Lodi but Champaran could not coming prominence till the last days of the Muslim rule.

During the close of the Mughal empire, Champaran witnessed ravages of contending armies. prince Al Gauhar later known as Shah Alam invaded Bihar in 1760 and Khadin Hussain, the Governor of Purnit invited with his army to join him. In the mean time, Nawab Sirajudaulla of Bengal had already been defeated and killed as a result of the joint conspiracy of Mir Jagarkhan and the British, in June, 1757 . Before Khadim Hussain could meet Shah Alam's forces captain Knox led a British force and defeated him at Hajipur. There after he fled to Bettiah.

BRITISH PERIOD

With the rest of Bengal Champaran passed into the hands of East India Company in 1764 but military expeditious were still I. necessary to curb the independent spirit of the chiefs. In 1766 , Robert Barkar easily defeated the local chiefs and forced them to pay tribute or revenue which they had destined till them. however , the Raja of Bettiah did not pay revenues regularly and revolted but was crushed. He fled to Bundelkhand and his estate was consequently confiscated. But to the British it was difficult to manage the affairs of the estate in the make of strong popular resentment. At the time of uprising the estate was restored by the Raja in 1771 .

In the mean time for reaching consequences were taking place in neighboring Nepal. A confrontation was going,. In between the Gurkhas, under Prithvi Narayan of Newar line and British forces. Ultimately a treaty was concluded at Sugauli .There remained peace for 25 years followed by treaty but trouble started after 1840 when a Gurkha troops entered the estate of Raja Ramnagar and extended their claim over his territory. However, Gorkha troops had to retreat due to determined resistance. Later, the Nepalese proved faithfully allies of the British in suppressing the National Movement of 1857.

The repression of the Wahabi movement at Patna furthered of seething discontent of tenants against the activities of the administration as well as the Indigo --Planters. The cultivators were forced to grow indigo even in the face of recurring losses in this account . More over many kinds of illegal realization were effected by the landlords. The administration was the cut do - sac of the oppressions.

In the beginning of 1857 movement the position of Britishers was precarious. Major Hoimes who was commanding the 12th Irregular cavalry, stationed at sugauli was apparently panicked and proclaimed martial law on his own authority. This measure had not attracted hole-hearted support of higher authorities. Major Holmes lad repressive measures and executed some sepoys. Consequently members of the cavalry revolted again the authority. The Major his wife and other members of his family were stained. The Soldiers proceeded towards Siwan to join other forces who had risen against the British authority. The revolt was, however calmed down to enlist support Honorary Magistrates from among the indigo planters were appointed and also authorized them to recruit local police. Some of the big estate holders like the Raja of Bettiah even gave support to the British Gurukha troops of the British were asset to them.

The later history of the district is inter woven with the saga of exploitation of the indigo planters. Britain used to get supplies of indigo from her American colonies which ceased after war of .Independence fought in 1776 leading to their freedom. Britain had to depend upon India for supplies of Indigo. Europeans steered many factories in the indigo producing areas of Bengal and Bihar.

Estate of Bettiah and Ramnagar gave lease of land to them on easy terms for cultivation of indigo. The arrangement made for the cultivation of indigo were (1) Zirat and (2)Tenkuthiya . Apparently ,nothing went wrong by the introduction of both the systems. But actually, the peasants suffered a lot due to both the systems. The wages paid to laborers were extremely low and entirely inadequate. The were forced to labor hard and were severely punished for alleged slackness on their part Sri Raj kumar

shukla, an indigo cultivator of the district having heard about the None Co-operation Movement had by Gandhijee in South Africa met and apprised him about miserable plight of indigo Cultivators in the Champaran District. He persuaded him to visit the district. Almost at same time;The Indian Nation congress in December ,1916 passed at Lucknow a resolution for requesting Government to appoint a committcd of both officials and non-officials to enquire into the agrarian trouble facing the district.

Gandhijee paid historic visit to Champaran. His visit was stoutly opposed by the British rulers. An order asking him to leave Champaran was served upon him as soon as he arrived at Motihari. Gandhijee defied the order of the several prominent persons who rallied round him mention may be made of Dr .Rajendra Prasad Acharya Kriplani ,Mahadeo Desai, C.F. Andrews, H.S.Pollock, Anugrah Narayan Singh, Raj Kishore Prasad, Ram Nawami Prasad and Dharnidhar Prasad after considerable struggle Govt. was compelled to lift the ban on Gandhi's stay here for he first time on Indian soil Satyagarh, was successfully put to test. Eventually, a committee of enquiry was appointed by the Govt. under the chairmanship of Sri Frank shy, Gandhijee was also made one of the member of the committee. On the basis of vauled a recommendations of the committee, the Champaran Agraria low (Bihar and Orissa Act I of 1918) was passed. In course of time, the development of synthetic dyes made the cultivation of indigo redundant.

In 1920,Gandhijee made an extensive tour of Bihar before launching the non-co-operation movement, which earned full support in the district as well. In 1929 a group of volunteers from Champran district came to demonstrate a against the Simon commission in the same year the 21st session of the Bihar students conference was held at Motihari. As a reaction against the failure of Round table conference held in 1932 there was popular gathering at Motihari to take pledge for Independence. Police lathi charge and fired upon the gatherings. people of Champaran will be remember for their active and significant participation in the National movement

EAST CHAMPARAN DISTRICT PROFILE

ESTABLISHED

CHAMPARAN	1866
PURBI CHAMPARAN	1971

POLITICAL

AREA	3968.0 Sq. Km.
NEAREST RAILWAY STATION	MOTIHARI
NEAREST AIRPORT	PATNA

GEOGRAPHICAL LOCATION

LONGITUDE	EAST 84^0 - 30'& 85^0 16
LATITUDE	NORTH 26^0 - 16' & 27^0 -1

BOUNDARY

NORTH	NEPAL
EAST	SHEOHAR, SITAMARHI
SOUTH	MUZAFFERPUR, GOPALGANJ
WEST	PASHCHIM CHAMPARAN, GOPALGANJ

DISTANCE FROM

PATNA	170 Km.
MUZAFFERPUR	90 Km.
HAZIPUR	150 Km.
BETTIAH	50 Km.

NATURAL

RIVERS	GANDAK, SIKARHANA, BAGMATI AND LAL BAKEYA, TILAWE, KACHNA, MOTIA, TIUR, DHANAUTI

CLIMATE

RAINFALL(NORMAL)	1241.6 Millimeter
TEMPERATURE	MAX 46 & MIN 5 DEGREE CELCIUS

ADMINISTRATIVE

NO OF SUBDIVISION	6
NO OF BLOCKS	27
NO OF POLICE STATION	41
NO OF PANCHAYAT	
NO OF REVENUE VILLAGE	1345

AGRICULTURE (AS PER 2003-2004 DATA)	
AREA	**391401 Hectare**
CULTIVABLE LAND	**303923 Hectare**
NON CULTIVABLE LAND	**87478 Hectare**
IRRIGATED LAND	**176115 Hectare**
NON IRRIGATED LAND	**127808 Hectare**
MAJOR CROPS	**Rice Paddy (Basmati Rice), Sugar Cane, Jute, Lentis**

DEMOGRAPHY (ACCORDING TO 2001 CENSUS)

URBAN	Male	135366
	Female	115720
	Total	251086
RURAL	Male	1941681
	Female	1747006
	Total	3688687
Total		

LITERACY (ACCORDING TO 2001 CENSUS)

MALE	**49.3%**
FEMALE	**24.3%**
AGGREGATE	**37.5%**

EDUCATION : NO OF SCHOOLS AND COLLEGES

PRIMARY

RURAL	1734
URBAN	31
TOTAL	1765

UPPER PRIMARY

RURAL	384
URBAN	21
TOTAL	405

HIGH SCHOOL

RURAL	83

URBAN	6
TOTAL	98
DEGREE COLLEGES	
RURAL	11
URBAN	6
TOTAL	17

PURBI CHAMPARAN
Bihar
N
NEPAL
PASCHIM CHAMPARAN
SITAMARHI
SHEOHAR
GOPALGANJ
MUZAFFARPUR
Raxaul
Adapur
Champapur
Ramgarhwa
Narkatia
Ghorasahan
Sagauli
Lakhaura
Chiraiya
Dhaka
MOTIHARI
Harsidhi
Noniya
Turkaulia
Gunjrauliya
Jiwdhara
Pakridayal
Palahi
Paharpur
Areraj
Gobindganj
Sangrampur
Pipra
Great Gandak
Kalyanpur
Madhuban
Kesariya
Rajpur
Chakia
Mehsi
28A
PHC
APHC
Referal Hos.
Dist. Hos.
Town
Roads
River
Railway Track
International Boundary
National Highway
Map not to Scale
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PURBI CHAMPARAN
Bihar
N
NEPAL
PASCHIM CHAMPARAN
SITAMARHI
SHEOHAR
GOPALGANJ
MUZAFFARPUR
Raxaul
Adapur
Champapur
Ramgarhwa
Narkatia
Ghorasahan
Sagauli
Lakhaura
Chiraiya
MOTIHARI
Dhaka
Noniya
Harsidhi
Turkaulia
Pakridayal
Palahi
Gunjrauliya
Jiwdhara
Paharpur
Areraj
Gobindganj
Sangrampur
Pipra
Great Gandak
Kalyanpur
Madhuban
Kesariya
Rajpur
Chakia
Mehsi
28A
PHC
Major Road
District Headquarter
Taluk Headquarter
Town
Roads
River
Railway Track
International Boundary
National Highway
Map not to Scale
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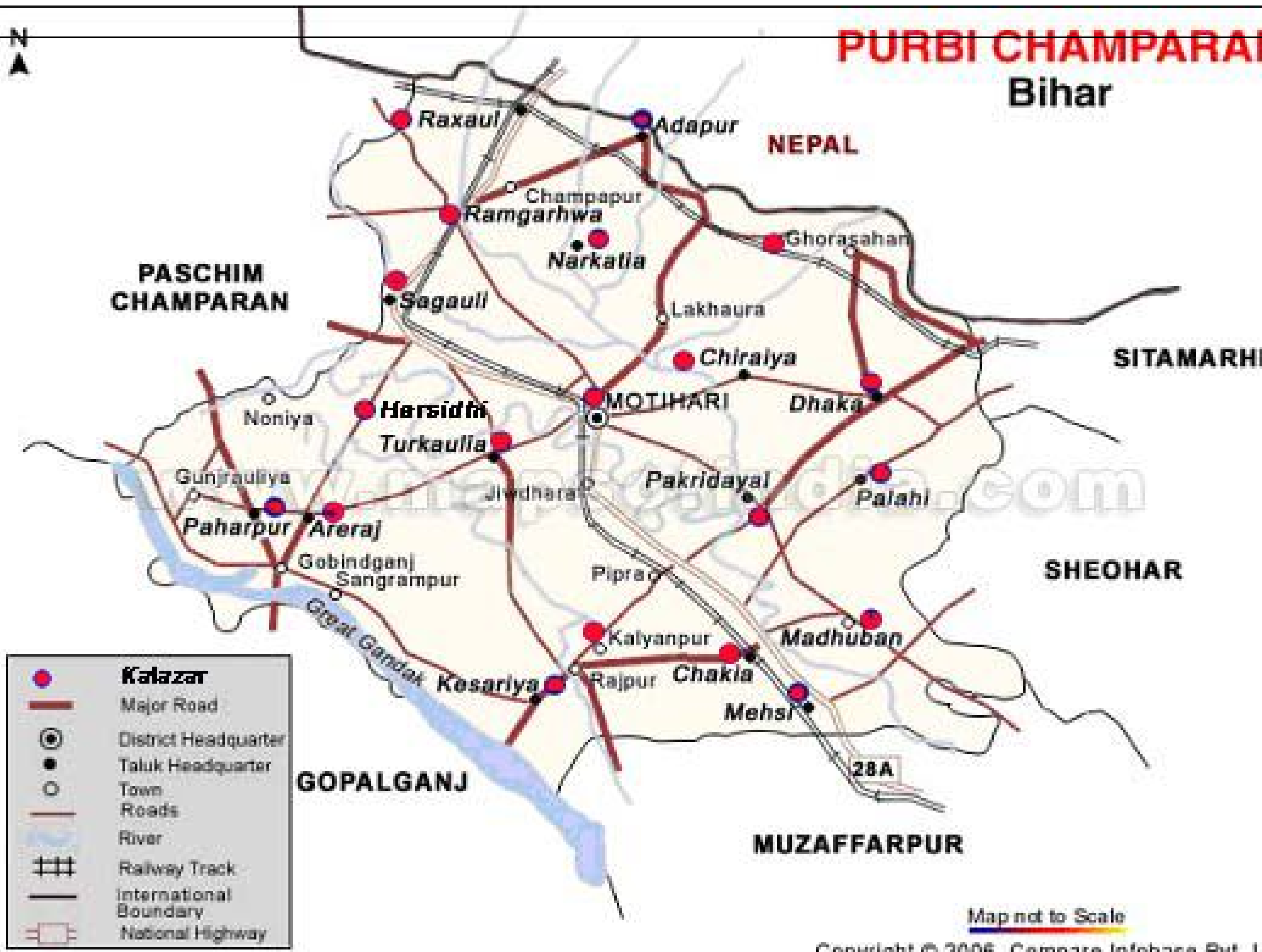
PURBI CHAMPARAN
Bihar
N
NEPAL
PASCHIM CHAMPARAN
SITAMARHI
SHEOHAR
GOPALGANJ
MUZAFFARPUR
Raxaul
Adapur
Champapur
Ramgarhwa
Narkatia
Ghorasahan
Sagauli
Lakhaura
Chiraiya
MOTIHARI
Dhaka
Noniya
Harsidhi
Turkaulia
Gunjrauliya
Pakridayal
Palahi
Jiwdhara
Paharpur
Areraj
Gobindganj
Sangrampur
Pipra
Great Gandak
Kalyanpur
Madhuban
Kesariya
Rajpur
Chakia
Mehsi
28A
Kalazar
Major Road
District Headquarter
Taluk Headquarter
Town
Roads
River
Railway Track
International Boundary
National Highway
Map not to Scale
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Situation Analysis for
District Health Action Plan

Name of the District… Champaran East

DISTRICT PROFILE

No.	Variable	Data
1.	Total area	3698 Sq. k.m
2.	Total no. of blocks	27
3.	Total no. of Gram Panchayats	421
4.	No. of villages	1634
5.	No of PHCs	20
6.	No of APHCs	48
7.	No of HSCs	319
8.	No of Sub divisional hospitals	0
9.	No of referral hospitals	03
10.	No of Doctors	91 (R) + 98 (C)
11.	No of ANMs	291 (R) + 110 (C)
12.	No of Grade A Nurse	17 (R) 38 (C)
13.	No of Paramedical	2210
14.	Total population	4725938
15.	Male population	2531960

16.	Female population	2270699
17.	Sex Ratio	1000/897
18.	No of Eligible couples	
19.	Children (0-6 years)	736733
20.	Children (0-1years)	143332
21.	SC population	624345
22.	ST population	4708
23.	BPL population	2667646
24.	No. of primary schools	1581
25.	No. of Anganwadi centers	3897
26.	No. of Anganwadi workers	3897
27.	No of ASHA	2766
28.	No. of electrified villages	583
29.	No. of villages having access to safe drinking water	1445
30.	No of villages having motorable roads	1815

Health Sub-centres

S.No	Block Name	Population 2009 with growth @ 2.7%	Sub-centres required Pop 5000	Sub-centers Present	Sub-centers proposed	Further sub-centers required	Status of building		Availability of Land (Y/N)
							Own	Rented	
1	PATAHI	169618	34	20	13	1			N
2	PAKRIDEYAL	250000	27	17	10	10			N
3	PAHARPUR	16955	33	13	8	12			N
4.	CHAKIA	204504	22	14	22	4			N
5.	MEHSI	166514	34	13	1	10			N
6.	RAMGHARWA	183733	34	13	21	21			N
7.	HARSIDHI	241200	48	16	17	15			N
8.	CHAURADANO	154488	30	15	15	0			N
9.	KALYANPUR	307863	30	21	44	0			N
10.	DHAKA	312007	65	13	52	52	4	9	N
11.	ADAPUR	186426	19	13	19	4			N
12.	MADHUBAN	233118	46	19	17	10			N
13.	CHIRAIYA	262025	51	18	33	33			N
14.	GHORASAHAN	251377	50	18	9	23			N
15.	RAXAUL	202007	20	16	20	4			N
16.	ARERAJ	137335	27	18	22	0			N
17.	SUGAULI	189168	13	13	10	03	5	8	N
18.	KESARIA	147663	29	12	18	0			N
19.	TURKAULIA	346625	70	21	49	49			N

20.	MOTIHARI URBAN	763312	152	16	21	115	6	10	N
	Total	4725938	834	319	421	366	15	27	

Section A: Health Facilities in the District

Additional Primary Health Centers (APHCs)

No	Block Name	Population 2009 with growth @ 2.7%	APHCs required (After including PHCs)	APHCs present	APHCs proposed	APHCs required	Status of building		Availability of Land
							Own	Rented	
1	PATAHI	169618	6	3	1	2			N
2	PAKRIDEYAL	250000	10	2	8	8			N
3	PAHARPUR	16955	6	2	3	1			N
4.	CHAKIA	204504	4	2	4	1			N
5.	MEHSI	166514	7	4	1	3			N
6.	RAMGHARWA	183733	5	0	0	5			N
7.	HARSIDHI	241200	8	2	4	2			N
8.	CHAURADANO	154488	5	2	2	1			N
9.	KALYANPUR	307863	10	2	9	0			N
10.	DHAKA	312007	5	4	0	5			N
11.	ADAPUR	186426	4	3	2	4			N
12.	MADHUBAN	233118	8	3	4	1			N
13.	CHIRAIYA	262025	9	1	6	9			N
14.	GHORASAHAN	251377	8	2	0	6			N
15.	RAXAUL	202007	7	2	4	6			N
16.	ARERAJ	137335	4	3	5	0			N
17.	SUGAULI	189168	4	2	4	4	2	2	N
18.	KESARIA	147663	5	2	3	0			N
19.	TURKAULIA	346625	11	4	5	2			N

20.	MOTIHARI URBAN	763312	25	3	8	14	1	2	N
	Total	4725938	151	48	73	74	3	4	N

Section A: Health Facilities in the District

Primary Health Centers

No	Block Name/sub division	Population	PHCs Present	PHCs required @ Pop 80000 - 120000	PHCs proposed
1	PATAHI	169618	1	2	1
2	PAKRIDEYAL	250000	1	3	2
3	PAHARPUR	16955	1	2	1
4.	CHAKIA	204504	1	3	2
5.	MEHSI	166514	1	3	2
6.	RAMGHARWA	183733	1	3	2
7.	HARSIDHI	241200	1	3	2
8.	CHAURADANO	154488	1	2	1
9.	KALYANPUR	307863	1	4	3
10.	DHAKA	312007	1	3	2
11.	ADAPUR	186426	1	3	2
12.	MADHUBAN	233118	1	2	1
13.	CHIRAIYA	262025	1	3	2
14.	GHORASAHAN	251377	1	3	2
15.	RAXAUL	202007	1	2	1
16.	ARERAJ	137335	1	2	1
17.	SUGAULI	189168	1	2	1
18.	KESARIA	147663	1	2	1
19.	TURKAULIA	346625	1	4	3
20.	MOTIHARI URBAN	763312	1	7	6

	Total	4725938	20	58	38

Section A: Health Facilities in the District

PHC

No	Block Name/sub division	Population	PHCs Present	PHCs required @ Pop 120000 and above	PHCs proposed
1	PATAHI	169618	1	2	1
2	PAKRIDEYAL	250000	1	2	1
3	PAHARPUR	16955	1	2	1
4.	CHAKIA	204504	1	2	1
5.	MEHSI	166514	1	2	1
6.	RAMGHARWA	183733	1	2	1
7.	HARSIDHI	241200	1	2	1
8.	CHAURADANO	154488	1	2	1
9.	KALYANPUR	307863	1	2	1
10.	DHAKA	312007	1	2	1
11.	ADAPUR	186426	1	2	1
12.	MADHUBAN	233118	1	2	1
13.	CHIRAIYA	262025	1	2	1
14.	GHORASAHAN	251377	1	2	1
15.	RAXAUL	202007	1	2	1
16.	ARERAJ	137335	1	2	1
17.	SUGAULI	189168	1	2	1
18.	KESARIA	147663	1	2	1
19.	TURKAULIA	346625	1	2	1
	MOTIHARI URBAN	763312	1	6	5

	Total	4725938	20	44	24

Section A: Health Facilities in the District

Sub-Divisional Hospital

No	Name of sub division	Population	Sub- Divisional Hospital Present	Sub- Divisional Hospital required	PHCs proposed
1.	NIL	0	0	0	0
	Total	0	0	0	0

Section A: Health Facilities in the District

District Hospital

No	Name of District	Population	District Hospital Present	District Hospital required	PHCs proposed
1.	EAST CHAMPARAN	4725938	1	1	24
	Total	4725938	1	1	24

Section B: Human Resources and Infrastructure

Sub-centre database

	No. of Sub center present	No. of Sub center required	Gaps in Sub centers	ANMs (R)/(C) posted formally	ANMs (R)/(C) posted required	Gaps in ANMs(R)/(c)	Building ownership (Govt)	Required Building (Govt)	Gaps in Buildings (Govt.)	ANM residing at HSC area (Y/N)	Condition of residential facility (+++/++/+/#)	Status of furniture's	Status of Untied fund
1	319	834	515	291/110	128/393	128/393	190	129	129	Y	+++	#	unexpended

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

Section B: Human Resources and Infrastructure

Additional Primary Health Centre (APHC) Database: Infrastructure

No	No. of APHC present	No. of APHC required	Gaps in APHC	Building ownership (Govt)	Building Required (Govt)	Gaps in building	Building condition (+++/++/#)	Condition of Labour room (+++/++/#)	No. of rooms	No. of beds	Condition of residential facility (+++/++/+/#)	MO residing at APHC area (Y/N)	Status of furniture	Ambulance/ vehicle (Y/N)
1	48	151	103	24	127	0	#	#	52	104	#	Y	NA	Y
Tot.	48	151	103	24	127	0	#	#	52	104	#	Y	NA	Y

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

Section B: Human Resources and Infrastructure

Additional Primary Health Centre (APHC) Database: Human Resources

No	No. of APHC	Doctors		ANM		Laboratory technician		Pharmacists / dresser		Nurses A Grade		Accnt/Peons/Sweeper/Night Guards	Availability of specialist
		Sanction	In Position	Sanction	In position	Sanction	In position	Sanction	In position	Sanction	In Position		
1	48	02	0	0	0	0	0	0	0	2	0	0/1/1/0	0

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

Section B: Human Resources and Infrastructure

Primary Health Centres : Infrastructure

No	No. of PHC present	No. of PHC required	Gaps in PHC	Building ownership (Govt)	Building Required (Govt)	Gaps in Building	No. of Toilets available	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. Places where rooms > 5	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/++/#)
1	20	58	38	20	38	38	20	20	+++	20	6 (per PHC)	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

B: Human Resources and Infrastructure

Section B: Human Resources and Infrastructure

Referral Hospital : Infrastructure

Referral Hospital : Human Resources

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

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

	Referral Hospital	Population Served	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses		Specialists		Storekeeper
			Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	3	726763	12	11	8	4	0	0	0	0	4	2	3	2	1

Section C: Equipment, Drugs and Supplies

No.	Name of facility	Equipment required
1	Family Planning	BP Blade, BP Handle, Forceps, Scissors, Catguts etc.
2	JBSY	Labor Table, Mattress, Labor conducting for forceps etc.
3	Immunization	Deep Freezer, ILR ect.
4	Puls Polio	Vaccision Career ect.
5	Filareia	Vehicles etc.

