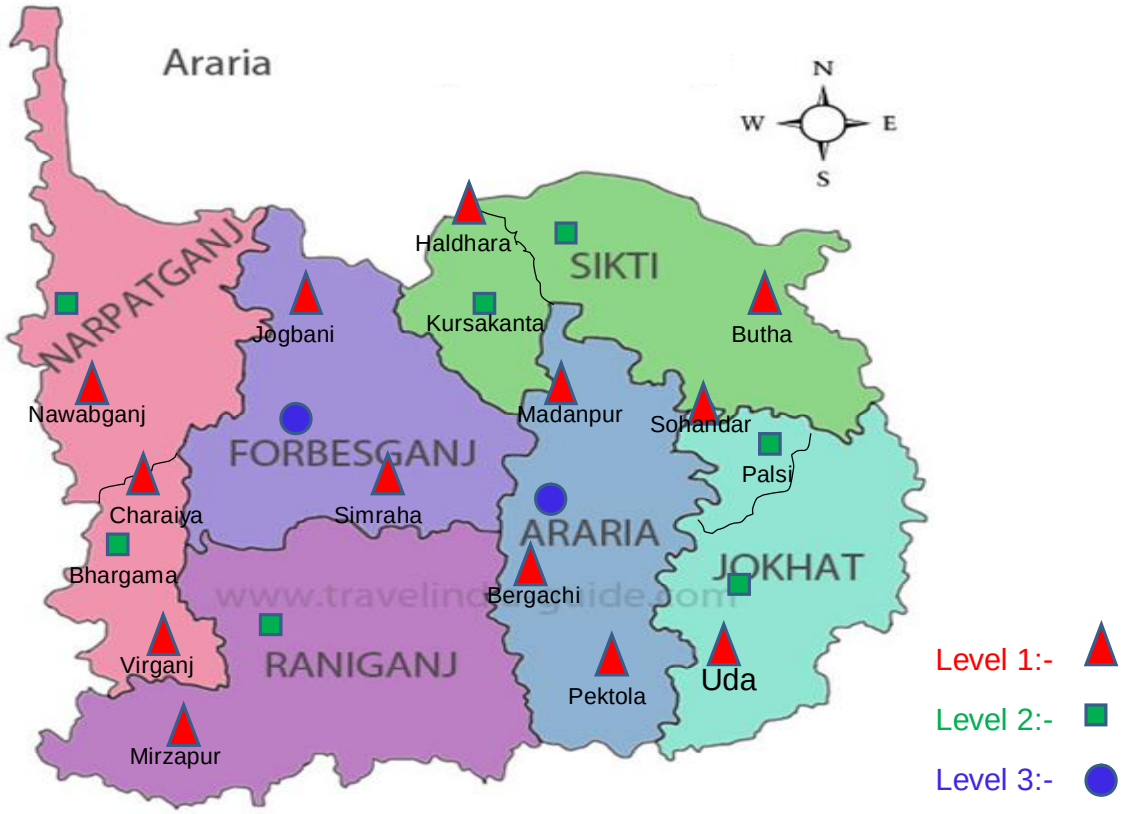
DISTRICT HEALTH SOCIETY, ARARIA

DISTRICT HEALTH ACTION PLAN, 2011-12

DISTRICT HEALTH ACTION PLAN 2011-12

MAP OF THE DISTRICT



Name of the district

CONTENTS

Forward

District Health Action Plan have assumed a new centrality and urgency in the Current Context of the National Rural Health Mission. The rationale for having District Health Action Plans comes from the concept of addressing local needs and local specificities of health and Nutrition in a district. Districts vary widely in their specific population needs and even more in innovations for intervention.

This District Health Action Plan (DHAP) is one of the key instruments to achieve NRHM goals. This plan is based on health needs of the district.

After a thorough situation analysis of district health scenario this document has been prepared. In the plan, it is addressing health care needs of rural poor especially women and children, the teams have analyzed the coverage of poor women and children with preventive and promotive interventions, barriers in access to health care and spread of human resources catering health needs in the district. The focus has also been given on current availability of health care infrastructure in public/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.

The goals of the Mission are 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.

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

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

M. Sarvanan, IAS

(DM, Araria)

About the Profile

Health is now being given due attention by the State with the upgradation of Health infrastracture, manpower, outsource facilities, availibility of free medicines and througha mechanism of web-based monitoring, better health out comes realised in the District. By focusing on the outcomes and the associated key processes for the achievement of these outcomes. Under the National Rural Health Mission this District Health Action Plan of Araria district has been prepared. From this, situational analysis the study proceeds to make recommendations towards a policy on workforce management, with emphasis on organizational, motivational and capability building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps identified and addressed. It looks at how the facilities at different levels can be structured and reorganized.