Availability of Equipment

Procurement and Logistics Management for Drugs

No.	Name of facility	Drugs required	Stock outs last year	
			Name of Drug	Months
1	Family	Atropine, Catmin, Diagipam inj, Antibiotics etc.		

	planning			
2	JBSY	Mathalzin inj & Tab., Antisparkodic inj. Etc.		
3	Immunization	Hub Cutter etc.		
4	Filareia	MDA, DEC		

Procurement and Logistics Management for Supplies

No.	Name of facility	Supplies required	Stock outs last year	
			Name of Supply	Months
1	ALL 20 PHC	CHAIR, TABLE, FAN, BULB,STOCK REGISTER		
2				
3				
4				
5				
6				

Section D: RKS, Untied Funds and Support Services

Rogi Kalyan Samitis

No	Name of Facility	RKS set up (Y/N)	Number of meetings held	Total Funds	Funds Utilized
1	ALL 20 PHC LAVEL	Y	12	2500000	1500000
2	SADAR HOSPITAL	Y	12	200000	110000

Untied Funds

No.	Name of the Facility	Funds received	Funds utilized
1	ALL 20 PHC LAVEL	3150000	3150000

Support Systems to Health facility functioning

No	Facility name	Services available								
		Ambulance	Generator	X-ray	Laboratory services O/I/ NA				Canteen	Housekeeping
		O/I/ NA	O/I/ NA	O/I/ NA	Pathology	Malaria/kalaazar	T B		O/I/ NA	
1	20 PHC LEVEL	O	O	O	O	I	I		NA	O/I
2	SADAR HOSPITAL	I	O	I/O	I	I	I		**NA**	O

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

Section E: Health Services Delivery

Name of the District:			
No.	**Service**	**Indicator**	**District Data**
1	***Child Immunisation***	% of children 9-11 months fully immunized (BCG+DPT123+OPV123+Measles)	61.09%
		% of immunization sessions held against planned	85%
2	***Child Health***	Total number of live births	10485

		Total number of still births	288
		% of newborns weighed within one week	90%
		% of newborns weighing less than 2500 gm	20%
		Total number of neonatal deaths (within 1 month of birth)	85
		Total number of infant deaths (within 1-12 months)	51
		Total number of child deaths (within 1-5 yrs)	20
		Number of diarrhea cases reported within the year	453
		% of diarrhea cases treated	100%
		Number of ARI cases reported within the year	NA
		% of ARI cases treated	NA
		Number of children with Grade 3 and Grade 4 undernutrition who received a medical checkup	NA
		Number of children with Grade 3 and Grade 4 undernutrition who were admitted	334
		Number of undernourished children	NA
		% of children below 5 yrs who received 5 doses of Vit A solution	96%
3	***Maternal Care***	Number of pregnant women registered for ANC	37458
		% of pregnant women registered for ANC in the 1st trimester	60%
		% of pregnant women with 3 ANC check ups	56%
		% of pregnant women with any ANC checkup	95%
		% of pregnant women with anaemia	12%
		% of pregnant women who received 2 TT injections	100%

		% of pregnant women who received 100 IFA tablets	96%
		Number of pregnant women registered for JBSY	37218
		Number of Institutional deliveries conducted	37218
		Number of home deliveries conducted by SBA	12358
		% of institutional deliveries in which JBSY funds were given	100%
		% of home deliveries in which JBSY funds were given	NIL
		Number of deliveries referred due to complications	1445
		% of mothers visited by health worker during the first week after delivery	98%
4	***Reproductive Health***	Number of MTPs conducted	NA
		Number of RTI/STI cases treated	NA
		% of couples provided with barrier contraceptive methods	50%
		% of couples provided with permanent methods	28.40%
		% of female sterlisations	34%
5	***RNTCP***	% of TB cases suspected out of total OP	2.85%
		Proportion of New Sputum Positive out of Total New Pulmonary Cases	55.06%
		Annual Case Detection Rate (Total TB cases registered for treatment per 100,000 population per year)	57.10%
		Treatment Success Rate (% of new smear positive patients who are documented to be cured or have successfully completed treatment)	90.99%
		% of patients put on treatment, who drop out of treatment	4.7%
6	***Vector Borne Disease Control Programme***	Annual Parasite Incidence	NA
		Annual Blood Examination Rate	NA
		Plasmodium Falciparum percentage	NA

		Slide Positivity Rate	NA
		Number of patients receiving treatment for Malaria	NA
		Number of patients with Malaria referred	NA
		Number of FTDs and DDCs	NA
7	***National Programme for Control of Blindness***	Number of cases detected	147520
		Number of cases registered	131053
		Number of cases operated	18640
		Number of patients enlisted with eye problem	42413
		Number of camps organized	65
8	***National Leprosy Eradication Programme***	Number of cases detected	678
		Number of Cases treated	678
		Number of default cases	03
		Number of case complete treatment	739
		Number of complicated cases	NIL
		Number of cases referred	NIL
9	***Inpatient Services***	Number of in-patient admissions	66253
10	***Outpatient services***	Outpatient attendance	865231
11	***Sergical Services***	No. of Major surgeries conducted	
		No. of Minor surgeries conducted	

*** data collection is under process.

Section F: Community Participation, Training & BCC

Community Participation Initiatives

S. No	**Name of Block**	**No. of GPs**	**No. VHSC formed**	**No. of VHSC meetings held in the block**	**Total amount released to VHSC from untied funds**	**No. of ASHAs**	**Number of ASHAs trained**		**Number of meetings held between ASHA and Block offices**	**Total amount paid as incentive to ASHA**
							Round 1	**Round 2**		

1	PATAHI	19	19	-	-	146	113	-	12	NA
2	PAKRIDEYAL	10	10	-	-	81	8	-	12	NA
3	PAHARPUR	21	21	-	-	89	76	-	12	NA
4	CHAKIA	18	18	-	-	189	165	-	8	NA
5	MEHSI	15	15	-	-	99	99	-	12	36000
6	RAMGHARWA	16	16	-	-	128	107	-	12	NA
7	HARSIDHI	19	19	-	-	181	150	-	12	600000
8	CHAURADANO	15	15	-	-	110	77	-	12	NA
9	KALYANPUR	27	27	-	-	185	151	-	12	NA
10	DHAKA	27	27	-	-	184	88	95	12	1864
11	ADAPUR	19	19	-	-	93	63	-	12	NA
12	MADHUBAN	13	13	-	-	87	24	-	9	4320
13	CHIRAIYA	21	21	-	-	190	190	-	9	500000
14	GHORASAHAN	14	14	-	-	191	145	-	12	NA
15	RAXAUL	13	13	-	-	92	67	-	12	NA
16	ARERAJ	13	13	-	-	215	151	-	12	NA
17	SUGAULI	18	18	-	-	108	108	-	12	NA
18	KESARIA	17	17	-	-	76	76	-	12	NA
19	TURKAULIA	13	13	-	-	177	177	-	12	NA
20	MOTIHARI SADAR	19	19	-	-	145	145	-	12	NA
21	BANJARIA	11	-	-	-	-	-	-	-	-

22	BANKATWA	10	-	-	-	-	-	-	-	-
23	KOTWA	14	-	-	-	-	-	-	-	-
24	PHENHARA	10	-	-	-	-	-	-	-	-
25	PIPRA KOTHI	6	-	-	-	-	-	-	-	-
26	SANGRAMPUR	12	-	-	-	-	-	-	-	-
27	TETARIA	11	-	-	-	-	-	-	-	-
	TOTAL	421	346			2766	2180		230	

Note- Untied fund release to all HSC'S. RS 10,000 each.

Training Activities:

S.No	Name of Block	Rounds of SBA Trainings held	No. of personnel given SBA Training	Rounds of IMNCI Trainings held	No. of personnel given IMNCI Training	Any specific issue on which need for a training or skill building was felt but has not being given yet
1.	District level	4	24 per batch	1 round	24	Required more training for TOT and block level training to improve the quality of

						health worker.

BCC. ACTIVITY-

No.	Name of Block	BCC campaigns/ activities conducted
1	PATAHI	Community meetting, Mahila Mandal Meetting, I.E.C., etc.
2	PAKRIDEYAL	Do
3	PAHARPUR	Do
4	CHAKIA	Do
5	MEHSI	Do

6	RAMGHARWA	Do
7	HARSIDHI	Do
8	CHAURADANO	Do
9	KALYANPUR	Do
10	DHAKA	Do
11	ADAPUR	Do
12	MADHUBAN	Do
13	CHIRAIYA	Do
14	GHORASAHAN	Do
15	RAXAUL	Do
16	ARERAJ	Do
17	SUGAULI	Do
18	KESARIA	Do
19	TURKAULIA	Do
20	MOTIHARI SADAR	Do
21	BANJARIA	Do
22	BANKATWA	Do
23	KOTWA	Do
24	PHENHARA	Do
25	PIPRA KOTHI	Do
26	SANGRAMPUR	Do

27	TETARIA	Do

District and Block level Management

S.No	Name of Block	Health Manager Appointed (Y/N)	Accountant appointed (Y/N)	Store keeper appointed (Y/N)
	DISTRICT	DPM-Y	DAM-Y, DA-Y	N
1	PATAHI	Y	N	N
2	PAKRIDEYAL	Y	N	N
4	PAHARPUR	Y	N	N
5	CHAKIA	Y	N	N
6	MEHSI	Y	N	N
7	RAMGHARWA	Y	N	N
8	HARSIDHI	Y	N	N
9	CHAURADANO	Y	N	N
10	KALYANPUR	N	N	N
11	DHAKA	Y	N	N
12	ADAPUR	Y	N	N
13	MADHUBAN	Y	N	N
14	CHIRAIYA	Y	N	N
15	GHORASAHAN	Y	N	N
16	RAXAUL	Y	N	N

17	ARERAJ	Y	N	N
18	SUGAULI	Y	N	N
19	KESARIA	N	N	N
20	TURKAULIA	Y	N	N
21	MOTIHARI SADAR	Y	N	N
22	BANJARIA	N	N	N
23	BANKATWA	N	N	N
24	KOTWA	N	N	N
25	PHENHARA	N	N	N
26	PIPRA KOTHI	N	N	N
27	SANGRAMPUR	N	N	N

Health Sub Centers:

The overall objective is to provide health care that is quality oriented and sensitive to the needs of the community. The objectives for Sub-Centers 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.

Indicators	Gaps	Issues	Strategy	Activities
Infrastructure	1) Sub centers present – 319; Sub centers proposed – 834; Sub centers required – 1153	1) To increase the number of HSCs (319 to 1153) 2) To make functional 315+472 = 787 HSCs	Short Term Strategy: 1) To optimize the use of existing resources by their	Short Term: 1. Repairing of existing building and infrastructure 2. Where repairing is not

	2) The district needs 319 +834= 1153 HSCs to start and make functional 3) 58.09 (183 out of 319) HSCs are on rent and rent is outstanding science 5 years and above. 4) Building conditions are very poor. Out of 319 existing HSCs, 218 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 &	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.	repairing and upgrading 2) To hire buildings if required 3) Short term measures to enhance the infrastructure requirements 4) Resolution of local or political issues and handover of buildings Long Term Strategy: 1) Development of proposed HSC 2) Sanctioned of	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: tube well 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

	furniture as per IPHS Norms 9) Non availability of HMIS formats/ registers and stationary 10) Unavailability of labor rooms, clinic rooms, examination rooms, toilets 11) Lack of display boards, visiting schedule of ANM, complain/suggesti on box 12) No residential accommodation facility		further required HSC Monitoring:	buildings according to IPHS norms. Assure completion within one year. 3. Community mobilization for promoting land donations at accessible locations. 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.
Human Resource	1) Only one ANM is posted at one HSC. Required HSC =834 Existing HSC = 319 Total ANM = 1153 Total HW = 2) Lack of Male and Female Health Workers and volunteers at HSC 3) Lack of Skilled ANM and HW 4) Below standard record keeping and reporting	1) To hire 344 ANM required 2) To post at least one Male Health Worker at each HSC 3) To train ANM and Health Workers 4) Continuous training at local level by Medical Officers in the block 5) To focus on record keeping and reporting system at HSC level	Short Term: 1) Effectively and efficiently use the existing human resource – Proper Placement and Transfer 2) Local Training for improvement of Knowledge, Skill and Attitude 3) Performance based incentive/ punishment plans Long Term: 1) Recruitment and Selection 2) Training and	Short Term: 1) Bimonthly review and training programs at PHC/ APHC level to the existing ANM and HW by MO/ MOIC or BHM 2) Bimonthly meeting/ review of all ASHA and AWW at HSC with ANM and BHM 3) Monitoring and evaluation of work at HSC level by MO/ BHM 4) Mobile team for uncovered areas including one MO, one ANM and one HW. Weekly visit plan to that uncovered areas. 5) More focus on weekly meeting at PHC level. Long Term: 1) Staff recruitment 2) Capacity building 3) Strengthening of ANM

			Development	training school
				4) Public – private partnership for HR development
Drug kit availability	1) No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, 2) Irregular supply of drugs	Indenting Logistics	Strengthening of reporting process and indenting through form 2 and 6 and delegating the purchase power from District to PHC level. Couriers for vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs	1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through ANMs account 4.1 Purchasing of cold chain equipments as per

			storage	IPHS norms
				4.2 training of concerned staffs on cold chain maintenance and drug storage
Service performance	1) Unutilized untied fund at all HSC 2) No institutional delivery at HSC level 3) Hard to reach areas (12 blocks are flood affected 4) Antenatal Care 1. Early registration of pregnant women (only 18.7%) 2. Minimum three antenatal checkups (only 32.2%) 3. Other associated services (one TT inj. during pregnancy 69.7%) 5) Intra-natal and post natal care (Institutional birth 24.9%)(Mother who receive post natal care within 48 hr of	1) Operationalization of Untied fund. 2) Lack of delivery room and other facilities at sub centre level. 3) Improvement in quality of services like ANC, NC and PNC, Immunization, in Hard to reach areas in rainy season. 4) Integration of disease control programs at HSC level. 5) Family Planning services at HSC level 6)To improve reporting system from HSC to PHC regarding community needs and disease survillence 7) Need to develop ANM and Health Workers as a trainer	Capacity building of account holder of untied fund Renovation of HSC, through construction of delivery room & supply of equipments. Phase wise strengthening of	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts at HSCs untied fund 1. Establishment of a task force & Training of his staffs for working in drastic conditions 2. Give some addl. Remuneration/ incentives. 3. Arrangement of Boats/Vehicles for movement in Hard to reach areas 4. Involvement of community leaders / PRI. 1 Gap identification of HSCs through facility survey 2.strengtheing one HSC

	delivery 9.5%) 6) Child Health: Children fully immunized 30.2% Children who receive BCG 76.2% Children who receive 3 doses of Polio 39.7% Children who receive 3 doses of DPT 45.3% Children who receive measles Vaccine 40.4% 7) Field Visits: Poor Tour Plans not followed 9) Community Need Assessment: Poor 10) Curative Services : Not available at HSC 11) Training, coordination and monitoring	to train ASHA and AWW	HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through HSC level Community focused Family Planning services	per PHC for institutional delivery in first quarter 3.Ownering first delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on

				IUD insertion
			Convergence	1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. 2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues

Additional PHC:

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.

Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	The district altogether need 156 APHCs but there are only 46 functioning APHC 86 APHC are newly sanctioned & 24 Aphc are still to be formed. Out of 46 APHCs only 40 are having own building Existing 25	Lack of facilities/ basic amenities in the constructed buildings Nonpayment of rent Land Availability for new construction Constraint in transfer of constructed building. Lack of community ownership.	Strengthening of VHSCs, PRI and formation of RKS	1.Strengthen community ownership 2.Nukkad Nataks on Citizen's charter of APHCs as per IPHS 3. Registration of RKS 4.Monthly meetings of VHSCs, Mothers committees and RKS **A. Strengthening of APHCs having own**

	buildings are not properly maintained Nonpayment of rent of 6 APHCs for long period. 128 APHC need new building construction All Existing APHC Need Major repair Running water supply is not available Non availability of Labour room. None of the APHC has Power Supply. All Existing APHC require new construction of toilet Lack of equipments, Lack of appropriate furniture Non availability of		Strengthening of Infrastructure and operationalization of construction works in Three phase	**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 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments

	HMIS formats/registers and stationeries			as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new APHC buildings as standard layout of IPHS norms. C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New APHC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed APHCs buildings. 4 Biannual facility survey of APHCs through local NGOs as per IPHS format 4.1 Regular monitoring of APHCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of

			Monitoring	renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.
Human Resource	Out of 46 APHCs have 92 doctor is required but only 8 doctors posted, Out of 184 grade A Nurse only 24 grade A Nurse has been appointed , but they are deputed at PHC or district Hospital Out of 184 Male Health Worker only 80 have been posted.	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building	1.Selection and recruitment of ….Doctors/Grade A nurse/ANMs 2.Selection and recruitment of …male workers 3. Sending back the staffs to their own APHCs. 1. Training need Assessment of APHC level staffs 2. Training of staffs on various services

				3. EmoC Training to at least one doctor of each APHC
			Strengthening of ANM training school	1. Analyzing gaps with training school 2. Deployment of required staffs/trainers 3. Hiring of trainers as per need 4. Preparation of annual training calendar issue wise as per guideline of Govt of India. 5. Allocation of fund and operationalization of allocated fund
Drug kit availability	No drug kit as such for the APHCs as per IPHS norms. (Kit A, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs) and	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 2 and 6	1.Weekly meeting of APHC staffs at PHC for promoting APHC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC

	contraceptives,			wise logistics route map
	Only need based emergency supply Irregular supply of drugs			2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the APHC to PHC(First reminder-Red, Second reminder-Blue, Third reminder-Yellow)
			Couriers for vaccine and other drugs supply	3.1 Hiring of couriers as per need 3.2 Payment of courier through APHC account
			Phase wise strengthening of APHCs for vaccine / drugs storage	4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage

Service performance	RKS has not been formed at any of the APHC. Unutilized untied fund at APHC level No institutional delivery at APHC level OPD for 2days only in most of the APHC No inpatient facility available No ANC, NC and PNC and family planning services. No lab facility 6 Ayush practitioner posted	Formation of RKS Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps. Integration of disease control programs at	Capacity building of account holder of untied fund Phase wise strengthening of 16 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms. Mobile Medical Units (MMUs) to be operationalized	1.Training of signatories on operating Untied fund / RKS account, book keeping etc 2. Assigning PHC RKS accountant for supporting operationalization of APHC level accounts 2. Timely disbursement of untied fund/ seed money for APHCs RKS. 3. 1 Gap identification of 16 APHCs through facility survey 2.strengtheing one APHC per PHC for institutional delivery in first quarter 3.Ownering first delivered baby and ANM Medical Care: 1. OPD (40/day/doctor) 2. 24 hr emergency services 3. Referral services 4. inpatient services 6 beds 1 Review of all disease control programs APHC wise in existing Tuesday

	No rehabilitation services No safe MTP service No OT/ dressing and Cataract operation services. Approx 80% of APHC staffs not reside at place of posting Lack of counseling services Problem of mobility during rainy season Lack of convergence at APHC level Operational gaps: There is no link between HSCs and APHCs and the same way there is no link between APHC and PHC	APHC level. Family Planning services Convergence Operational issues	Implementation of disease control programs through APHC level where APHC will work as a resource center for HSCc. At present the same is being done by PHC only. Community focused Family Planning services	weekly meetings at PHC with form 6 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 5.Weekly meeting of the staffs of concerned HSCs (as assigned to the APHC) 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1.Outsourcing services for Generator, fooding,

			PPP	cleanliness and ambulance i
			Convergence	1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. 2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues 3. Arrangement of Hand Pump through PHED 4. Electricity connection through local electricity department 5. Telephone connection.

Staff Position in APHCs as per IPHS norms

Staff Designation	Existing Position	Recommended Position
Medical Officer	1	2(one may be from AYUSH or Lady Medical Officer)
Nurse-midwife (Staff nurse)	1	3 (for 24-hour PHCs) (2 may be contractual)
Health Worker Female	1	1
Health educator	1	1
Health Assistant (Male and Female)	1	2
Clerks	1	2
Lab Technicians	1	1
Driver	1	1
Grade IV	4	4

Primary Health Centers:(30 beaded)

Indicators	Gaps	Issues	Strategy	Activities
Infrastructure	The district altogether needs 27 PHCs but there are only 20 functioning PHC. 7 PHC are required to be formed. All 20 PHCs are having own building All 20 PHCs are running with only six bed facility. **Delivery** : At present only 20 PHC's is conducting delivery.0020 At an average of 5 delivery per day Out of which only 14 PHC having an average of 10 delivery per day. **Family Planning** 20 PHC's are conducting at an average of 3 Family Planning Operation	Available facilities are not compatible with the services supposed to be delivered at PHCs. Quality of services Community participation.	Up gradation of PHCs into 30 bedded facilities. ISO certification of selected PHCs in the district. Strengthening of BMU	1.Need based (Service delivery)Estimation of cost for up gradation of PHCs 2. Preparation of priority list of interventions to deliver services. 1. Selection of any two PHCs for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers in rest of the vacant place & Accountants in all institutions. 3. Training to the RKS signatories for account

	per week.			operation.
	OPD / Minor operation/ Emergency is 185 per day This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms 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		Ensuring community participation. Strengthening of Infrastructure and operationalization of construction works	4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community representatives on erecting boundary, beautification etc, 2. Nukkad Nataks on Citizen's charter of HSCs as per IPHS 1.1 Monthly meetings of VHSCs, Mothers committees **3A.Strengtheing of HSCs having own buildings** A.1Rennovation of HSCs A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of

	equipments.			equipments
	Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries Operation of RKS: Lack in uniform process of RKS operation. Lack of community participation in the functioning of RKS. Lack of facilities/ basic amenities in the PHC buildings			A.5 Printing of formats and purchase of stationeries **3B. Strengthening of HSCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new HSCs C1. Preparation of PHC wise priority list of HScs according to IPHS population and location

				norms of HScs
			Monitoring	C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings. 4 biannual facility survey of HSCs through local NGOs as per IPHS format 4.1 Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work.

				4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.
Human Resource	Doctors : Existing 20 PHC district have 138 sanctioned post of regular doctor only 80 (r) + 91 (c) are working . Grade A Nurse : Out of 26 sanctioned post only 2 are working. ANM :- Out of 428 sanctioned post only 291 are working. Lab Technician :-	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training	1. Selection and recruitment of ….ANMs 2. Selection and recruitment of …male workers 1. Training need Assessment of HSC level staffs 2. Training of staffs on various services 1. Analyzing gaps

	Out of 52 sanctioned post only 17 are working. Pharmacist :- Out of 52 sanctioned post only 20 are working. Block Extension Educator :- Out of 12 sanctioned post only 11 are working. Health Educator :- Out of 32 sanctioned post only 29 are working. L.H.V :- Out of 29 sanctioned post only 22 are working. Out of 20 BHM & Accountant but at present all are vacant.		school	with training school 2. Deployment of required staffs/trainers 3. Hiring of trainers as per need 4. Preparation of annual training calendar issue wise as per guideline of Govt of India. 5. Allocation of fund and operationalization of allocated fund
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time. Only … % essential drugs are rate contracted at state level .	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system	1.training of store keepers on invoicing of drugs 2.Implementing

				computerized invoice system in all PHCs
	Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.		Phase wise strengthening of APHCs for vaccine / drugs storage	3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	1.Exessive load on PHC in delivering all services i.e. 10 delivery per day, Family Planning operation/emergency operation and 185 OPD per day in each PHC. Lack of counseling services Problem of mobility during rainy season	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization,	Capacity building of account holder of untied fund Phase wise strengthening of 30 HSCs for Institutional	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts at HSCs untied fund 1 Gap identification of 30 HSCs through facility survey

	Lack of convergence	Family Planning services Convergence	delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through HSC level Community focused Family Planning services	2.strengtheing one HSC per PHC for institutional delivery in first quarter 3.Ownering first delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of

				AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion
			Convergence	1. Fixed Saturday for meeting day of ANM, AWW, ASHA, with VHSCs rotation wise at all villages of the respective HSC. 2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues
Operational				

S.No.	Indicators	Present Status (09-10)	% Availability	Availability as per DLHS 3	%age Availability
1	PHC having Residential Quarter for Medical Officer	20 (Repairable)	100%	19	95%
2	PHC having separate Labour Room	20 (Repairable)	100%	11	55%
3	PHC having Personal Computer	0	0	0	0
4	PHC having Normal Delivery Kit	12	60%	12	60%

5	PHC having Large Deep Freezer	6	30%	6	30%
6	PHC having regular water supply	20	100%	21	105%
7	PHC having Neonatal Warmer (Incubator)	0	0	2	10%
8	PHC having Operation Theater with Boyles Apparatus	3	15%	3	15%
9	PHC having Operation Theater with anaesthetic medicine	1	5%	9	45%

Sub divisional / Referral Hospital

Indicators	Gaps	Issues	Strategy	Activities
Infrastructure	The district has been requiring 5 sub divisional Hospital but there are no any functioning. The district has 3 Referral Hospital are functioning. Referral Hospital have own building but not adequate space. Require additional building **Delivery** : At present normal delivery is 10 cesarean or other operation 3 Conducting per day	Available facilities are not compatible with the services supposed to be delivered at Referral Quality of services Community participation.	Upgradation of Referral into 100 bedded facilities. ISO certification of selected Referral in the district. Strengthening of BMU	1.Need based (Service delivery)Estimation of cost for upgradation 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

	Family Planning			monthly meeting of RKS.
	Family Planning Operation 3 per week. OPD / Minor operation/ Emergency is 185 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		Ensuring community participation.	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

	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		Strengthening of Infrastructure and operationalization of construction works Monitoring	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.

Human Resource	Doctors :	Filling up the staff shortage	Staff recruitment	* Recruitment of Doctors like Obstetrician & Gynecologist, Anesthetist
	Lack of Obstetrician & Gynecologist, Anesthetist Lack of Grade A Nurse, O.T Assistant, Ward Boys, Sweeper, Chowkidar, Ophthalmic Assistant	Untrained staffs	Capacity building Strengthening of ANM training school	1. Selection and recruitment of Grade A Nurse 2. Selection and recruitment of male workers like O.T Assistant, Ward Boys, Ophthalmic Assistant 3. Training need Assessment of Sub div. level staffs 4. Training of staffs on various services 5. Deployment of required staffs/ trainers 6. Hiring of trainers as per need 7. Preparation of annual training calendar issue wise as per guideline of Govt of India.

				8. Allocation of fund and operationalization of allocated fund
Drug kit availability	Irregular supply of drugs because of improper assessment and improper supply and centralized distribution. Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 8 Strengthening of drug logistic system Phase wise strengthening of A Referral for vaccine / drugs storage	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all Referral 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	1.Exessive load on Referral Hospital in delivering all services i.e. 10 delivery per day,	Operationalization of Untied fund. Improvement in	Capacity building of account holder of untied fund	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of

	Family Planning operation/emergency operation and 185 OPD per day in each Hospital. Lack of counseling services Problem of mobility during rainy season Lack of convergence	quality of services like ANC, NC and PNC, Immunization,	Phasewise strengthening of Institutional delivery and fix a day for ANC as per IPHS norms. Community focused Family Planning services Convergence	untied fund form DHS Strengtheing Sub Div. Hospital for institutional delivery in first quarter Submission of reports of all programs by the supervisors duly signed by the respective Head. 1. Ensuring supply of contraceptives with three month's buffer stock at Sub Div. Hospital 3. Training of staffs on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1. Fixed Saturday for meeting day of ANM, AWW, ASHA
Operational				

District Hospital

The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of the people of the district. The specific objectives of IPHS for DHs are:

i. To provide comprehensive secondary health care (specialist and referral services) to the community through the District Hospital.
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 people of the district and the hospitals/centers from which the cases are referred to the district hospitals

Indicators	Gaps	Issues	Strategy	Activities
Infrastructure	1) Size of Hospital: Number of beds is 100 which are far less than the requirement. Standard is 500 beds. 2) Building and Space Requirement: Poor building conditions need minor repairing Number and conditions of toilets are poor.	To increase number of beds up to 500 Repairing and Maintenance of Old Building New buildings for RCH, wards, diagnostic services, waiting space etc Need of new toilets Expantion of delivery wards to make it 60 bedded ward One ward of 30 beds for Family Planning Operation	Repairing of existing buildings and infrastructures Repairing of boundary wall Hand-over of buildings already completed Timely completion of work in progress Construction of new buildings needed One water tank One separate	1.Need based (Service delivery)Estimation of cost for upgradation of Referral 2.Preparation of priority list of interventions to deliver services. 1.Selection of any two Referral for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular

	3) Ambulatory Care Area (OPD):	New building for laundry, kitchen, mortuary etc	transformer for power supply	monthly meeting of RKS.
	No general or subsidiary waiting space/ room for patients	Repairing of water tank. Installation of new tube wells (5 at least)	Upgradation into 500 beded facilities.	
	Diagnostic Services: No ultrasound, radio-diagnosis facility	New buildings for residential quarters and community hall.	Strengthening of BMU	2. Appointment of Block Health Managers, Accountants in institutions 3. Training to the RKS signatories for account operation.
	Clinical Laboratory: Outsourced			
	Blood Bank:	Not Functioning		4. Trainings of BHM and accountants on their responsibilities.
	4) Intermediate Care Area (Inpatient Nursing Units):	General Wards need Minor repair	Community participation	1.Meeting with community representatives on erecting boundary, beautification etc,
	5) Critical Care Area (Emergency Services):	. Not independent of OPD		2.Monthly meetings of DHS, RKS A.1Rennovation of **buildings**
	6) Therapeutic Services:	OT: Not according to IPHS Delivery Suit Unit: No distinct antenatal and postnatal wards		A.2 Purchase of Furniture
	Toilet condition poor			A.3 Prioritizing the equipment list according to service delivery
	Sanitation, waste			A.4 Purchase of

	disposal poor		Strengthening of	equipments
	Physiotherapy: Need separate building 7) Hospital Services: Hospital Kitchen: Central sterile and supply department: Hospital Laundry: Mortuary: Medicine and General Store 8) Engineering and Services: Electric engineering: Generator and lighting Call Bells: Mechanical Engineering: AC, Room Heating Public Health Engineering: Water Supply:	Need new building Storage Condition is poor Continuous Water Supply – not	Infrastructure and operationalization of construction works Monitoring	A.5 Printing of formats and purchase of stationeries 3C. Construction of new **buildings** according to IPHS norms 3.1 Monitoring of renovation/construction works through DHS/RKS members.

	Drinking Water:	continuous for 24		
	Drainage and Sanitation: Poor Waste disposal System: 9) Fire Protection: 10) Telephone and Intercom: Parking: Committee room: Residential Quarters:	hours Not available. Dependent on tube well. No separate parking area No separate committee room		Need minor repairs Insufficient, more quarters are needed (7 for doctors, 6 for paramedical staffs)
Human Resource	Doctors: Only 13 doctors. Sanctioned 14 Standard 25 Paramedical: Only 7 Nurses. Sanctioned 8 Standard is 100-150	Appointment of new Doctors and Paramedical Staffs Use of Contractual Staffs and Outsourcing for different services	Staff recruitment Capacity building	Selection and recruitment of Doctors and Paramedical Staffs Selection and recruitment of …male workers Training need Assessment of Dist. level staffs Training of staffs on various services

	lab technician:			
	Sanctioned 3 Pharmacist: Only 1 Sanctioned 1 Standard 5 Dresser: Only 3 Sanctioned 3 No O.T Assistant: Sanctioned 1 Standard 5 Other Staffs are also insufficient and not according to the norms of IPHS		Strengthening of ANM training school	Analyzing gaps with training school Deployment of required staffs/trainers Hiring of trainers as per need Preparation of annual training calendar issue wise as per guideline of Govt of India. Allocation of fund and operationalization of allocated fund
Drug kit availability	(A) Drugs 1) OPD Drugs: Only 37 OPD Standard is 104 2) IPD Drugs: Only 57 IPD Drugs Standard is 107	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 8 Strengthening of	

	(B) Equipments 1) Imaging Equipments: No Dental X-ray Machine, No Ultra sonogram, No C.T. Scan 2) X-Ray room accessories: Not according to IPHS 3) Cardiac Equipment: ECG 1 Not according to IPHS 4) Labor Ward & Neo Natal Equipments: Lacking weighing machines, baby incubators, phototherapy unit, etc as according to IPHS		drug logistic system	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all Referral 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	Blood Bank ECG Nonfunctioning of RKS	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization, Integration of disease control programs at	Capacity building of account holder of untied fund	It provides effective, affordable healthcare services (curative including specialist services, preventive and promotive) for a defined population, with their full participation and in co-operation with agencies in

		Dist. level.		the district that have
	6. Essential Services (Minimum Assured Services) Services include OPD, indoor, emergency services. Secondary level health care services regarding following specialties will be assured at hospital: Consultation services with following specialists: General Medicine General Surgery O&G services Pediatrics including	Family Planning services	Community focused Family Planning services	similar concern. It covers both urban population (district headquarter town) and the rural population in the district. 2. Function as a secondary level referral centre for the public health institutions below the district level such as Sub-divisional Hospitals, Community Health Centres, Primary Health Centres and Sub-centres. 3. Technical and administrative support and education and training for primary health care

	Neonatology			
	Emergency (Accident & other emergency) Critical care Anesthesia Ophthalmology ENT Dermatology and Venerology (Skin & VD) RTI/STI Orthopedics Radiology including ultrasonologist Radiotherapy Dental care Public Health Management Psychiatry Plastic Surgery Allergy Super Specialties Cardiology Cardio-thoracic Vascular Surgery			

	Gastro-entomology			
	Surgical Gastro-entomology Nephrology Urology Neurology Neurosurgery Oncology Endocrinology/Metabolism Diagnostic and other Para clinical services regarding: Laboratory services Imaging services CT Scan services Pornography ECG EEG Echocardiogram Endoscopy Angiography Echocardiography			

	Pathology Physiotherapy Dental Technology (Dental Hygiene) Drugs and Pharmacy Ancillary and support services: Following ancillary services shall be ensured: Medico-legal /postmortem Ambulance services Dietary services Laundry services Security services Waste management Counseling services for domestic violence, gender violence, adolescents, etc. Gender and socially sensitive service delivery be assured. Ware housing/			

	central store			
	Maintenance and repair Electric Supply (power generation and stabilization) Water supply (plumbing) Heating, ventilation and air-conditioning Transport Communication Medical Social Work Nursing Services Sterilization and Disinfection Horticulture (Landscaping) Lift and vertical transport Refrigeration Administrative services (i) Finance* (ii) Medical records (Provision should be			Outsourcing of services like laundry, ambulance, dietary, housekeeping and sanitation, waste disposal etc. to be arranged by hospital itself. Manpower and outsourcing work could be done through local tender mechanism

	made for computerized medical records with anti-virus facilities whereas alternate records should also be maintained) (iii) Procurement (iv) Personnel (v) Housekeeping and Sanitation (vi) Education and training (vii) Inventory Management Services under various National Health and Family Welfare Programmes Epidemic Control and Disaster Preparedness			Medical Superintendent to be authorized to incure and expenditure up to Rs.25.00 lakhs for repair/upgrading of impaired equipments/instruments with the approval of executive committee of RKS. Financial powers of Head of the Institution Financial accounting and auditing be carried out as per the rules along with timely submission of SOEs/UCs. No equipment/instruments should remain non-functional for more than 30 days. It will amount to suspension of status of IPHS of the concerned institutions for absence period.

Non-Governmental Organization [NGOs]

Non-Governmental Organization [NGOs]: These are the following NGOs working in the field of Health Sector in District East Champaran viz.:

1. Samajik Sodh Evam Vikash Kendara.
2. Mahila Vikash Seva Sansthan
3. Bhagat Singh Jan Lok Kalyan Seva Sansthan.
4. Institute for Development & Educational Awareness
5. Mushahar Vikash Manch
6. Dunkun Hospital
7. Bharuka (Public Trust)

Significant contribution of NGOs in health sector (e.g. Rotary Club conducts eye camps):

<u>MNGO</u>: - Mahila Vikash Seva Sansthan, Motihari is working as MNGOs with District Health Society, in District East Champaran (Bihar) .

INFRASTRUCTURE PLANNING

Facility	Existing	2010-11
Projected Population	4725938	4853538
General Hospital	One at District	One
PHC/APHC	0	50
PHC	20	50
Subcentre	319	834

A decentralized participatory planning process has been followed in development of this District Action Plan. This bottom-up planning process began with consultations with block stakeholder groups, Block /core Group members and village communities in all villages of each Block of the District.

Block Action Plans were developed based on the inputs gathered through village action plans prepared by Village Health Water Sanitation Committees. The health facilities in the block viz. SCs, PHC and, PHC were surveyed using the templates developed by Government of India. The inputs from these "facility" surveys were taken into account while developing the Block Action Plan.

The District Planning Core Group (DCG) provided technical oversight and strategic vision for the process of development of District Action Plan.

The members of the DCG 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 DCG.

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 village level functionaries & 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.