The information related to data and others used in this action plan is authentic and correct according to my knowledge as this has been provided by the concerned medical officers of every block. I am grateful to the state level consultants (NHSRC/PHRN),District Health Society Consultants, ACMO, MOICs, Block Health Managers , Block Community Mobilizer, ANMs and AWWs from their excellent effort we may be able to make this District Health Action Plan of Araria District.

I hope that this District Health Action Plan(2011-12) will fulfill the intended purpose.

Dr. D.D. Prasad

(Civil Surgeon)

Araria

Introduction

Background

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

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

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

Core strategies of mission include decentralized public health management. This is supposed to be realized by implementation of District Health Action Plans (DHAPs) formulated through a participatory and bottom up planning process. DHAP enable village, block, district and state level to identify the gaps and constraints to improve services in regard to access, demand and quality of health care. In view with attainment of the objectives of NRHM, DHAP has been envisioned to be the principal instrument for

planning, implementation and monitoring, formulated through a participatory and bottom up planning process. NRHM-DHAP is anticipated as the cornerstone of all strategies and activities in the district.

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

Stakeholders in Process

- *Members of State and District Health Missions*
- *District and Block level programme managers, Medical Officers.*
- *State Programme Management Unit, District Programme Management Unit and Block*
  Program Management Unit Staff

- *Members of NGOs and civil society groups*
- *Support Organisation – PHRN and NHSRC*

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

Objectives of the Process

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

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

District Planning Process

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

Main Phase – Horizontal Integration of Vertical Programmes

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

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

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

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

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

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

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

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

Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon,District Health Society Consultants, ACMO (Nodal officer for DHAP formulation), all programme officers and NHSRC/PHRN as well as the MOICs, Block Health Managers, ANMs, as a result of a participatory processes as detailed below. After completion the DHAP, a meeting is organized by Civil Surgeon with all MOIC of the block and all programme officer. Then discussed and displayed prepared DHAP. If any comment has came from participants it has added then finalized. The field staffs of the department too have played a significant role. District Programme Manager, District Accounts Manager, District epidemiologist , District Planning Coordinator, District Data Assistant, & Data Entry Operator, have provided technical assistance in estimation and drafting of various components of this plan.
After a thorough situational analysis of district health scenario this document has been prepared. In the plan, it is addressing health care needs of rural poor especially women and

children, the teams have analyzed the coverage of poor women and children with preventive and promotive interventions, barriers in access to health care and spread of human resources catering health needs in the district. The focus has also been given on current availability of health care infrastructure in pubic/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.

District Health Action Plan Planning Process

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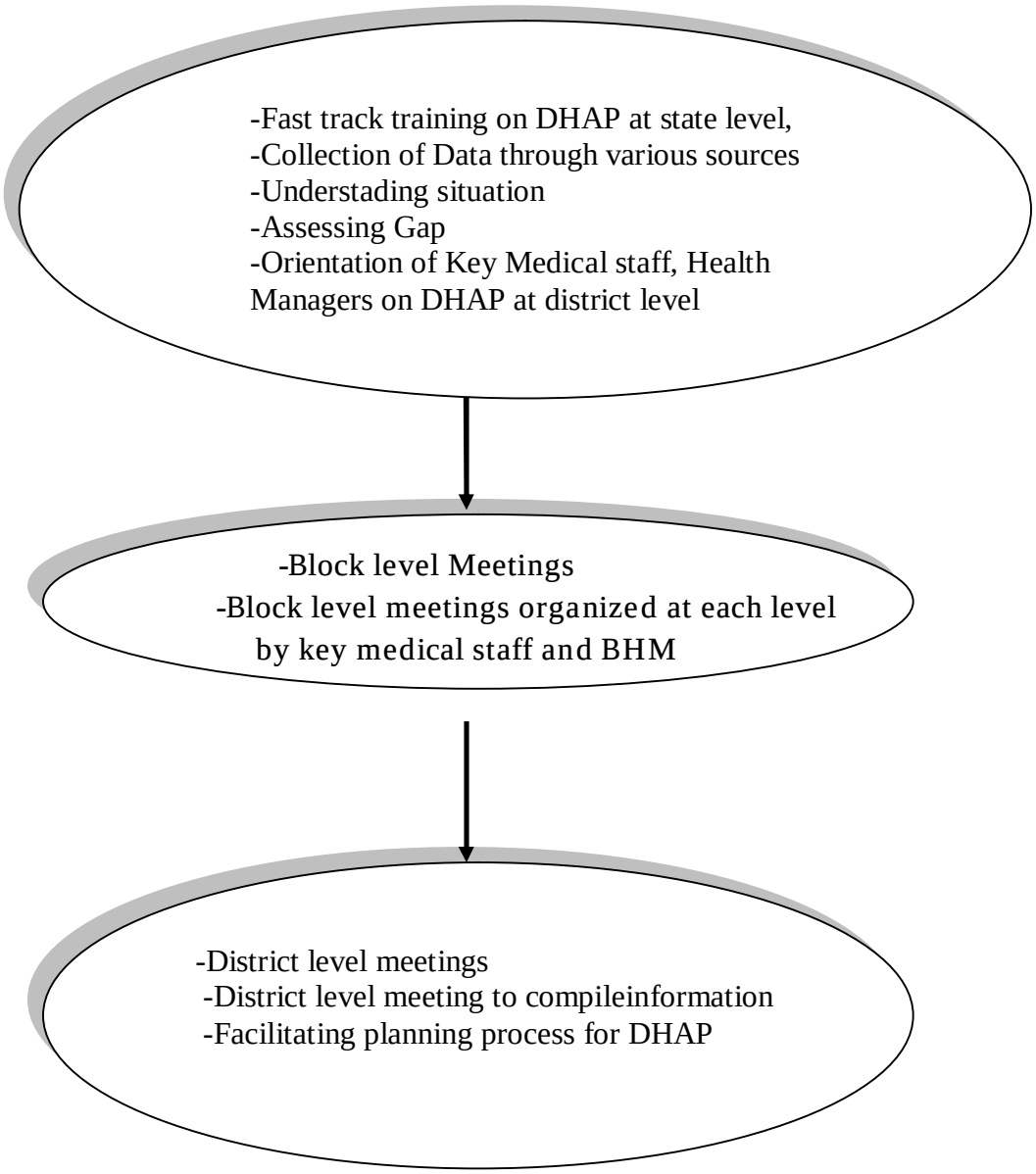