TECHNICAL INPUTS FROM: BIHAR STATE HEALTH & FAMILY WELFARE SOCIETY, MOTIHARI

SOURCES:-

1. CENSUS OF INDIA- 2001 (SOFT COPY)
2. ALL CONCERNED DEPARTMENTS
3. DISTRICT LEVEL HOUSEHOLD SURVEY – RCH, 2004-06
4. DISTRICT LEVEL HOUSEHOLD SURVEY-3 – RCH, 2007-08
5. SRS – 2007
6. CIVIL SURGEON OFFICE
7. NFHS – III

PREPARED AND CONTRIBUTION BY DPMU, EAST CHAMPARAN

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. Adverse Sex Ratio
2. Improving Maternal & Child Health & ensuring complete immunization, Ante natal and Post natal cover.
3. Improving Family Planning Services.
4. Reduction of morbidity due to 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. Improving behaviour change communication.
8. Ensuring edequate supply of drugs particularly at primary level to poorer sections.
9. Ensuring development of effective and sustainalble financing arrangements to protect the interest of marginalized sections.
10. Strengthening the HMIS and the monitoring system especially availability of correct data and its use.
11. Inter-sectoral convergence.
12. Strengthening of Civil Surgeon Office.
13. Quality services at all levels

SPECIFIC PRIORITIES OF THE DISTRICT

1. **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.
2. **Maternal Health:** Well managed system of institutional deliveries through Delivery huts and Emergency Obstetric Care services, JSY extended to all poor categories of persons, Blood Storage Units at all PHCs, 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 PHCs, PHCs, Training on IMNCI and IMCI, 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 of Mosquito transmitted diseases and increase case detection rate of NSP cases up to 70% and maintaining cure rate of 85%.
8. **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.
9. **Programme Management:** Better functioning of the District Health Society and a strengthened Civil Surgeon's Office and establishing BPMU.
10. **Infrastructure**: Increase in the number of Subcentres, PHCs, PHCs and Urban Health centres for the slums and urbanized population
11. **Human Resources:** Filling of the vacancies as per the population based norms for the year 2009-10, 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

4. 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		Goals for District
	Bihar	East Champaran	10-11
Reduction in Infant Mortality Rate (IMR)	57 (SRS 07)	57	50
Reduction Maternal Mortality Ratio (MMR)	162 (NFHS III)	162	140
Reduction in Birth Rate	23.9 SRS 07)	19.56*	16
Reduction in Total Fertility Rate	2.69 (SRS 07)	2.69	2.5
Reduction in Death Rate	6.5 (SRS 07)	5.04*	4.8
Increase in Couple Protection Rate	62 (DLHS 07-08)	62	70
% of Pragnant receiving full ANC	58.8 (NFHS III)	35.9%** DNA *	70%
Increase % of Women getting IFA tablets	28.3%(NFHS III)	82%* 11%**	90%
Increase Institutional Deliveries	39.4 (NFHS III)	60.2%* 36.8**	65%

Increase Delivery by Skilled Birth Attendants	54.2 (NFHS III)	83.5% 48.7%**	
Increase Complete Immunisation of Children (12-23 month of age)	65.3 (NFHS III)	90% 58.7%**	
Increase in Annualized NSP CDR (TB)		50/L*	
Decrease in API of Malaria (NVBDCP)		.34*	
Pravelance rate (Leprosy)			
Sex Ratio	861 (Census 01)	873*	

Note:

- **(*)** means data from Civil Surgeon's Office
- **(**)** means data from DLHS 2002
- **(#)** means SRS data
- DNA means Data Not Available

PART A: Reproductive and Child Health (RCH) II

A-1. MATERNAL HEALTH

Situation Analysis/ Current Status

Indicator	**No.**			
No of Pregnant women	37458			
Maternal Deaths	6 As per C.S.O. report			
ANC registration	No. 37458		% 88%	
Full ANC coverage	DNA		7.10% (DLHS02)	
Full ANC coverage (3 ANC)	DNA			
Institutional Deliveries (In the last reporting year)	40394		60.2%	
Deliveries by skilled birth attendants	40394		83.5%	
Home deliveries (Total No.): 6986	Skilled		Unskilled	
	No.	%	No.	%
	4049	58	2937	42
No. of pregnancy related complications referred to FRU level	DNA			

Source: Data from C.S.Office Dec 07 Report

ANC: 88% pregnant women in the last reporting year were registered for ANC checkups. The data regarding Full ANC is not available. As per DLHS 2002, only 7.1 % of the pregnant women had received full ANC care that is three doses of TT, required number of IFA tablet and at least 3 ANC checkups during

their pregnancy. The reasons for low ANC coverage are the shortage of staff, sociocultural beliefs, large areas and populations unreached and the unmotivated staff.

IFA: 82% of pregnant women receive IFA Tablets. As per DLHS 2002 only 11% of the pregnant women were receive adequate iron and folic acid tablets.

TT: As per DLHS 2002, 85 % women had received two or more than two doses of TT. This hence carries a grave risk for the pregnant women.

Deliveries: Institutional deliveries are 60.2% rest of all the deliveries being done by Skilled Birth Attendants.

Referrals: There is no adequate data for referrals during complications.

MTP: There are 927 cases of MTP held in the institutions in the district and out of these 820 held in the private institutions and 107 are at Govt. Institutions and the Govt Institutions is the only General Hospital and there is a problem of non availability of trained MOs in MTP. The General Hospital and some of the private clinics are performing MTP in the district. Most of the MTPs carried out are in the first trimester and mainly in the age group 20 to 30 years. There is a need to have MTP facilities at all the Primary Health Centres for carrying out MTPs upto the first trimester so that safe abortions can be done.

Janani Surakha Yojana: The JSY scheme has been launched in Haryana and 3426 women have benefited till date. This low uptake has been due to poor awareness in the people and non availability of regular funds from the government at the health facilities.

Janani Suvidha Yojna:

Services: The Community does not have enough confidence in the government facilities since the personnel are not always available especially Lady MOs and also adequate infrastructure, equipment and drugs. There is a dearth of facilities as per the population norms for facilities. A large number of the women use private facilities. The government has started intensive efforts to improve the facilities through delivery huts, 24 hour PHCs, development of PHCs as per IPHS standards. At present there are 31 delivery huts are functional with special facilities for institutional deliveries. The Delivery huts should be at all the Subcentres.

Fixed Maternal, Child Health and Nutrition Days (MCHN days) are being organized but there is little awareness amongst the community about the days when these are held and also regarding the services

	being provided.
	RCH Camps: RCH camps would be organized in each block in each year to reach the community and provide services at the doorsteps. These camps provide specialist services with simple diagnostic tests. They also serve for screening of RTI and STDs.
Objectives	1. 100% pregnant women to be given two doses of TT 2. 90% pregnant women to consume 100 IFA tablets by 2010 3. 70% Institutional deliveries by 2010 4. 90% deliveries by trained /Skilled Birth Attendant by 2010 5. 95% women to get improved Postnatal care by 2010 6. Increase safe abortion services from current level to 80 % by 2010
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 PHCs and PHCs 5. Increased coverage under Janani 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. 11. Oprationalization of FRU 12. Skill Development of Human resources

	13. Community mobilization for strengthening the services
Activities	1. Identification of all pregnancies through house-to-house visits by ANMs, AWWs and ASHAs 2. Fixed Maternal, Child Health and Nutrition days • Once a week ANC clinic by contract LMO at all PHCs and PHCs • 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 3. 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 4. Provision of Weighing machines to all Subcentres and AWCs 5. Establishing Delivery Huts for all the Subcentres alongwith provision of additional ANMs in all these Delivery huts for 24 hour deliveries. 6. 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 7. Training of personnel for Safe motherhood and Emergency Obstetric Care (Details in Component on Capacity building)

	8. Developing the PHCs for quality services and IPHS standards (Details in Component Upgradation of PHCs and IPHS Standards) 9. Availability of Blood Bank at the General Hospital and Blood Storage Unit at PHC • Establishing Blood storage units at PHCs along with sadar hospital • Certification of the Blood Storage Centres 10. Improving the services at the Subcentres (Details in Component on Upgradation of Subcentres and IPHS) 11. Behaviour Change Communication (BCC) efforts for awareness and good practices in the community (Details in Component on IEC) 12. Increasing the Janani Suraksha Yojna & Janani Suvidha 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 Suraksha Yojana Helpline in each block through Swasthya Kalyan Samitis • Increase in the No. of Private Health Providers in Urban Areas for JSY. • Regular IEC Activities in the Urban Slum Areas for Janani suvidha Yojna 13. 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 14. Safe Abortion: • Provision of MTP kits and necessary equipment and consumables at all APHCs • 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 15. Development of a proper referral system with referral cards and arrangement of referral facilities to the complicated deliveries at all APHCs/PHCs. 16. Improvement of monitoring of ANM tour programme and Fixed MCHN days • Fixed MCHN days and Tour plan of ANM to be available at the PHCs with the MOs • Checklist for monitoring to be developed • Visits by MOs and report prepared on basis of checklist filled • Findings of the visits by MOs to be shared by MO in meetings 17. RCH Camps: These will be organized once each block per year to provide specialist services especially for RTI/STD cases and Maternal & Child Health. 18. Provision of free medicines to all the patients of deliveries. 19. Blood bank 20. Neo natal care facility 21. Facility for C- section 22. Equipments and drug logistics 23. Mapping of Human Resources 24. Training on EmOc , CmOc, LSAS and Neonates Care and Skilled birth Logistic management, hospital management and Human resource management 25. Asha/ AWW/ ANM training on identification of danger sign & symptom of pregnant women . Mass communication on FRU service availability to the community

	26. Referral transport planning and management.
State support	1. Issue of joint letters from Health & WCD department for joint working 2. Ensuring availability of personnel especially specialists and Public Health Nurses for the 24 hour PHCs, APHCs and two ANMs at the subcentres 3. Ensuring availability of formats and funds with the ANM for JSY and timely payments 4. Certification of PHCs as MTP centres 5. The State should closely monitor the progress of all the activities
MTP services at health facilities	
Gaps	MTP services are not available in Public sectors IEC Service providers are not aware about legal dimension of. Eligible private practitioners should be involved. Legal awareness about PC-PNDT & MTP Act.
Strategie	Strengthening of comprehensive abortion care (Safe abortion , Family planning)services at all Facilities such as :- Sadar Hospital, Referral Hospital, PHCs & APHCs. Training

Activity	selection of facilities for provision of safe abortion services
	Location of facility availability of trained service provider, space, equipments. **2. To Provide appropriate equipments at all facilities and MVA syringes.** **3.Putting the trained doctors at appropriate facilities to commence the services** **4. Training of Medical officers and Para medical staffs on Safe abortion services training including awareness about legal aspects of MVA/ EVA and Medical abortion by IPAS .** **5. Formation of district level committee (DLC) to accredit private sites as per GOI guide line .** **Develop reporting system of MTP services in private and public secter.** **6. Through training program make the govt doctors skilled to perform MTP in the approved sites.** **1. To Involve community to aware about location of services , process and legal aspects of MTP services through - AWW, ASHA & ANM, LRG and mass media.** **The services of Pregnancy testing should be strengthen and it should be linked with MTP services.** **2. NGO's and local Practitioner should be involved for counseling and information of facility** **3. Assurance of privacy and link with family welfare services counseling at all facility.** **Linkage with MTP services with NGOs (PPP) those who are working in Safe abortion services. and create one modal center at district and PHC level.** **Training of ASHA on medical abortion.**
RTI/STI services at health facilities	
Gaps	**No regular clinic at all PHCs & APHCs.**

Activity	Trained service provider on syndrome management of RTI/STI (As per GOI guide line) up to APHC level.
	Logistics of setting of clinics and free drugs availability 1. Integrated Counseling services in four public sector facilities by trained personnel . 2. IEC/BCC for awareness available RTI/STI services at all health facilities.
Operationalise Sub-canters **Referral Transport**	
Gaps	Non availability of Ambulance in as per the norms one ambulance/1lac population Pickup Service of pregnant women is not available
Activity	Ambulance should be available 24x7 for safe referral of patients /Pregnant women in time. Free transport for Pregnant women to reach them to government facility and cost should be reimbursed from RKS fund. In panel all existing Ambulance services provider.
Integrated RCH camps	
Strategie	Coverage of Slums & Maha Dalit Tola.

Activity	1. Identifying Socially Backward, Slums & Maha Dalit Tolas. 2. Hiring trained alternate vaccinator/ retired ANMs and Medical officer .hiring vehicle for fixed day out reach camps with drugs. Fixed day OPD clinics at APHC level and adjoining HSC of respective APHCs. with dedicated MO and support staff. 3. To make calendar for camps with date and identified areas. Community based reporting system through SMS. involve PRI members and training on reporting and Camp approach.
Monthly Village Health and Nutrition Days	
Gaps	1Fixed day AN clinic not conducted at any level - Early 2.registration is not done of pregnant women during “Muskan Ek Abhiyan”.
Strategie	Immunization Day could be use as VHND Community based monitoring

Activity	1. AWC should be develop Hub of activities (VHND) 2. Develop an activity plan calendar for VHND as seasonality. 4. Registration, Immunization, ANC, weighing of PW and Children, Feeding of PW, Demonstration of food preparation, health &sanitation practices etc. 6. Soft ware activity- Counseling of mothers on ANC, preparation for delivery, PNC, child care ,STI/RTI, and AYUSH, adolescent Health 7. Meeting of VHSC and preparation for area specific epidemiological planning and community based monitoring. 8. Skill development training is required to ANM , ASHA & AWW and Dular (LRG) Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourish children ,New born, DOTs and other services SMS reporting system of conducting VHND and ANM collect Data from field level and compile it in weekly/Monthly meeting. Fixed day AN clinic at APHC/RH/SDH/DH 9- EDD date of Pregnant women should be recorded by ASHA/ ANM for compulsory three ANC checkups and institutional delivery. Training of AHSA on identification of danger sign of obstetric complications, post partum family planning /sterilization
Janani Suraksha Yojana / JSY	
Gaps	1- Tracking of pregnant women from first Trimester is not done form the register. 2- Pregnancy Test Kit is not adequately available. 4- To much documentation process.

Activity	**1- Review of early registration with 3 AN checkup ,two TT.100/200 IFA Tab. in ASHA Diwas.** **2- Incentive of ASHA should be linked with above activity @ Rs 50 per AN mother for ASHA.** **2- Direct transfer of funds from district to PHC through core banking** **4. Home Delivery should be conducted by SBA trained Staff Nurse or ANM.** **5. "MAMTA" should be appointed at PHC level like Sadar Hospital.** **Make APHC as 24x7 with three Para medical workers.**
Home Deliveries	
Gaps	**1.Home Delivery is still prevailing through untrained traditional Dai's** **2. Reporting of home delivery is not done so the PNC is not provided**
Activity	**1. Provision of Dai Delivery kit(DDK) to TBA where institution access is poor. And it should be supervised by ANM for home deliveries.** **2. Delivery kit (equipment, medicine)for ANM should be supplied** **3. Number of delivery Kits as per number of deliveries conducted in home.** **Reporting of home delivery is responsibility of ASHA and she should report to ANM and**
Institutional Deliveries	

Gaps	1. C- Section deliveries are not conducted in institution. 2. infection control protocols is not at all maintain at all facilities 3. Welcome PW at Institution and PHC level. 4. Reporting of maternal death Maternal death reporting is usually not reported by worker . 5. Biomedical waste management is not properly taken care off at all institution 6. Complicated delivery cases are not being attained at any facilities. 7. Needy PW should be provided free blood and medicine. 8. Importance of Maternal death reporting
Strategie	Strengthen C- section services with infection control protocol in phases wise manner in district. Strengthen Record keeping Grading institution as per women and child friendly services at facilities. provide free of cost Blood for pregnant women who need blood transfusion for severe anemia / PPH Strengthening MMR reporting through ASHA

Activity	MIS for HR
	Mapiing of specialists/ multiskilled MOs Training load assessment A.1 EMOC for labour room. A.2 Specialist should be posted at Sadar Hospital/PHC. A.3 Incentive for c-section. A.4 Trained personnel at O.T level. A.5 Need based Equipments and drugs in O.T and Labour room. A.8. Incentives may be considered for the nurses / ANMs for the deliveries beyond a fixed number. Procurement of blood bank equipments, Licensing blood storage / blood bank Meeting infrastructure requirements as per norms Training of MO and lab tech/ staff nurse blood storage grouping /cross matching and management of transfusion reactions stabilized linkages with mother blood bank. Planning across the district to operationalize FRUs A.9 Blood Transfusion facility should be started. A.10 Functional Lab Facilities at c-section level. A.16 Direction can be issued from SHS to provide free of cost Blood for pregnant women who need blood transfusion for severe anemia/ PPH on prescribed through RKS Fund Procurement of equipment As per example Introduce color coded buckets for facilities as per IMEP established common treatment plant for safe disposal of biomedical waste
	Training of staff

Adolescent Heath	
Reproductive and sexual health	
Gaps	1. No training programme for adolescent particularly health and sex. 2. Preventions of anemia younger's. 3. Marriage before legal age. 4. Preventions of teen age pregnancy and abortion. 6. Preventions of addiction in boys. 7. Limited interventions for empowering adolescent girls 8. AWCs are not equipped to promote activities for girl empowerment

Activity	Multipurpose counselor can be used for adolescent care. Adolescent pregnancy should be addressed with priority care(eclampsia, 3 ANC, anemia, 100 IFA, 100% institution delivery, low birth Wight baby, Brest feeding.PNC with in 48 hours. Family counseling for adolescent pregnancy tracking on above mention through ASHA and AWW. ~~2.~~State to develop and issue guidelines for implementation of *Kishori Mandals*Formation of Kishori Mandals by registration of all girls (11-18 yrs) ~~3.~~Prepare a monthly plan of activities for one dayper week ~~4.~~1.Counseling nutrition, health and social issues every week at AWCs ~~5.~~2.Weekly distribution of IFA Tablets to out-of-school girls at AWCs ~~6.~~3.Distribution of Deworming tablets every 6 months ~~7.~~4.Arrange and facilitate training on income generation skills and Family life education Initiate family schools for learning child care , safe mother hood life skills and Family life education 1. Initiate family life education through special training 2. Income generation skills and support for marketing outlet 3. Adolescent girls kit-sanitary napkins to be included in medical kit that is made available at the AWC 4. *Kishori Mandals* to be involved in community level events and train them as Master trainer to support AWC services Provision of minimum supply and storage place in AWCs
Child Health	
IMNCI	

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Gaps	1.Inadequate monitoring of this activity at field level 2. 75% of doctors and majority of ANM & Staff Nurse not trained. 3.No ASHA is trained on IMNCI 3. Non availability of "MAMTA" at PHC level. 4 .Not Recognizing early sign and symptoms of illness of new born babies. 5. Neonatal Care Unit not up to mark. 7. Early breast feeding not encouraged. Monitoring Training Drugs availability PNC Referral 8. NSU and SNCU
Strategie	Monitoring through Supervisors Capacity building of front line workers on case management skill Strengthening of overall health system for effective management of IMNCI. Awareness generation among mothers, families and community on IMNCI issue.

Activity	1 Tearing load Incorporate ASHA in training team 2 Monitoring system 3. community based monitoring system through LRG ASHA kit regular supply. 1.Incentives for supervisors 2. Care of babies by "MAMTA" and ANM. 3. Encouraging mother regarding child care. 4. Frequent checkup of babies by Pediatrician. 5.fixing a day in a week for IMNCI related work at HSC level 6.Training to ANMs/doctors on operating baby warmer machines
Facility Based Newborn Care/FBNC	
Gaps	1.No PHC has baby warmer machines. 2. .ANMs and Doctors are not trained to operate these machines There is no provision of stay of mothers of neonates at PHC.he mothers neonates Capacity building Space and equipments
Strategie	Strengthening of NSU at PHC level and SNCU at district level. Counseling of mothers at institution.

Activity	1. All PHC and Referral should be equipped baby warmer machines. 2. Training of Doctors and ANM to operate baby warmer machine. 3. Provide new born care equipments for PHCs, referrals and district hospital with new born ward. 4. Organize training programme for newborn care for the nurses in the district hospitals.
Home Based Newborn Care/HBNC	Under IMNCI program home based new born care is also addressed.
School Health Programme	
Gaps	1. No Pre School Health checkup & complete Immunization card. 2. No training of school teacher for basic health care and personnel hygiene. 3. No regular health checkup camp at school. 4. No Training & Screening of school's teacher for eye sight test. 5. No other specific program has been formulated in the district.
Strategie	Coordination Non priority Strengthening of block level coordination committee, Designing visible plans to start work with schools.

Activity	1. Half yearly health checkup camp for children in schools should be organized. 2. Training of school teacher by the medical personnel with support administrative person. 3. Quarterly meetings of VEC representatives. School health anemia control programme should be strengthen with bi annually de worming . 4. Organizing competitions/Debates/Painting competitions/Essay/demonstration and model preparation of nutritional food and health. 5. Half yearly Health checkups and health card of all school going children. 6. Films shows on health, sanitation and nutrition issues 7. Social Lab activities. 8. Rally and Prabhat Phery in epidemic areas. (Kala-azar & Malaria) Referral system for the school children for higher medical care.
Infant and Young Child Feeding/ IYCF	
Gaps	Non awareness of breast feeding and proper diet of young children. Poor knowledge regarding new born care and child feeding practices. Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding. Lack of awareness on importance of appropriate and timely IYCF

Strategie	Training of Health and ICDS
Activity	Colostrum feeding and breast feeding inclusively for six months. Through IMNCI program. Baby friendly hospital Accreditation of nursing home and facility according to norms of baby friendly hospital. 1. Development of BCC activities 2. IEC material developed for LRP 3. Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA 4. Linking JBSY with colostrums feeding Maternal benefit scheme to provide incentive to mothers during pregnancy, for 3 ANCs, TT immunization and CF and BF. Counselling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries Folk performance to promote exclusive breast feeding 1. Uniform message on radio from state head quarter 1. Organize social events ▪ Strengthening of *Mahila Mandal* meetings- fortnightly with involvement of adolescent girl ▪ Organize healthy baby shows, healthy mother / pregnant woman. ▪ Appreciation and reorganization of positive practices in community. ▪ Celebration of "*Annaprashan Day*" at AWC Demonstration of recipes.
Care of Sick Children and Severe Malnutrition	
Activity	Establish nutrition rehabilitation center in district hospital, FRU and one PHC .

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Management of diarrhea, ARI and Micronutrient Malnutrition	
Activity	Procurement of ORS with Zinc , Bi annual Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup. And fortified micronutrient supplementation for 6m to 2 years children in shattu at AWC. 2. Provision of three eggs to all pre school children at least one per week through AWC.
Other strategies/activities	
Activity	1. Involvement of ICDS, school teachers and PRI for mentoring an evolution.
FAMILY PLANNING	
Terminal/ Limiting Methods	
Goal	Lack of knowledge of small family norms.
Activity	Ensure one MO trained on on minilep and NSV up to PHC Training of nurses and ANMs on IUD and other spacing methods Ensure availability of contra septic (indenting , logistic management) .

Dissemination of manuals on sterilization standards & quality assurance of sterilization services	
Activity	Quality assurance committee formed and regular meeting been held as per GOI guide line . Translation of GOI guideline IN Hindi. Printing of Guide line.
Female Sterilization camps	
Gaps	Laparoscopy surgery not done.
Activity	Trained doctors on laparoscopy. Procure Laparoscopy equipments for trained docters.
NSV camps	
Gaps	**Trained doctors are not available.**
Activity	**Training of doctors needed.** **Procurement of equipment.**

Compensation for female sterilization	
Activity	Immediate disbarment of incentive after sterilization camps. Logistic planning is needed before organizing camps. Block Health manager could be hire one support staff for disbursement for logistic support.
Compensation for male sterilization	Immediate disbarment of incentive after sterilization camps. Logistic planning is needed before organizing camps. Block Health manager could be hire one support staff for disbursement for logistic support.
Activity	Immediate disbarment of incentive after sterilization camps. Logistic planning is needed before organizing camps. Block Health manager could be hire one support staff for disbursement for logistic support.
Accreditation of private providers for sterilization services	
Gaps	No Accreditation of private nursing home.
Activity	Accreditation of private nursing home. As per GOB guide line.
Spacing Methods	
IUD camps	

Gaps	Camps not held.
Activity	Training of ANM & staff nurse for IUD insertion. Procurement of IUD. Equipments for IUD insertion.
IUD services at health facilities	
Accreditation of private providers for IUD insertion services	
Gaps	No accreditation of private providers for IUD insertion services.
Activity	Accreditation of private providers for IUD insertion services. As per GOI guide lines.
Social Marketing of contraceptives	
Activity	Social marketing of need based OC & IUD. Increasing access to contraceptive through communities based distribution system free of cost.
Contraceptive Update seminars	
Gaps	Not being held.
Activity	seminars for MO and other through Professional bodies (FOGSI. BMA, Nursing association etc..on Copper-t 380-A should be popularized. Awareness for emergency contraceptive.

Other strategies/activities	
INNOVATIONS / PPP/ NGO	
PNDT and Sex Ratio	
Gaps	No registration of ultra sound clinic.
Activity	**Registration and monitoring of ultra sound clinic.** **MTP clinic should be watched for termination of pregnancy following USG.** **IEC on PNDT act.**
Public Private Partnerships	
Activity	District /PHC level managers should be aware about the TOR of PPP which is finalized at State level. Build the capacity of manager to manage contracts of PPP Reimbursement of service charges of BPL family from RKS.
NGO Programme	
Gaps	Non involvement of NGO in F.P programme, Institutional delivery, Blindness control programme.

Activity	Networking with all NGOs working in the district. for strengthening communalization process of Health in the dis Devlop directory of all NGOs ASHA Programme manager could be facilitated Networking with NGOs. Capacity building training programme for NGOs office bearer with the help of professionals on system straignthening .component. Mentoring Group at district level. Participatory Reporting mechanism should be develop of NGOs work in the district. Co-ordination with community based orgnisation as SHG, LRG, VEC, VHSC,PRI etc.
Other innovations(if any)	
INSTITUTIONAL STRENGTHENING	
Human Resources Development	
Activity	Expose visit of DPM/BHM /ASHA and to other state where facility is comparatively working better. Action 1 can be copied.

Logistics management/ improvement	
Activity	Indenting of medicine through form 6 should be strengthening and training of ANM on indenting process. Drugs chapter on HSC pest Need based procurement and distribution of ANM Kit through Form 6. Decentralization of Medicine purchasing at the PHC as per Central purchasing committee list.
Monitoring & Evaluation / HMIS	

Activity	Training of District and PHC level Mangers on New HMIS formate. Translation of HMIS formate in Hindi All Pursing formate should be linked with line formate. As muskan reporting format data should be linked with HIMS format and review of HSC and PHC based on HIMS format Monthly meeting of MOIC and BHM should be conducted on the basis of HIMS format and Power point presentation is mandatory in meeting. HIMS data could be validated by BHM on four indicator (accessibility, availability, coverage, adequate coverage, effective coverage.) Training of BHM on Validation component. and use data for decision making .
Behaviour change communications/IEC	
Gaps	Lack of appropriate materials No nodal officer for BCC in the districts

Activity	1. Materials development for CDPOs-Supervisors and AWWs on: ▪ Modification of Dular material (MCH kit) and reprinting of implementation module ▪ Module on growth monitoring ▪ Counselling tools on micronutrient deficiencies, supplementation and or fortification for prevention control and treatment. ▪ Material on IYCF focusing, initiation of breast feeding, exclusive breast feeding and complementary feeding. ▪ Hand book on management of Poshahar for Poshahar Samiti members. ▪ Booklet of low-cost nutritious recipes from locally available foods for AWWs. Guidelines on record/register ▪ maintenance ▪ Guidebook on adolescent girl ▪ Handbook on building communication skill development ▪ Managing Nutrition-Health-Sanitation issues in emergencies ▪ Guidelines on NRC management Home-based treatment of SAM children.
Training	~~1.~~2.
Gaps	~~1.~~3.No nodal officer for training in the districts Absence of training plan Training infrastructure at district and block levels.
Activity	~~2.~~District level training team lead by training coordinator in each districts for all training program. Annual Training plan of functionaries at different levels to be prepared. ~~1.~~Involving training institutes and supporting trainings in the absence of such institutes in the districts for round the clock training in the districts Develop district level training centre with required Trainers materials/ equipments and support staff

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Timeline	Activity	2009-2010
	Strengthening of the Fixed MCHN days	x
	Developing the PHCs for EmOC	All PHCs
	Blood Storage Units	PHCs&APHCs
	Developing Delivery huts	40
	Developing MTP centres	All PHCs
	JSY beneficiaries	3000
	Promoting Medical Abortion	All PHCs
	RCH Camps	At all PHCs/APHCs

Budget	Activity / Item	2010-11
	Consultancy for support for developing Microplan for MCHN days	1
	Adult Weighing machines @ Rs 1200 per machine x 772 AWCs & Maintenance	9.5
	31 Delivery Huts @ Rs 50000 /hut	15.5
	Recurring cost of 31 Delivery Huts @ Rs 109000 per year	33.79
	Blood Storage Unit @ Rs 3 lakhs per unit	6
	Referral Cards @ Rs 3 per card x 20,000	0.6
	MTP kits @ Rs 15000 Per kit at GH & PHCs/APHCs	1.2
	JSY beneficiaries @ Rs 700/person X 3000	21
	RCH Camps @ Rs 200000 per camp x 7	14

	Hiring of vehicle for referral at every PHC/PHC @5000x23x 12month	13.80
	Total	**116.39**

Recurring Costs per Delivery Hut for one year

S.No	Head	Unit	Unit Cost	Amount
1.	O.C	1 year	35000	35000
2.	Material and supply	1 year	50000	50000
3.	Motor Vehicles	12 mths	1500	18000
4.	Honorarium for TBA	12 mths	500	6000
	Total			**109000**

A-2. NEWBORN & CHILD HEALTH	
Situation Analysis/	

Current Status

SN	Indicator	Total	Rate%
1	Live Births	17393	
2	Infant Deaths	248*	57/1000
4	Child Deaths (1-5 years)	284*	
5	Still birth in the last year	238*	
6	Low birth weight newborns (less than 2.5 kgs)	3335*	
7	Complete Immunization 12-23 months age	19260*	
8	Severely malnourished children (Grade III,IV)	3	
9	ARI cases in the last year	3133	
10	Deaths in the last year due to pneumonia	D.N.A.	
11	Diarrhoea cases	3476	
12	Deaths in last year due to Diarrhoea	D.N.A.	

* CS Office

Breast feeding: As per DLHS 2002-04,only 22.3 % of the mothers breastfeed their children within two hours of birth and 21.6% children were breastfed exclusively for stipulated period of 4 months. There is lack of knowledge regarding the significance of colostrum and the socio-cultural factors associated with it.

Childhood illnesses

Diarrhoea: Undernutrition is associated with diarrhea, which further leads to malnutrition. The District data shows that 19.98% of children suffered from Diarrhoea. According to the DLHS 2002 although three fourths of the women were aware of what was to be done when a child got diarrhea but in practice very few women gave Oral Rehydration Solution (ORS) to the child and a negligible percentage gave more fluids to drink. This shows that there is a need for more knowledge regarding the use of ORS and increased intake of fluids and the type of food to be given.

	Pneumonia: The District data shows that 19.13 % of children suffered from Pneumonia. There is a need to create awareness regarding the danger signs of Pneumonia since only half of the women are aware of danger signs of pneumonia as per DLHS 2002. **Newborn and Neonatal Care:** There is very little data available for the newborns and the neonates. The District data shows that a negligible percentage of newborns and neonates died which is doubtful. Reporting regarding these deaths is not done properly. The various health facilities also are poorly equipped to handle newborn care and morbidity. The TBAs and the personnel doing home deliveries are unaware regarding the neonatal care especially warmth, prevention of infection and feeding of colostrum. **School Health:** In district there are 540 schools and 56596 students enrolled there. Up to Nov. 2008 358 school were visited and 34660 students were examined by the health staff. 5206 students were found ailing mainly with anemia, defective vision, poor orodental hygiene and skin disease.
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. Improving feeding practices for the infants and children including breast feeding 2. Promotion of health seeking behaviour for sick children 3. Community based management of Childhood illnesses 4. Improving newborn care at the household level and availability of Newborn services in all PHCs & hospitals

	5. Enhancing the coverage of Immunization 6. Zero Polio cases and quality surveillance for Polio cases 7. Preaperation of operational plan and guidelines for School Health. 8. Regular Monitoring and supervision. 9. Monitoring through Supervisors 10. Capacity building of front line workers on case management skill 11. Strengthening of overall health system for effective management of IMNCI. 12. Awareness generation among mothers, families and community on IMNCI issue.
Activities	**1.** 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 Colostrum • 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. **2.** 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 **3.** Improving newborn care at the household level • 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. • In case of suspicion of sickness the ASHA /AWW must inform the ANM and the ANM must visit the Neonate • Referral of the Neonate in case of any symptoms of infection, fever and hypothermia, dehydration, diarrhoea etc; • Supply of medicine kit and diagnosis and treatment protocols (chart booklets) for implementation of the IMNCI strategy • Strengthening the neonatal services and Child care services in General hospital Narnaul, General hospital East Champaran and all PHCs : This will be done in phases • In all of these units, newborn corners would be established and staff trained in management of sick newborns and immediate management of newborns. • 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 • Training of staff in Newborn Care, IMNCI and IMCI (MOs, Nurses, ANM, AWW, ASHA) including the management of sick children and severely malnourished children. • Availability of Paediatricians in all the General hospitals and PHCs • Ensuring adequate and free supply of drugs for management of Childhood illnesses. **4.** Strengthening the Fixed Maternal and Child health days (Also discussed in the component on Maternal Health)

	• 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 **5.** Strengthening Immunization (Discussed in Component C) **6.** School Health Programme • Preparation and dissemination of guidelines for School Health • Monthly visit by Deputy Civil Surgeon (School Health). • Coordinatiion and covergence with education department. • Training to School Teachers on Health Activities. 7 . Tearing load 8. Incorporate ASHA in training team 9. Monitoring system 10. community based monitoring system through LRG **ASHA kit regular supply**. a. Incentives for supervisors b. Care of babies by "MAMTA" and ANM. c. Encouraging mother regarding child care.

	d. Frequent checkup of babies by Pediatrician.
	e. Fixing a day in a week for IMNCI related work at HSC level f. Training to ANMs/doctors on operating baby warmer machines
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. Deptt. and PRIs 5.

Timeline

S.No	Activity	2009-10	
1.	Health Education of the families and the mothers on breast feeding, weaning and good practices, ORS by the ASHA/ANM/AWW	x	
2.	Identification of the malnourished children	x	
3.	Administration of Micronutrients – Vitamin A, IFA	x	
4.	Availability of ORS at ORS depots with ASHA	x	
5.	Identification of the nearest referral centre with yearly updation	x	
6.	Transport arrangements for emergencies by the PRIs and community leaders	x	
7.	Display of the referral centres and relevant telephone numbers in a prominent place	x	
8.	Training on IMNCI & IMCI of ASHA/AWW/ANM/MO/LHV on the home based Care package	x	
9.	Supply of medicine kit & diagnosis and treatment protocols (chart	x	

		booklets) for the IMNCI strategy		
	10.	Development of Referral system & referral cards	**x**	
	11.	Establishing Newborn Corner in hospitals and PHCs with equipment medicines and supplies and also Malnutrition Corners	GH Narnaul 2 PHCs	
	12.	Equipment and drugs for management of Childhood illnesses	**x**	
	13.	Provision of Large Invertor	All PHC/PHC	
	14.	Preparation and dissemination of School Health Plan		
	15.	Monitoring and supervision of School Health Activities by Deputy Civil Surgeon (School Health)		
	16.	Training to School Teachers	1000	

Budget	**Activity / Item**	**2009-10**
	Newborn Corner furnished with equipment @ Rs 2 lakh per facility	6
	Provision of Invertor @ 25000 x 23	5.75
	Examination table, chair, stool, table, other equipment @ Rs. 5000 x 772AWCs	38.6
	Infant Weighing Machines@Rs. 1200/AWCx 772	9.27
	Referral cards @ Rs 4 x 25000	1.0
	Free availability of medicines	10
	Monitoring of School Health Activities @ 10000 pm x 12 months	1.2
	Training of Teachers @ 200 x 1000 teachers	2.0

	Supply of Medicines, glasses, hearing aids	5.0
	Total	**78.82**
	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

A-3. FAMILY PLANNING

Situation Analysis/ Current Status

Indicators	**No. or Rate**
Eligible Couple	152306
Couple Protection Rate	62%
Female Sterilization operations in 2007	2319
Vasectomies in 2007	222
Couples using temporary method in 2007	27274

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

Currently 27274 couples are using temporary methods of contraception and 2631 have permanant sterlization (mainly Female sterilization). 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.

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 222 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 Sterlization. 2. Availability of all methods and equipments at all places 3. Increasing access to terminal methods of Family Planning 4. Promotion of NSV 5. Increased awareness for Emergency Contraception and 10 yr Copper T 6. Decreasing the Unmet Need for Family Planning 7. Expanding the range of Providers 8. Increasing Access to Emergency Contraception and spacing methods through Social marketing & Training of ANMs for IUD Insertions. 9. IEC/BCC activities for Family Planning Methods.
Activities	**1.** Each PHC and PHC will have one MO trained in any sterilization method. • All the PHC/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 PHCs will be trained in Laparoscopic Tubal Ligation.

	• At PHCs, one medical officer will be trained in NSV • Each PHC will be a static center for the provision of sterilization services on regular basis. The Static centers will be developed as pleasant places, clean, good ambience with TV, music, good waiting space and clean beds and toilets. **2.** 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/PHCs, 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 subcentres. • All the ANMs at 117 subcentres 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 convergance • 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 PHCs • 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 7. Ensure one MO trained on on minilep and NSV up to PHC Training of nurses and ANMs on IUD and other spacing methods Ensure availability of contra septic (indenting , logistic management) .
Support	• Availability of a team of master trainers/ANM tutors and RFPTC trainers for

<table>
<tr><td>required</td><td>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</td></tr>
<tr><td>Timeline</td><td>

	2009-10
Training of MOs for NSV	10 MOs
Training of MOs for Minilap	5 MOs
Training of Specialists for Laparoscopic Sterilization	3 MOs
Development of Static Centre at General hospital	GH NNL, PHC M/Garh
Sterilization Camps (Persons)	5000
NSV Camps	24
Accreditation of private institutions for sterilization	10
Supply of Copper T – 380	5000
Emergency Contraception	3000

</td></tr>
<tr><td>Budget</td><td>

Activity / Item	**2009-10**
NSV camps @ Rs. 233820 per 2 camps x 12	28.06
Sterilization Camps @ 1000 & 650 for 5000 cases	38.25
Copper T-380 @ Rs 50 / piece x 5000	2.5

</td></tr>
</table>

	Emergency Contraception @ Rs10/2 tabs	0.15
	Development Static Centres@Rs 2 lakh	4.00
	NSV Equipment @ Rs 800 x 5 GH & PHCs	0.40
	Laparoscopes @ Rs 3.00 lakhs	3.00
	Total	**76.36**

Detailed Calculations

Calculations per Case of NSV

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

Requirements for organizing 2 Camp per month (30 cases/camp)

S.No	Head	Unit	Unit Cost	Amount
1.	District Workshop	1	7500	7500
2.	Block workshops	1	7500	7500
3.	IEC activities @ per 2 camps			125820
4.	TA to Acceptor for Semen Analysis	60	50	3000
5.	Payment to NSV Advocate/motivator, Drugs & Dressings	60	1500	90000
	Total			**233820**

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	60	4320
6.	Electronic Media Publicity for 15 days			5000
7.	Wall writing & publicity			1500
8.	Other Innovative activities			10000
9.	**Total**			**125820**

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 5000 cases

S.No	Head	Unit	Unit Cost	Amount
1.	Per Case BPL @ Rs 1000	500	1000	500000
2.	Per Case Non-BPL @ Rs 650	4500	650	2925000
3.	IEC activities			100000
4.	Other activities and Office Expenses			300000
	Total			**38250000**

A-4. ADOLESCENT HEALTH

Situation Analysis	The adolescents are very vulnerable since out of 4227 girls married last year 47 were married before the age of 18 years. The awareness levels for various issues of RCH are low. As per DLHS 2002, 42.5% girls got married before the age of 18 years and had one child before the specified 19 years. It has been observed that the adolescents especially the boys are exposed to smoking, addictions, and peer pressure and there is no one to counsel them. Alcoholism and drug addiction is becoming a major problem and there is no de-addiction centre There is no intervention with the boys. NYK has done some awareness generation exercises with the out-of-school adolescents. No efforts have been made for any counselling of the adolescents. There is hence a great

	lacuna in the knowledge of the Adolescents. Data regarding the perceptions and practices of girls and boys is lacking especially in the context of rural setting, urbanized villages and urban slums. Lack of awareness regarding AIDS/HIV among the adults.
Objectives	1. Increase the knowledge levels of Adolescents on RH and HIV/AIDS 2. Enhance the access of RH services to all the Adolescents 3. Improvement in the levels of Anaemia to 50% by 2012
Strategies	1. 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:
	1. Formation of District Partnership for Adolescent Health (DPAH) consisting of representatives of: Health department, Education department, Social Welfare department, ICDS, NGOs, PRIs, National Service Volunteers, Nehru Yuva Kendra Sangathan, other youth organizations, local chapters of Indian Academy of Paediatrics and other stakeholder groups. 2. Workshop to develop an understanding regarding the Adolescent health and to finalize the operational Plan 3. Provision of Adolescent friendly health services at PHCs, PHCs, 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. 4. 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 5. Awareness building amongst the PRIs, Women's groups, ASHA, AWWs 6. Provision of IFA tablets to all Adolescents, deworming every 6 months, Vitamin A administration and Inj TT. 7. Carrying out the services at the fixed MCHN days. 8. Involvement of NGOs for Environment building. One NGO per Block will be selected. NGO will select the counsellor in the villages.

Budget	Activity	2009-10

	Awareness generation @ Rs 2000 per village	7.52
	Workshop of all the partners	0.5
	Training a district pool of Master trainers	1
	Training of Councellors at every PHC/PHC/@ 10000/batch x 25	2.5
	Orientation & Reorientation Health personnel	0.25
	Counselling sessions @ Rs 1000/per month/per PHC/PHC	3.0
	Counselling Clinics renovation, furnishing and Misc expenses @ Rs 10000 x all PHCs/PHCs	2.5
	Joint Evaluation by an agency & Govt	1
	Total	**18.27**

B-1. ASHA – Accredited Social Health Activist	
Situation Analysis	ASHA is an honorary worker and will be reimbursed on performance-based incentives and will be given priority for involvement in different programmes wherever incentives are being provided (like Institutional Delivery, 3 ANC & PNC Registration, Death & Birth registration,

	Safe MTP, Motivation for Sterlization etc. She will be able to earn about Rs. 1,000 per month In district East Champaran 642 ASHAs have been selected and 225 have received training.
Objectives	1. Availability of a Community Resource, service provider, guide, mobilizer and escort of community 2. Provision of a health volunteer in the community at 1000 population for healthcare 3. To address the unmet needs
Strategies	1. Selection and capacity building of ASHA. 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. Training of all remaining ASHAs who have not received any training regarding the related other modules. 5. Provision of a kit to ASHAs 6. Formation of a District ASHA Mentoring group to support efforts of ASHA and problem solving 7. Review and Planning at the Monthly sector meetings 8. Periodic review of the work of ASHAs through Concurrent Evaluation by an independent agency
Support required	1. Timely Payments to ASHA 2. Advance of Rs. 5000 always with ASHA for prompt payments to the women

	Activity	2009-10
	Selection of additional ASHAs	58
	Total ASHAs	700
	Training of new & untrained ASHAs	400
	Reorientation of the initial ASHAs	400
	District ASHA Mentoring group	x
Timeline		
Budget	**Activity / Item**	**2009-10**
	Kit @ Rs 2000/ ASHA	12.84
	Reorientation @ Rs 1000/ ASHA	4
	Expenses for the District mentoring group – meetings, travel @ Rs 5000 per month x 12 months	0.6
	Incentive for ASHAs	30
	Total	**47.44**

Activities	Approval by State for Life skill education and to be initiated in all schools Manpower and funds 9. Involvement of ASHAs as counsellor and one Male & Female person of all the villages, and training of all the health personnel in the Subcentres, PHCs and PHC in the block 10. 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. 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 11. Close monitoring of the under 18 marriages, pregnancies, prevalence of RTI/STDs.	
Support required		
Timeline	**Activity**	**2010-11**
	Awareness generation	x
	Workshop of all the partners	x
	Training a district pool of Master trainers	x
	Selection of Councellors through NGOs	x
	Training of Councellers and followup re-orientation	x
	Orientation of the Health personnel	x
	Counselling Clinics	All PHCs

B-2. Untied Funds and Annual Maintenanse grant for Sub Centres

Situation Analysis/ Current Status	Rs. 10000 as Untied Fund for each Sub Centre is available. Rs. 1020000 is available for 102 Sub Centres and Rs. 361932 is expended till December 2008. Rs. 10000 is also provided for Annual Maintainence Grant for Sub Centres. Rs. 1020000 is also available as Annual Maintainence Grant for all the Sub Centres in the District. The most of Sub Centres are in very pathetic condition A number of equipment needed some repair due to which they were lying unutilized. The Gram Panchayat members were never involved in any activities of the Subcentre.
Objectives	1. Strengthening of the Subcentre to provide basic health care, Ante natal care & post natal care and safe deliveries at Sub center level.
Strategies	1. Provision of Untied funds of Rs 10000 each year to the Subcentres at the disposal of the ANM for local needs 2. Provision of Rs 10000 for Annual maintenance Grant for Sub Centres.
Activities	1. Each Subcentre would be given an untied support of Rs. 10,000 per annum. The fund would be kept in a joint account to be operated by the ANM and the local Sarpanch. 2. Rs 10000 will be given as Annual Maintenance Grant to each Subcentre. This will be under the mandate of the Gram Panchayat SHC Committee for undertaking construction and maintenance. This will bring in greater community control and the sub-centres would be brought fully under the Panchayati Raj framework. 3. Activities suggested for the untied funds include minor modifications, cleanliness of premises, transport of emergencies, transport of samples, purchase of consumables, etc; 4. This fund will not be used for salaries, vehicle purchase and recurring expenses of Gram Panchayat **5.** Monthly and quarterly expenditure statement will be submitted alongwith UC
Support	1. Fund flow process to be made easier

required	2. Sarpanch to ensure proper usage and accounts

Timeline

	2010-11
Untied Fund of Rs 10000/subcentre	117
Annual Maintenance grant and repair of Rs 10000/SC	X
Plan for maintenance to be developed and approved by Gram Panchayat	X
Plan for use of untied funds	X
Gram Panchayat to identify mode of construction and repair	X

Budget

Activity / Item	**2010-11**
Untied Fund of Rs 10000/SC	11.7
Annual Maintenance grant and repair of Rs 10000/SC	11.7
Total	**23.4**

B-3. Provision of Untied Funds and Annual Maintainance Grant at PHCs

Situation Analysis/ Current Status	Rs 375000 are available as Untied Fund for 15 PHCs @ 25000 for each PHC and Rs 49628 is expended till Dec. 2008. Rs 750000 are available as Maintainance grant for 15 PHCs @ 50000 per PHC and Rs 1500000 is available to the PHC's SKS to provide additional facilities to the Patients for 15 PHCs @ 100000 per PHC. A number of equipment needed some repair due to which they were lying unutilized.
Objectives	1. Strengthening of the PHC through financial support
Strategies	1. Provision of Untied funds of Rs 25000 each year to the PHCs at the disposal of the Swasthya Kalyan Samities 2. Provision of an Annual Maintenance grant of Rs 50,000 to the PHCs 3. Provision of fund of Rs 100000 for providing additional facilities to the Patients
Activities	These funds will be routed through the Swasthya Kalyan Samitis who will approve the yearly activities and the related budgets and also undertake and supervise improvement and maintenance of physical infrastructure. 1. An untied fund of Rs 25000 will be provided each year for activities as per the local needs including minor modifications, cleanliness of premises, transport of emergencies, transport of samples, purchase of consumables, etc; This fund will not be used for salaries, vehicle purchase and recurring expenses of Gram Panchayat or any other facility. 2. An Annual Maintenance grant of Rs 50,000 will be given to the PHCs for water, toilets, maintenance of building. 3. An Annual Grant of Rs 100000 will be given to the PHCs for providing additional facilities to the Patients. 4. Monthly and quarterly expenditure statement will be submitted alongwith UC
Support	1. Timely release of funds

required	2. Meetings of the Swasthya Kalyan Samitis to be regularly held

Timeline		
	Activity	**2010-11**
	Untied Fund of Rs 25000/PHC	18
	Annual Maintenance grant of Rs 50000/PHC	X
	Plan for maintenance to be developed and approved by the Swasthya Kalyan Samitis	X
	Plan for use of untied funds	X
	Swasthya Kalyan Samitis to identify mode of construction and repair	X
	Special Fund to give facilities to the patients @100000/PHC	X
Budget	**Activity**	**2010-11**
	Untied Fund of Rs 25000/PHC	4.5
	Annual Maintenance grant of Rs 50000/PHC	9
	Annual Fund to give facilities to the paients of Rs 100000/PHC	18
	Total	**31.5**

B-4. Provision of Untied Funds and Annual Maintenance grant at PHCs

Situation Analysis/ Current Status	Rs. 300000 is available for 6 PHCs as Untied Fund for local health action @ 50000 per PHC. Rs. 600000 is available for 6 PHCs as Improvement and Maintenance of physical infrastructure of the PHC @ 100000 per PHC and Rs. 600000 is available to the SKS for providing additional facilities to the patients. A number of equipment needed some repair due to which they were lying unutilized.
Objectives	1. Strengthening of the PHC through financial support
Strategies	1. Provision of Untied funds of Rs 50000 each year to the PHCs at the disposal of the Swasthya Kalyan Samities 2. Provision of an Annual Maintenance grant of Rs 100,000 to the PHCs 3. Provision of an Annual fund of Rs 100000 for providing additional facilities to the patients to the PHCs.
Activities	These funds will be routed through the Swasthya Kalyan Samitis who will approve the yearly activities and the related budgets and also undertake and supervise improvement and maintenance of physical infrastructure. 1. An untied fund of Rs 50000 will be provided each year for activities as per the local needs including minor modifications, cleanliness of premises, transport of emergencies, transport of samples, purchase of consumables, etc; This fund will not be used for salaries, vehicle purchase and recurring expenses of Panchayat or any other facility. 2. An Annual Maintenance grant of Rs 100,000 will be given to the PHCs for water, toilets, maintenance of building. 3. An annual fund of Rs 100000 is provided for providing additional facilities to the patients to the PHCs. 4. Monthly and quarterly expenditure statement will be submitted alongwith UC
Support	3. Timely release of funds

required	4. Meetings of the Swasthya Kalyan Samitis to be regularly held

Timeline	Activity	2010-11
	Untied Fund of Rs 50000/PHC/APHC	7
	Annual Maintenance grant of Rs 100000/PHC	X
	Plan for maintenance to be developed and approved by the Swasthya Kalyan Samitis	X
	Plan for use of untied funds	X
	Swasthya Kalyan Samitis to identify mode of construction and repair	X
	Annual grant for the facilities to the patients Rs 100000/PHC	X

Budget	Activity / Item	2010-11
	Untied Fund of Rs 50000/PHC/APHC x PHCs/APHCs	3.5
	Annual Maintenance grant of Rs 100000/PHC	7
	Annual grant for the facilities to the patients of Rs 100000/PHCs	7
	Total	**17.5**

B- 5. Mobile Medical Units

Situation Analysis/	There is only one mobile dispencery is available in East Champaran Hospital. But most of the time the vehicle is busy in some other activities. As per the NRHM guideline there is

<table>
<tr><td>Current Status</td><td>no Mobile medical unit exist.</td></tr>
<tr><td>Objectives/</td><td>Meeting the unmet health needs of the people residing in difficult and underserved areas, through provision of healthcare at their doorstep</td></tr>
<tr><td>Strategies</td><td>Operationalizing a Medical Mobile Unit (MMU)</td></tr>
<tr><td>Activities</td><td>1. Joint meeting of the District Health Society and the Swasthya Kalyan Samiti (SKS) to decide the appropriate modality for Operationalization of the MMU.
2. Formation of a Monitoring Committee
3. The SKS will operate the MMU for long-term sustainability of the intervention.
4. Staff will be hired on contract by the SKS.
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 essensial accessories, basic laboratory facilities, semi-auto analyser and generator etc.
8. Wide publicity before the arrival of the MMU
9. Periodic Review.</td></tr>
<tr><td>Support required</td><td>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</td></tr>
<tr><td>Timeline</td><td><table>
<tr><td></td><td>2010-11</td></tr>
<tr><td>Operationalizing the MMU</td><td>1</td></tr>
<tr><td>Orientation & reorientation of the staff</td><td>X</td></tr>
<tr><td>Wide Publicity</td><td>X</td></tr>
<tr><td>Strengthening the MMU</td><td>X</td></tr>
</table></td></tr>
</table>

	Addition of services	X

Budget	Activity / Item	2010-11
	Hiring staff	15.48
	Orientation of the staff	0.10
	Joint Workshop for finalizing modalities	0.10
	Cost of Vehicle, equipment and accessories	26.55
	Recurring Cost of Drivers, Drugs, supplies, Mobile phones, POL, Maintenance	3.52
	Total	**45.75**

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	18,00,000
3.	Prefabricated tents & Furniture	1,50,000
4.	Equipment	2,00,000
5.	Mobile Phone (one for each Driver)	10,000
	Total	**26,55,000**

Budget of Personnel

S.No	Head	Unit	Unit Cost	Amount
1.	Emoluments to MOs -1	12 mths	25000	300000
2.	Emoluments to Specialists –2 (Part time)	12 mths	40000	960000
3.	Lab Technician	12 mths	7500	90000
4.	Pharmacist	12 mths	7500	90000
5.	Nurse	12 mths	9000	108000
	Total			**1548000**

Budget for Recurring Expenses

S.No	Head	Unit	Unit Cost	Amount
1.	Salary of Drivers –2	12 mths	5000	120000
2.	Drugs			100000
3.	POL & Maintenance of Vehicles			100000
4.	Maintenance of equipment			20000
5.	Mobile Phone bill -2	12 mths	500	12000
	Total			**352000**

B – 6. Upgrading PHCs to IPHS

Situation Analysis/ Current Status	There are 5 PHCsin the Distt. PHC Mohindergarh and PHC Ateli are under process to be as per the IPH Standards. There is shortage of Staff & Specialists in all PHCs. Rs 20 lakhs was provided for each PHC for IPHS Up gradation and 2 specialists were hired under IPHS in the district for each PHC for providing Specialists services to the people.
Objectives	Upgrading the General hospitals and the PHCs to IPHS standards
Strategies	1. Availability of all personnel as per IPHS 2. Proper building 3. Adequate Laboratory, Blood Storage Unit, Equipment and Drugs
Activities	1. Hiring of additional staff as per IPHS with 7 Specialists and MOs, in each of the facilities, 10 staff nurses, 1 PHN, 1 Computer clerk, 1 Dresser, 1 Pharmacist, 1 Lab Technician, 1 BEE, 1 Radiographer, 1 UDC, 1 Accountant, 1 Clerk, 1 Epidimiologist and ancillary staff like Aya, Chowkidar, Dhobi, Sweepers, Peon and filling of Vacancies 2. Repair of PHCs 3. Equipment as per IPHS norms
Support required	State to sanction posts as per IPHS Allowing Contractual Personnel at Market Rates
Timeline	As FRUs, Contractual Specialists and equipments by 2009-10

Budget	**Activity/ Items**	**2009-10**
	Building for new PHC	0
	New Building for 2 existing PHC	48
	Furniture	2.4

	Equipment	44.38
	Vehicle /Ambulance	5
	Recurring cost for existing PHCs	473.11
	Recurring costs of additional PHCs	0
	Repair of building for PHCs	10
	Total	**582.89**

B – 7. Upgrading PHCs for 24x7, IPHS and others requirements of PHCs	
Situation Analysis/ Current	8 PHCs were developed for 24 x 7 PHCs but staff is inadequate and neither is the equipment. The Staff quarters need to be built so that all the staff can stay and be available.

Status	None of the PHCs are near the IPHS standards. As per the population norms at least 25 PHCs will be required by 2009-10 and there are only 18. Only 34 Staff quarters are available.10 PHCs don't have any staff quarters
Objectives	To establish 4 no. of PHCs for 24x7 and IPHS To increase the number of PHCs to 20 by 2009-10
Strategies	1. Availability of all personnel as per IPHS 2. Proper building with staff quarters in all PHCs 3. Adequate Laboratory, Equipment and Drugs 4. Additional PHCs
Activities	Hiring of additional staff as per IPHS with 2 MOs(maybe Ayush), in each of the facilities, 3 staff nurses, 1 PHN, 1 Lab Technician, Part time Pharmacist, 1UDC, 1 Accountant, and Class IV and filling of Vacancies Building addition /Expansion of 09 PHCs and Repairing of 11 PHCs. Construction of staff quarters for the existing PHCs Upgrading the Laboratory for tests necessary for 24 hour PHCs Furniture, Drugs and Equipment as per IPHS norms Identification of sites for 2 new PHCs and developing them as per IPHS. Staff quarters for the existing PHCs
Support required	State to sanction posts as per IPHS Allowing Contractual Personnel at Market Rates
Timeline and	Increase the no. of PHCs and 24x7 PHCs by 2009-10

Budget	Activity / Item	2009-10
	New Buildings for 2 PHCs with equipment, Drugs and Furniture and quarters as per IPHS	63.23
	Equipment and furniture for existing facilities as per IPHS	12
	Repair/Additions of PHCs	50
	Staff Quarters as per IPHS	100
	Recurring costs of the additional PHCs	30.53
	Total	**255.76**

B – 8. Upgrading Sub Centres and Additional Subcentres

Situation Analysis/ Current Status	Out of the existing 117 Subcentres, 95 Subcentres are in their own buildings and 6 are in Panchayat buildings and 1 are in rented buildings. Electricity is required in 50 buildings and Water supply in 43 Subcentres. Toilets are present in 71 Subcentres, needing minor repairs and 31 do not have toilets. Out of 95 Subcenters running in their own building 55 SCs are in very bad condition and need major repair. Rest Subcdenters also need some minor repaires. There are no staff Quarters in 7 Subcentres, 59 Subcentres have one quarter.

	Also looking at the projected population for 2009-10 at 9.29 lakhs, it will be essential to plan for these new Subcentres. In those Subcentres where there are Delivery huts, there are 2 ANMs. As per IPHS norms each Subcentre should have 2 ANMs.
Objectives	1. Upgrading of Subcentres as per IPHS standards 2. Quarters for the ANMs 3. Opening Additional Subcentres to cater to the entire population
Strategies & Activities	Building new buildings for 30 Subcentres Quarters for the Subcentres Provision of Electricity to 50 Subcentres Provision of Water connection to 43 Subcentres Provision of toilets to 31 Subcentres
Support required	State to sanction posts as per IPHS Allowing Contractual Personnel at Market Rates

Timeline	**Activity / Item**	**2009-10**
	New buildings with quarters, equipment and Furniture (10)	22
	Repair of SCs (55)	30
	2 Staff Quarters (7)	7
	1 Staff Quarter (59)	30
	Electricity connections	50

	Water Connections	43
	Toilets	31
	New Subcentres	15 SCs
Budget	**Activity / Item**	**2009-10**
	New buildings with quarters	108.61
	New Subcentres	74.06
	Repair of SCs	15
	2 Staff Quarters	21
	1 Staff Quarter	45
	Recurring Costs	10
	Total	**273.67**

Note: Toilets, Electricity and Water connections will be implemented from the Untied funds

B-9 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 & Water Sanitation Committees (VHWSC) in each village. These committees are responsible for the health of the village. In District East 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 East Champaran there are 17 villages with population less than 500. There are 144 villages with population between 2001 and 5000. There are 16 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 upto a population of 1500
Activities	1. Provision of Annual Untied funds of Rs 10000 each year to the village's upto a population of 1500. Villages with more than 1500 population upto 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	

	2009-10
Untied Fund of Rs 10000/unit for Pop 2000/unit x 186 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	2009-10
	Untied Fund of Rs 10000/unit 1500/unit x 186 units	18.6
	Untied Fund of Rs 20000/unit 3000/unit x 144 units	28.8
	Untied Fund of Rs 30000/unit 5000/unit x 16 units	4.8
	Total	**52.2**

PART C: Immunisation

C-1. Strengthening Immunization	
Situation Analysis/ Current Status	As per the District data immunization coverage is 100%. But for complete immunization data is not available. Complete Immunization is present only in 58.7% children in the age group 24-35 months and 11.4% did not receive any vaccine, as per DLHS 2002 data. The dropout rate is also high. The availability of health facilities in villages definitely affected and increased the immunization of children. 50 percent were immunized at government health facility and rest of them at private health facility. Regarding Vitamin A supplement 21 % of the children got at least one dose of Vitamin A. The reasons for children not being Immunized are related to the ignorance of the mothers on the importance of immunization, the place and time of Immunization sessions and fear of side effects.

	The community perceives that the Polio drops given repeatedly at the time of Pulse Polio campaign are equivalent to the complete immunization. The ANMs have to take the vaccines from the PHC headquarters resulting in them not reaching the hamlets and also the difficult areas and also the Pulse Polio campaign. Supervision is not done properly at PHC level. Also there is large gap between reported and evaluated coverage. There are 25 Nos. of Deep Freezers, 31 ILR and 28 Cold Boxes are available in the district. There is need of these above said cold chain equipments.
Objectives/ Milestones/ Bench marks	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) 100% Measles vaccination of children (12-23 month of age) 100% Vitamin A vaccination of children (12-23 month of age)
Strategies	1. Strengthening the Deputy Civil Surgeon (Immunization) 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 Deputy Civil Surgeon (Immunization) office. • Support for the mobility Deputy Civil Surgeon (Immunization) (@ Rs.5000 per month towards cost of POL) for supervision and monitoring of immunization services and MCHN Days • One Computer assistant for Deputy Civil Surgeon (Immunization) @7500 pm 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 • Hiring of vehicle for Extension of Immunization at brock kilns in the field every month. 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 & PHC will be given each year • For minor repairs, Rs. 10,000 will be given per year. • 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. • Availability of cold chain equipments at all PHCs/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

Timeline

Activity	2009-10
Alternative Vaccine delivery	X
Mop up Round	X
IEC activities	X
Tracking bags	X
Orientation on Tracking bags	X
Purchase & Maintenance of Cold Chain Equipments	X
Provision of Large Invertor with Battery	X

Budget

Activity	2009-10
Mobility Support for Deputy-Civil Surgeon (Immunization) as POL @ 5000	.60
Salary of Computer Assistant for Dy.C.S.(Immunization) @ 7500 pm	.90
Mobility support for alternative vaccine delivery Rs. 50 per session for 1 planned sessions per week at each Subcentre village for 12 months = Rs. 50x1 sessionsx4 weeks/mthx12 months x 117 SCs	2.81

	Mobility Support Mop up campaign @ Rs 10000 per PHC (Including travel, vaccine delivery, IEC) x 6 rounds/ year x PHCs	12
	Mobilization of Children by Social Mobilizers @ Rs. 100/ session x4 sessions per month X 117 units x12month	5.62
	Contingency fund for each block @ Rs.1000/month x 7 blocks x 12 months	.84
	Printing of Immunisation cards @ 4 per card x 30000 cards each year	1.2
	Tracking Bags to ANMs (and @ Rs. 200 per tracking bag x 230	.46
	Supply of Cold Chain Equipments: Deep Freezer-8, ILR- 7, Cold Boxes- 10	State
	Maintenance of Cold Chain Equipments (funds for major repair) (@ Rs.750 per PHC/PHC per month and Rs 50,000 annual for minor repairs	2.75
	POL & maintenance for Vaccine delivery van at district level @ Rs.15000/month x 12 mths	1.8
	Provision of Large Size Invertor with battery at all facilities upto PHC/PHC @ 25000 x 25	6.25
	Running cost of ILRs & Deep Freezers (for electricity bill) (@ Rs 300 per month for PHCs/PHCs x 15 x 12 mths	3.36
	Hiring of vehicle for extencion of immunization at brick kilns @ Rs 1000pm/PHC	3
	Total	**41.59**

Priorities and Activities for RNTCP

District –

D-1. RNTCP

Gaps	Priority Areas	Activity planned under each priority area
• Lack of proper monitoring and supervision at TU and District Level • Proper counseling of patients by the DOTS provider and by the STS is not being done. • Schedule of Follow-up is not being maintained • Regular intake of drugs is not being ensured	**Increase Cure-rate*** **(56%(DTO) to 85%)**	**(a) Effective monitoring and supervision to ensure the follow-up sputum smear examinations done according to guidelines** **(b) 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.** **(c) Ensure return of empty blister packs during weekly collection of drugs** **(d) Participation of ASHAs and AWWs for providing DOTS so as to reach services close to the patients for decrease default rate.** **(e) Ensure proper counseling of the patient by the health workers.**
2.	**Increase Case-detection** **(29%(DTO) to 70%)**	**(a) Organizing awareness campaign and community meetings to aware people about the TB and DOTS.** **(b) 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)** **(c) Sensitization of all Lab Technician for Correct Sputum Smear Microscopy(5%-15% positivity is expected among patients examined for diagnosis)**

		(d) Ensuring 3 sputum smear examinations for TB patients
3.	**Ensure Quality of DOTS** • Lack of dispensing medication properly as per technical guidelines in district. ANMs providing DOTS at HSCs do not visit Center on DOTS day. • Regular intake of Drugs is not being conducted by DOTS providers • Delay in initiation of Treatment of NSP Patient within a weak • Follow-up sputum smear microscopy examination at the end of Intensive Phase and at the end of the treatment is not done in	(a) Participation of ASHA and Community Volunteers to provide effective DOTS. (b) Incentive to ASHA and Volunteers for timely Sputum smear microscopy Collection and follow-up. (c) Initiation of treatment of New Smear Positive (NSP) patients within a weak of diagnosis. To control spared of infection in Group. (d) Proper Monitoring/Supervision to ensure regular and interrupted DOTS as per guidelines. (e) Proper counseling of patients by the DOTS provider and supervisory staffs.

	many cases	
4	**Provide Quality DMC services** • **Microscopes of many DMCs are defective or dysfunctional** • **Proper space with electricity connection for keeping microscopes and proper water supply in the DMCs is not available** • **Poor maintenance of microscopes** • **Irregular supply of Lab consumables**	**(a) Maintenance/Replacement of defective Binocular microscopes.** **(b) Establishment of new DMC as per need and repairing/renovation of closed DMCs with proper electricity connection and water supply.** **(c) Refreshment training of Lab Staffs specially Lab Technician for maintenance of microscopes.** **(d) Ensure regular and adequate supply of laboratory consumables to DMCs from |District TB Center(DTC)**

	i.e., Slides, sputum containers and chemicals	
5	**HR Issues** • **Lack of staffs i.e., Lab Technician(LT), STS, STLS, TBHV and other Staffs** • **Operational Issues:** **Lack of coordination between ASHA, AWW and ANMs.**	**(a) Recruitment of Counselor at PHC level** **(b) Active participation of community specially ASHA and AWW.** **(c) Capacity building of ASHA** **(d) Remuneration to ASHA/Community volunteer for providing DOTS will be paid timely.** **(e) New recruitment for lacks in staffs i.e., Lab Technician, STS, STLS, TBHV and other staffs.**

*****Cure-rate***: No. of cured NSP cases/Total No. of NSP cases X 100**

***Cured Cases*: Initially sputum smear-positive patient who has completed treated and had negative sputum smears, on two occasions, one of which was at the end of treatment.**

D-2. RNTCP

Situation Analysis/ Current Status

Indicators	No. / Rate
New Sputum Positive cases (NSP)	455
Annualized new case detection rate per one lakh population	49.65/L
Total No. of patient put on treatment	1247
Annual total case detection rate per one lakh population	136/L
Cure rate of New Smear Positive cases	85.2%
Smear Conversion Rate	90%
Defaulter cases	7%
Failure cases	5%
Source : DTBO Office	

To fight Tuberculosis the Revised National Tuberculosis Control Programme based on the DOTS regime was launched in 2003 in Mohindergarh. Under this programme in District East Champaran Tuberculosis Unit at microscopic centres were setup.

Objectives

1. 85 % Cure rate in New Cases
2. Detection of 70% new smear positive cases once cure rate of 85% is achieved
3. Reduction in the defaulter rate to less than 5%

	4. Reduction in failure rate to less than 3%
Strategies	1. Improvement in the infrastructure 2. Improvement in the quality of the intervention 3. Increasing the outreach of the programme 4. Increasing the awareness regarding Tuberculosis
Activities	1. One more DMC as per norms 2. Improvement in the quality of testing of sputum • Training to the RNTCP staff in the district • Equipment maintenance – Microscope, Computer and Others • Adequate supply of drugs **3.** Increasing the outreach of the programme by Increasing the DOTS providers through involvement of ASHAs who will be paid Rs. 250 per caser for providing services. She will be oriented regarding DOTS. Also the AWH should be involved in reporting suspicious cases. Training will be given to ASHA for identifying the suspects. 4. Increasing the awareness regarding the various issues of Tuberculosis through involvement of Rotary clubs and the Lions clubs and NGOs. Special drive for detection of cases on World TB day through the involvement fo all departments **5.** DOTS regime to be strictly monitored through the VHWSC, the PRIs and the PHC MO **6.**
Support required	Timely supply of medicines
Timeline	2009-10

	1. One New DMC in TU Narnaul 2. Increasing the DOT providers through ASHAs 3. Training to RNTCP staff and ASHA 4. Awareness drives 5. Involvement of the AWW

Budget	**Activity / Item**	**2009-10**
	Civil Works	.3
	Laboratory Material	1.70
	Honorarium	1.1
	IEC/Publicity	.74
	Equipment maintainance	.44
	Training	1.85
	Vehicle Maintainence	.6
	Vehicle Hiring	2.4
	NGO/PP support	.92
	Contractual Services	14.5
	Printing	1.37

	Procurement Vehicle	1
	Procurement Equipment	.3
	Miscellaneous	2.5
	Total	**29.72**

Salaries of Contractual Staff

	Personnel	Unit Cost	Units	Months	Amount
1	TB health visitor for urban areas	6750	1	12	91800
2	STS	8625	2	12	207000
3	STLS	8625	2	12	207000
4	LT	7500	6	12	540000
5	Data Entry Operator	6900	1	12	82800
6	Accountant	2000	1	12	24000
7	C.F.	8750	1	12	105000
8	MO	16000	1	12	192000
	Total				**1449600**

D-3. LEPROSY

<table>
<tr><td rowspan="4">Situation Analysis/ Current Status</td><td colspan="2">Balance Cases at beginning of year</td><td colspan="2">New cases detected in year (April 08 to Nov 08)</td><td colspan="2">Cases Discharged in year</td><td colspan="2">Balance Cases at end of year</td><td colspan="2">Per 10,000 Population</td><td rowspan="2">Proportion of Deformity Ratio among cases</td></tr>
<tr><td>PB</td><td>MB</td><td>PB</td><td>MB</td><td>RFT</td><td>O.D</td><td>PB</td><td>MB</td><td>PR</td><td>NCDR</td></tr>
<tr><td>203</td><td>241</td><td>487</td><td>191</td><td>729</td><td>10</td><td>174</td><td>209</td><td>.82</td><td>1.85</td><td>1.03</td></tr>
<tr><td colspan="11">The Nodal Officer for monitoring the Leprosy programme is the District TB Officer.</td></tr>
<tr><td>Objectives</td><td colspan="11">Eradication of Leprosy</td></tr>
<tr><td>Strategies &
Activities</td><td colspan="11">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 Leprosy
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 MDT
8. Block leprosy awarkers coupaign- 3 Block</td></tr>
<tr><td>Support required</td><td colspan="11">Availability of regular supply of drugs
(Preduisolace)</td></tr>
</table>

Objective	Bulde up capacity Building of MIS & General Health staff.	
Activities	1. Training of Medical officer- 150 2. Training of General Health staff- 300 3. ASHA'S Training – 500 4. Health Mela- 5. School Quiz in 100 school 6. Urban Leprosy programme- 7. Raily & Bkker (Leprosy day) 8. Patiuf welfare-	
Timeline	1. BLAC (Black leprosy awareness campaign)- in Four P.H.C. April 2009 to May 09. 2. School quiz in hundred schools by (N.H.A.)- 100 school- June 2009 & July 2009 3. ASHA Training- Aug 2009 4. Training of MDS & General Health staff- Sept. 2009 5. Urban Leprosy programme- Oct. 2009 6. Raily & Banner (Leprosy day) 30th Jan 2010. 7. Health Mela- Jan. 10 & Feb. 10 8. Patient welfare- 30th Jan 2010	
Budget	**Activity / Item**	**2009-10**
	Salary to Contractual Staff	46200.00
	Office Expenditure	10000.00

	Account work	4800.00
	Contagious	15000.00
	Audit fee	4000.00
	Vehicle reparing (Two vehicle)	60000.00
	POL & Maintenance 4000/vehicle	80000.00
	Supporting maintenance	15000.00
	Patient welfare	10000.00
	Raily & Leprosy day	6000.00
	School Quiz in (100 school)	50000.00
	Health Mela	4000.00
	Oneday orientation training MOS & General Health staff	171000.00
	Urban Leprosy programm	47000.00
	BLAC (4 PHC)	460000.00
	Total (nine lac eighty three thousand only)	**983000.00**
DUES **Year 2007-08 & 2008-09**	**Note- 1. Rs. 59925.00 (fifty nine thousand nine hundred twenty five) dues of BLACK programm of 07-08** **2. Rs. 50050.00 payment of confractual staff (Driver) due for the year 08-09** **3. Rs. 2500.00 (Two thousand five hundred) dues of office expenditure** **Total dues- 112475.00 (one lac twenlve thousand foru hundred seventy five)**	

D-4. 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):	311	
Slide Positivity Rate (SPR)		.27
Annual Parasite Index (API)		0.34
Slide Positive plasmodium falciparum Rate (PFR)	DNA	
Deaths:	0	

In Haryana 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 PHC 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	2009-10
Hiring Contractual Staff	x
Purchase of Jeep and Trucks	x
Fogging & Spraying	x
Hoardings	4 PHCs 1 GH 12 PHCs
Hatcheries for Gambusia Fish	3 PHCs & 1GH,
IEC activities	X

Budget

Activity / Item	2009-10
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 PHC, and for PHC Rs 10000	3.8

	Board hoarding: ten 8'x 12' at 10 sites initially at the PHCs 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 PHCs for Gambusia fish @ Rs 1.00 lakh per PHC, 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**

D-5. OTHER VECTOR BORNE DISEASES

<table>
<tr><td>Situation Analysis/ Current Status</td><td>

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

</td></tr>
<tr><td>Objectives</td><td>Decrease in incidence of Dengue to nil

Prevention of JE, Chikingunya and other new infections</td></tr>
<tr><td>Strategies</td><td>1. Reduction of vector density
2. Mosquito-man contact reduction
3. Community awareness</td></tr>
<tr><td>Activities</td><td>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</td></tr>
</table>

	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	2009-10
	Budgeted in Malaria	
	IEC and awareness to the people	1
	Unforeseen expenses	0.5
		1.5

D-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 APHCs. General Hospitals and PHCs 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 East Champaran. The nearest Eye Bank is at Rohtak Medical College.

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 2010
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 PHCs 8. Supply of basic Eye medicines like eye drops, eye ointments and consumables for Primary Eye Care in PHCs/PHCs. 9. All PHCs and PHCs to be developed for vision screening and basic eye care

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
	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	**2009-10** Health Mela Development of PHCs as Vision Centres Development of General Hospital Narnaul as Eye Unit School Screening Cataract Camps		
Budget	**Activity / Item**	**2009- 10**	
	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 410	0.41
	Training of PRIs @ Rs 100/head x 410	0.41
	Repair and purchase of equipment and maintenance	12.00
	Total	**24.17**

D-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 Haryana 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 ▪ Upgradation 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 GH Narnaul 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
Timeline	

Activity / Item	**2009-10**
Renovation of Labs with provision of equipment, furnishings, material	1Gen Hosp, + 20 PHCs
Training	X
Contractual staff	X
Software for DSU & training of staff	X
WEN connectivity	X
Sensitization of Community	
Meetings with SHGs	X
Meetings with teachers	X

Budget	Activity / Item	2009-10
	Renovation of Labs at20 PHCs and general hospitals@ Rs 25,000 x 21	5.25
	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	10.5
	Equipment for Lab at District @ Rs 5,00,000	5
	Computer and Accessories at PHC and general hospitals @500000	105
	Computer and Accessories at DSU@630000	6.30
	Office Equipment for PSU at PHC and general hospitals @ Rs 10,000 per unit	2.1
	Office Equipment for DSU @ Rs 10,000	0.10
	Software for DSU@ Rs 350000	3.5
	Furnishing of Lab at PSU at PHCs and general hospitals @ Rs 10,000	2.1
	Furnishing of Lab at DSU @ Rs 60,000	0.60
	Material and supplies at Lab at PSU at PHCs and general hospitals @ Rs 10,000	2.1
	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	

Detailed Budget for Trainings

Personnel	Unit Cost	Units	Amount
ANM	900	443	3.99
Lab Assistant at PHCs	1000	20	.2
Lab Assistant at Distt	3500	2	.07
MOs	2000	189	3.78
		Total	**8.04**

D-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 East 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; Demonstraion 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	**2009-10** • 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	2009-10
	Large Village meetings for awareness on IDD and consumption of Iodized salt	1.00
	Programme in schools –1765 Primary, Upper Primary, Secondary- Govt and Private by School health team	5.00
	Awareness programme with the SHGs and shopkeepers @ Rs 500 per village x 1634villages	8.17
	Total	**14.17**

6.1 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	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

- Leprosy - IDD - Tuberculosis - IDSP - HIV / AIDS - Water borne diseases		Diseases Surveillance

6.2 ICDS projects

Issues / Areas	Areas of cooperation	Areas of convergent action
Maternal and child health care, complete immunization Anemia and Malnutriton	• 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 Handpumps 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 handpumps

		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 Subcentre 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 alongwith 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 55.82%. Malnutrition and anemia 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

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. Realignmant 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 PHC 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	**2009-10** 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**	**2009-10**
	Meetings of the Block Committees @ Rs 2000 /meeting x 27 blocks x 12 months	6.48
	Meetings of the Village groups @ Rs 100 per village x 1634 villages x 12	19.61
	Joint monitoring at the sector level Hiring of vehicle @ RS 1000/ day x 5 days/month x 20 sectors x 12 months	12
	Joint monitoring at the block level Hiring of vehicle @ RS 1000/ day x 5 days/month x 27 blocks x 12 months	16.2
	Yearly joint Planning Workshops at the Block level for development of the Action Plans @ Rs 0.10 lakhs per block x27 blocks	2.7
	Yearly joint Planning Workshops at the District level for development of the Action Plans @ Rs 20000	.20

	Yearly joint Workshops to consolidate the findings at the block levels at the District level for development of the Action Plans @ Rs 20000	.20
	Total	**57.39**

Community Health Action	
Situation Analysis/ Current Status	Constitution of Village Health Water and Sanitation Committees (VHWSC) has been done and now these committees are the part of Village Level Committees formed by the Women & Child Development Department but subsequently no activities have been carried out leading to dysfunctional committees. No efforts have been carried out nor did any monitoring done by the District authorities to keep these Committees function. Monthly meetings of the SMS groups are held but these need to be more focussed and also with specific actions. They can also be linked to the SHGs. Community health action is thereby very limited.
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 microplan 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 fo 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	**2009-10** Training of Village Level Committees Review of Village health action Plans Formation of Emergency Fund and development of Microplan for the SMS Public hearing in every cluster Health camps Strengthening the Block health committee

Budget	Activity / Item	2009-10
	Training of the VLC @ Rs 200 per person x 15 persons/Committee x1634 villages	49.02
	Meetings of the VLC @ Rs 200 per village x 1634 villages x 12 months	39.22
	Meetings of SMS @ Rs 100 per month x 1634 villages	1.63
	Total	**89.87**

8. Public Private Partnerships

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/PHC 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
Timeline	

Activity	2009-10
Increasing the partnership with Private partners by their involvement in RCH	20
Accreditation to private facilities	5
Inviting Private providers for using Govt facilities, putting in specialized equipment in the Govt hospitals	**x**

	Activity	
	Outsourcing facilities to private providers	x
	Involvement of private Specialists in Govt facilities	x
	Training to the Private providers	X
Budget	**Activity / Item**	**2009-10**
	Arogya Kosh	3
	Hiring of specialists-2 @ 30000 pm	7.2
	Training of NGO personnel and the Private sector @ Rs 500 for 2 days per person x 40 persons	0.4
	Workshop for involvement of the Private sector	0.5
	Total	**11.1**

Gender and Equity	
Situation Analysis/ Current Status	Gender discrimination is a common phenomenon. It has a direct bearing on the health status of women and children. Some of the parameters are the Sex Ratio, Age at marriage, enrolment of girls in schools, Male sterilization. The main reason is dowry. The **Sex Ratio** shows a bad picture in district East Champaran. The Sex Ratio as per Census of 2001 was 918.The Sex Ratio for 0-6 years as per 2001 census was 817. Now the Sex Ratio is 873. It seems that there a large number of bachelors and that crime has increased in this area. But still a lot has to be done. Advisory committees have been constituted in all the districts and their meetings are held periodically. The topics of PNDT Act, Gender issues and Declining Sex ratio have been included in RCH training for Medical Officers conducted at SIHFW. The **Age at marriage** for boys is 21.8 and 17.8 for girls as per DLHS 2002. 42.8% of girls in the rural areas were married below 18 years. As per the block data out of 4227 girls who got married last year 47 were less than 18 years. There is no specific data on **Gender Based Violence** but women take it as part of marriage and hence undermine the facts. **Male involvement in Family Welfare** is minimal since there are very few Vasectomies as against Tubectomies. The **indicators for morbidity and mortality** also show differential values for boys and girls. The service providers are also not **gender sensitive**.
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 PHC 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 East 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 PHC/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 upto the age of 18 years. 7. Improving the Literacy status and promotion of education upto 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	Strict enforcement of the PCPNDT Act

required	Support from other departments as mentioned under intersectoral convergence

Timeline

Activity	2009-10
Workshops with all stakeholders	x
Incentives for early registration of Pregnancy	x
Promoting male involvement through Vasectomy	x
Study on the plight of bachelors	x
Developing strategies to publicize the problem of the bachelors	
IEC for Vasectomy	x
Health Card for girl Child	x
Advisory group meetings	x

Budget

Activity / Item	2009-10
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% enrollement in the schools @ 20000	1.0
	Monitoring and meetings of advisory committee	1.0
	Computer and other asseceries	.50
	Total	**19.6**

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 alongwith 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. 225 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 2009-10, 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 Rohtak 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 Rohtak 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 Laproscopic Sterilization for Surgeons, Gynaecologists, SN, OT attendants for 12 days
- Skill upgradation 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 Support	• SIHFW to develop the training calendar and organize the trainings as per schedule • 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	2009-10
	SBA training for 95 MOs x 2 batches for 14 days	20
	MVA MTP training to all PHC MOs for 14 days x 38 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 Rohtak 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 Rohtak	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 Laproscopic 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**	**2009-10**

	SBA training for 95 MOs x 9715 x 2 batches for 14 days	258.4
	MVA MTP training to all PHC MOs for 14 days x 38 MOs x 21630 x 5 batches	575.36
	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 49 ANMs	184.58
	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	
	Integrated skill training of all SN @ 4200 x 10 persons	.42
	Integrated skill training for ANMs @ 2100 x 443 persons	9.3
	Integrated skill training for MOs @ x 3700 x 5 persons	.19
	Training of MOs, SN in Mgt of Newborns & sick children	-
	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 Laproscopic 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	**1048.01**

Human Resource Plan

<table>
<tr><td>Situation Analysis/ Current Status</td><td>
The Human Resources in district East Champaran are grossly inadequate. There is a 40 % turnover of doctors' inspite of the fact that contractual doctors are being hired. The fast urbanization and unparalleled growth in the nearby villages will have to look at the health facilities which are unable to cope with the demands today. In 2012 the population will be around 10 lakhs at least with the slum population increasing five fold.
There is no motivation for the doctors to work and promotions are hard to happen. Due to the increased urbanization the doctors prefer to work in Private facilities.
Subcentre level

The number of subcentres including urban centres will have to be increased from 117 to 132
The requirement of ASHAs will be around 1000 including the urban[norm of one for 1000 population]
The requirement of ANMs will be around 264 in Government as per IPHS norms of 2 ANMs per Subcentre.
Delivery huts will be required for each of these subcentres. At present there are 31 delivery huts. In 2009-10, 40 will be required.
There are 16 villages having population coverage more than 5000, these villages needs additional ANMs

PHC level

The PHCs required in 2009-10 will be around 25
HR Requirement is reflected in gaps identified in Facility survey.

PHC Level

The PHCs required in 2009-10 will be around 7 and at least 2 General hospitals.

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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.

Activity / Item	Current Status	2009-10 Proposed	2009-10 Required
Sub Center	**315**	**472**	**229**
ANM (R)	291		128
ANM (C)	152		351
Health worker Male	6	60	54
ASHA	2686	3689	1003
PHC	**20**	**30**	**50**
MO (R)	91		
MO (C)	98	128	30
Pharmacist			
Staff Nurse (R)	17		7
Staff Nurse (C)	30	165	135
Health Educator/Male supervisor	30	31	1
LHV	17	43	26
UDC/ Computer Clerk	20	40	20
LDC	89	109	20
Lab Tech	5	42	37
Class IV	231	306	75
SMOs	2	4	2
Staff Nurse	12	70	58
PHN	0	7	7
Computer cleark	3	7	4

Budget for Contractual Staff	Activity / Item	Unit Cost(per year)in lacs	2009-10	2009-10
	Sub Center		**132**	
	ANM	1.3626	33	44.97
	Health worker Male	1.188	46	54.65
	PHC		**20**	0
	MO	2.5266	8	20.22
	Pharmacist	1.5372	7	10.76
	Staff Nurse	1.5372	49	75.33
	ANM	1.3626	6	8.18
	Health Educator/Male supervisor	1.5372	10	15.37
	LHV	1.7118	11	18.83
	PHN	1.7118	18	30.82
	UDC/ Computer Clerk	1.188	18	21.39
	LDC	0.9133	18	16.44
	Lab Tech	1.188	16	19.01
	Class IV	0.6933	46	31.90
	PHC		**0**	0
	SMOs	3.15225	5	15.77
	Staff Nurse	1.5372	58	89.16
	PHN	1.7118	7	11.99
	Computer cleark	0.9133	4	3.66
	Dresser	0.6933	7	4.86
	Pharmasist	1.5372	0	0

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 alongwith achievements 17. Bal Nutrition Melas 4 times at each Subcentre 18. Wall writings 19. Pamphlets for various issues packed in an envelope
State Support	State to give guidelines for the good practices and also training module on BCC

Timeline and	**Activities**	**2009-10**
	Finalizing the messages	x

Budget	Advertisements	x
	TV spots	x
	Folk Media shows x 286 villages	x
	Hoardings on highways and prominent places	100
	Display boards	90
	Pamphlets x	10,000
	Developing Nirdeshika for holding Fixed Health & Nutrition days	4000
	Monthly Swasthya Darpan	4000
	SMS meetings in each village	x
	Bal Nutrition Melas in each SC	x
	Kishori Shakti meetings in each village	x
	Opinion leaders workshops	100
	Wall writings	x
Budget	**Activities**	**2009-10**
	Finalizing the messages	.50
	Advertisements	2.0
	TV spots	1.0
	Folk Media shows @ Rs 1000/1634 village	16.34
	Hoardings @ Rs 10000/hoarding x 100 hoardings	10

	Display boards @ Rs 2000/board x 160 Display boards	1.8
	Pamphlets @ Rs 5/pamphlets x 100000 pamphlets	5
	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 1634 villages	8.17
	Total	**53.02**

12. PROCUREMENT AND LOGISTICS

Procurement and Logistics	
Situation Analysis/ Current Status	In district East Champaran there 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 one storekeeper in the General hospital and two in the District Malaria Office. 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 4.
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

Timeline	Activity / Item	2009-10
	Construction of Warehouse	x

	Software	x
	Computer system with UPS, Printer, Scanner,	x
	Equipment & Hardware	x
	Pharmacist @ Rs 9000/mth	
	Assistant Pharmacist @ Rs 5000/mth	
	Packers -2 @ Rs 4000/mthx2	
	Security Staff @ Rs 6000/mth	
	Training of personnel	
	Consultancy to agency for Operationalization of the Warehouse	x
Budget	**Activity / Item**	**2009-10**
	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**

13. PROGRAMME MANAGEMENT

Strengthening of District Health Management	
Situation Analysis/ Current Status	The District Health Mission and Family Welfare Society have formed been registered in East 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 DH&FWS 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 & Family Welfare 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 Mission and DH&FW 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 Mission and Society on strategic management, financial management & GoI/GoH 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 GoH for proper functioning of the societies and monitoring committee. 4. Funds to maintain society office & staff.

Timeline	2009-10 1.Orientation Workshops of the members of the District Health Mission and District Health & Family Welfare Society 2. Monthly Review and Planning Meetings will be organized. 3. Formation of the monitoring Committee and will start the monitoring visits. 4.Strengthening of the Monitoring Committee	
Budget **In Lakhs**	**Activity / Item**	**2009-10**
	Orientation Workshop	0.5
	Monthly Meetings	.12
	Mobility for Monitoring	0.5
	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 Data Assistant have being provided in each district. These personnel are there for providing the basic support for programme implementation and monitoring at district level under DH&FW Society. 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 Data Assistant (DDA) 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 Subcentre. 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

Coordination with Community Organizations PRIs

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, DDM 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**

- 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.
- Financial management training of the officials and the Accounts persons
- 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 Block Data Assistants (BDA) 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 Subcentres 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**

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 Data Manager. 5. Developing the capacities of the Civil Surgeons and other district officials to utilize the capacities of the DPM, DAM and DDA 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	2009-10 • Selection of District level consultants, their capacity building and infrastructure • Development of an operational Manual 2009-10 • 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,DDA and Consultants	30.0	
	Travel Costs for DPMU @ Rs 10,000/ per month x 12 mths	1.2	
	Infrastructure costs, Furniture, computer systems, fax, UPS, Printer, Digital Camera	9.	
	Workshops for development of the operational Manual at district and Block levels	1.	
	Untied Fund	5.	
	Joint Orientation of Officials and DPM, DAM, DDM	0.25	
	Management training workshop of Officials	0.5	
	Personnel for BPMU	39.24	
	Training of DPM and Consultants	0.5	
	Review meetings @ Rs 1000/ per month x 12 months	1.2	
	Office Expenses @ Rs 10,000/month x 12 months for district	1.2	
	Annual Maintenance Contract for the equipment	0.5	
	Travel costs for BPMU @ Rs 5000 per month per 27 block	16.2	
	Monitoring of the progress by independent agencies	1.	
	Hiring of vehicles at block level @ Rs 800x 5 days /mth x 20 PHC/APHCsx12 mths	9.6	
	Office expenses for Blocks @ Rs 5000 x 27 blocksx 12	16.2	
	Total	**132.59**	**554.359**

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	23000	276000
	District Accounts Manager	1	18000	216000
	District Data Assistant	1	15000	180000
	Consultant for Maternal Health	1	40000	480000
	Consultant for Child Health	1	40000	480000
	Consultant for Civil Works	1	40000	480000
	Consultant for HMIS	1	40000	480000
	Consultant for Behaviour Change	1	40000	480000
	SubTotal			**3072000**
	Personnel at Block level			
	Block Health manager	20	15000	300000
	Block Accounts Manager	20	12000	240000
	Block Data Operator	20	10000	200000

	Subtotal			3812000
	Hiring of vehicles at block level @ Rs 800x 5 Days x27 blocks x12 months	20	4000	**1296000**
	Office Automation with Furniture, Computer system, Camera, Printer, etc	20for BPMU 1 for DPM 1 for DAM	100000	**2200000**
	Gross Total			**7308000**

Financing Health Care	
Situation Analysis/ Current Status	For sustainability and needs based care, health financing is the key. In District East champaran Rogi Kalyan Samiti(RKS) have been formed in each of the hospitals,and PHCs. 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 Bihar who have developed modules and conducted trainings for the management of these Societies. **4.** Provision of Seed money to each RKS at PHCs and PHCs 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

	Activity	2009- 10
Timeline	**Activity**	**2009- 10**
	Provision of Seed money @ Rs 1 lakh per PHC @ Rs 1.00 lakhs	**20**
	Training of the Incharges and second in command @ Rs 800 per person	**0.16**
Budget	**Activity**	**2009- 10**
	Provision of Seed money @ Rs 1 lakh per PHC @ Rs 1.00 lakhs	**20**
	Training of the Incharges and second in command @ Rs 800 per person x 1 day	0.16
	Total	**20.16**

HMIS	
Status	HMIS is a monitoring tool for the performance that provides information to support planning, decision-making and executive control for managers in the Health & FW department. In this sector Data collection is ongoing for more than 60-90 different conditions. The basis of HMIS is the data collected by the ANM who is over burdened with a substantial amount of her time being spent on surveillance related activities. Each year a CNAA exercise is carried out but the set procedures under the CNAA are generally not followed in development of annual action plans and in their utilization in planning the activities of health workers. The action plans are prepared more as a normative exercise rather than as a management tool for estimation of service needs and monitoring the programme outputs. There is no horizontal integration of surveillance activities of existing disease control programmes. Absence of clear case definitions and poor supervision or crosschecking of the data collected hampers the quality of reporting. Non-Communicable diseases are not included in surveillance even though the burden due to them is high. Absence of formats for reporting diseases also affects quality of the data collect. The data from the ANMs is sent upto the district level with no analysis done at any of the higher levels. There is no system of feedback to the lower levels in the health system. The transmission of data is affected by poor communication facilities available. Data is not collected from private practitioners, private laboratories and private hospitals both in rural and urban setting. Data collected during emergencies and epidemics is of better quality The response system at the District level is activated only in times of outbreaks. There is lack of coordination between departments. Discrepancy between the data of the Health

	department and the ICDS. There is large gap between reported and evaluated coverage. The District administrative system not able to make use of the health data. There is inadequate understanding regarding the classification of diseases. HMIS software consisting of all the data collected right from the Sub-centres with online facilities is not available Computers have been supplied upto the PHCs. The HMIS Software is developed by health department on their Web Portal and monthly reports are sending through the Software.
Objective	Integration of several parallel running programme software HMIS is used for decision making on regular basis Inclusion of RCH indicators monitoring Linkage to decision making at Central level Refresher training Make it more useful for State level officials
Strategy	1. Proper implmentation of RCH HMIS performa up to the SC level 2. Improvement in the CNAA 3. Computerized HMIS

Activity	1. Printing of Reporting & Monitoring Formats of SC,PHC,PHC and District Level 2. Training of all related Health Staff for HMIS. 3. Joint CNAA by the ANM, AWW, ASHA alongwith the PRIs so that there is one data validated by the PRIs 4. Computerization of all the formats and software for the various programmes and finances 5. Computer training for data entry 6. Internet connectivity upto all PHCs for online transfer of data. The ANMs will get the data entered each month after the household and Eligible Couple entries have been made 7. AMC for all computers 8. MIS Officer for management fo all reporting in HMIS at district level.
State Support	Provision of software for data entry
Time line	

Activities	**2009-10**
Internet connectivity	x
AMC for computers	20 comp.
Consumables for computers	x
Training for Data Entry and all other related staff	x
Printing monitoring Charts	2000
Provision of MIS Officer for the district	1

Budget	Activities	2009-10
	Internet connectivity @ Rs 500 /mth x No of facilities x12 mths	**01.2**
	AMC for computers @ Rs 5000 /computer /year x No of computers	01.0
	Consumables for computers @ Rs 2000/mth/facility x 12 mths	04.8
	Training of Staff related to HMIS up to SC Level @ 200 x 150 persons	06.0
	Printing monitoring Charts @ Rs. 5 per monitoring chart	00.5
	Salary to MIS Officer @ 12000 pm x 12 months	28.8
	Total	**42.3**

Monitoring	
Situation Analysis/ Current Status	Monitoring is an important aspect of the programme but it is not happening effectively and regularly. Each officer and the PHC Incharges, MO 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 Subcentre level Committee, PHC level Committee, SKS at PHC, 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. Each official and PHC MO 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

Timeline

Activity / Item	**2009-10**
Review meetings	x
Mobility support for Deputy Civil Surgeon (Family Welfare & Immunization)	x
Mobility support for monitoring MCHN days	x
Quality assessment	All
Trainings of all the committee members	x
Maternal and Child death Audit	300

Budget	Activity / Item	2009-10
	Review meetings @ Rs 1000/mtg x facilities x 12 mths	2.40
	Mobility support for Deputy C.S. (Immunization and Family Welfare) for Monitoring for POL	0.60
	Mobility support for monitoring MCHN days @ Rs. 800 X 5 days X 4 monitors X 12 months	1.92
	Quality assessment of all health institutions each year @ Rs 2000/inst	0.40
	Trainings of all the committee members	1.00
	Maternal, Child death Audit @ Rs 1000/death	3.00
	Total	**9.32**

16 Bio-Medical Waste Management

Bio-Medical Waste Management	
Situati on Analysi	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

s /	waste from all Nursing homes, hospitals, Pathological labs and Blood Banks.
Current Status	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 2012 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

Timeline

Activity	2009-10
Orientation and Reorientation for the personnel for Biomedical Waste Management at District and Block levels	x
Consumables	x
Maintenance of the Plasma Pyrolysis plant	x
Payment for the incinerators	393

Budget

Activity	2009-10
Orientation and reorientation for Biomedical Waste Management at District and Block levels	1.5

	Consumables	1.0
	Maintenance of the Plasma Pyrolysis plant	3.5
	Payment for incinerators@ Rs. 8 per bed 12 mths	0.38
	Total	**6.38**

Objectives:

- **Reduction in neonatal, infant, child and maternal mortality**
- **Prevention and control of communicable and non – communicable diseases**
- **Universal access to integrated and comprehensive primary health care services**

Sr. No.	Activity Indicators	Planned for 2009-10	
		No.	%
1	ANC registration during the first trimester increased to	36418	60%
2	Complete ANC coverage increased to	19000	95%
3	Institutional Deliveries increased to	14000	70%
4	Deliveries by skilled birth attendants increased to	16000	80%
	No. of women benefited under JSY	2000	
5	Low birth weight new born reduced by	DNA	25 %
6	Complete Child Vaccination(in 12-23 months age) increased to	22000	95%
7	Severely malnourished (III & IV) decreased by	0	0 %
8	Increase CPR		70%

9	Female sterilization operations to be performed during the year	5000	
10	Vasectomies to be performed in the year	600	
11	Leprosy – Detection of new cases	0	0%
12	Tuberculosis – Detection of NSP cases	67/L	70%
13	Tuberculosis- No. of defaulters reduced to	<5	<5 %
14	No. of Malaria Deaths reduced to	00	100%

18. BUDGET AT-A-GLANCE (In Lakhs)

S. N	Components	2009-10
A	**RCH-II**	
1	DHS	

2	DPMU	
3	Maternal health	
4	Child Health	
5	Family Welfare	
6	Adolescent Health	
7	Gender & Equity	
8	Capacity Building	
9	HR	
10	IEC	
11	HMIS	
12	Monitoring	
	Total	
B	**NRHM**	
1	ASHA	
2	SC Untied Fund & Maintenance	
3	PHC Untied Fund & Maintenance	
4	PHC Untied Fund & Maintenance	
5	MMU	
6	Upgradation of PHC	
7	Upgradation of PHC	

8	Upgradation of SC	
9	VLC	
10	Community Action Plan	
11	PPP	
12	Health Care Financing	
13	Logistics	
14	Biomedical Waste	
	Total	
C	**Immunization**	
1	Immunization	
D	**NDCP**	
1	RNTCP	
2	Leprosy	
3	Malaria	
4	Vector Borne	
5	Blindness Control	
6	IDSP	
7	IDD	
	Total	
E	**Others**	

1	InterSectoral	
	Grand total	

DISTRICT HEALTH SOCIETY,EAST CHAMPARAN

BUDGET FOR 2010-2011

Sl.	Name of Activities	Opening balance as on01.04.08	Fund Received during the year	Total fund available on 31.12.08	Total Expenditure during the year 31.12.08	Closing Balance as on 31.12.08	Demand for the year 09-10
1	Janani evam bal suraksha yojna	20031736	20000000	40031736	25819000	14212736	24000000
2	Family Planning	11776330	0	11776330	3817550	798780	0
3	Female Sterlization camp	252000	0	252000	0	252000	0
4	Blood storage centre	244600	400000	644600	0	644600	480000
5	In land letter	18750	0	18750	0	18750	
6	A.N.M. ('R') Honorarium	6142500	912600	7055100	659000	6396100	1095120
7	Training of A Grade Nurse	450000	0	450000	0	45000	0
8	Contractual A.N.M. Honorarium	52650	0	52650	0	52650	0
9	S.B.A. Training	231520	0	231520	208508	23012	0
10	I.M.N.C.I. Training	924624	0	924624	0	924624	0
11	Health worker Training for R.I.	188050	0	188050	188050	0	0
12	A.N.M. Instrument	238249	0	238249	0	238249	0
13	Drug Kit-A & Kit -B			9945000			
14	RCH/PHC/FRU Kit						
15	Fund for Different Kit's	9945000	0		3154359	6790641	0
16	ASHA Drug Kit	786680	0	786680	0	786680	0
17	ASHA Bag	117750	0	117750	0	117750	0
18	Health Mela	6000	0	6000	0	6000	0
19	IEC (Laminated Board)	160	0	160	0	160	0
20	IEC (Health realated Publicity)	713177	100000	813177	95276	717901	120000
21	District Flexi Pool fund	1798712	0	1798712	290674	1508038	0
22	Grant to Rogi Kalyan Samiti	300000	100000	400000	300000	100000	120000
23	District Action Plan	50000	0	50000	0	50000	0
24	Untied fund for sub centre	1650000	0	1650000	0	1650000	0
25	ASHA Identity Card	14634	0	14634	0	14634	0
26	ASHA Divas	743520	664020	1407540	385200	1022340	796824
27	ASHA Training	2513744	0	2513744	0	2513744	0
28	Construction of 2 M.O. Qtr at Areraj.	954450	0	954450	763560	190890	0
29	Rennovation of HSC Bulding	1317844	0	1317844	366600	951244	0
30	Rennovation of ICU	0	0	0	0	0	0
31	Vehicle for D.M.O.	30000	0	30000	30000	0	0
32	D.P.M.U. Salary	61259	636000	697259	0	697259	763200
33	State Management Fund	5360137	0	5360137	289992	5070145	0
34	ORS Purchase	343233	0	343233	0	343233	0
35	Routine Immunization Programme	4071823	2302199	6374022	899373	5474649	2762639
36	Pulse Polio Programme	222207	11737103	11959310	11675303	284007	14084523
37	Muskan Ek Abhiyan	10474500	0	10474500	3715760	6758740	0
38	Data Center at District Level	1369941	0	1369941	48000	1321941	0
	Total	**83395780**	**36851922**	**120247702**	**52706205**	**67541497**	**44222306**

PROGRAMME WISE FUND UTILIZATION AGAINST ALLOTMENT AND REQUIREMENT

OF ALLOTMENT FOR 2010-11

Sl. No.	Name of Activities	Budget Alloted during 2009-10	Expenditure during this year up to Nov. 09	Fund Required for F.Y 2010-11
1	NRHM- A (RCH-II)	95884733	68507230	119855916
2	NRHM- B (RCH-II)	222586495	12223743	222586495
3	NRHM-C (Puls Polio)	25522151	22025699	25522151
3	NRHM-C (R.I)			
	Total	**343993379**	**102756672**	**367964562**