Historical Perspective

Araria District came into existence on the Makar-Sankranti day of 1990 after the bifurcation of the erstwhile Purnea district into three districts, Purnea itself, Araria and Kishanganj.

Araria has a very prestigious past though shrounded in midst of uncertainties. Some passages in the Mahabharata (Sabha Parva and Vana Parva) describing the conquest of Bhima in the eastern India furnish valuable information regarding the antiquity of the district.

In ancient times ruled by three important clans of Indian history Araria may be termed as a place of confluence of three entirely different cultures. The important tribe of Kiratas governed the northern side , while the eastern side was under the Pundras and area west of the river Kosi, at that time flowing somewhere near the present Araria, by Angas.

Angas are believed to be the earliest inhabitants of the district, mostly in the area west of the river Kosi and these are among the easternmost tribes as described in the Atharva-Samhita known to the Aryans. Pundras are said to be the descendents of Saint Vishwamitra. Whereas the Kiratas were among the few most important ruling clans of that time. It is said that Raja Virata of Mahabharata had married a Kiranti woman who was the sister of Raja Kichaka , King of Kiratas.

Manu regards the Kiratas as Kshatriyas. Mahadeva was associated with Kiratas and Bhima meets the Kiratas in the east of Mithila, i.e. the present Araria district. He is credited with having defeated seven of the Kirata rulers. Kiratas are described in the Kirata-Parva and Vana-Parva of Mahabharata and they were considered so powerful that even the Lord Shiva is said to have taken the form of a Kirata.

During the Mauryan period this area formed the part of the Mauryan Empire and according to Asokavadana the Emperor Asoka put to death many naked heretics of this area who had done despite to the Budhist religion. In later times the district formed the part of the empire of Imperial Guptas.

In the sixth century A.D. the area south of the Himalayan pilgrim center of Varaha Kshetra, namely the Gupta kings Budhgupta and Devagupta gave Koti-varsha for the

maintenance of the said pilgrim centre. Present district of Araria seems to be part of the Koti-varsa.

A brief account of this area and its people has been left by Huen-tsang, the famous Chinese traveler , who visited about 640 A.D. As he saw it had a flourishing population and was studded with tanks , hospices and flowering groves. The land was low and humid with abundant crops and genial climate.

According to the Ancient History of India by S. Beal the area west of the river Mahananda, i.e., the present Araria district was held by the Vrijis, a confederacy of tribes, who had come in from Nepal many centuries before.

At the beginning of 7^{th} century the tract now included in the district seems to have been under Sasanka , the powerful king of Gauda. He was worshipper of Lord Shiva and hated Buddhism. He destroyed the Budhist convents and scattered the monks carrying his persecutions towards the Nepalese hills.

Harsha, the great Budhist ruler of 7^{th} century defeated Sasanka. But after the death of Harsha it seems likely that Araria became a part of Magadhan Empire under Aditya sena. From the 9^{th} to 12^{th} century it was under the Pala kings and on their decline became subject to the Senas of Bengal.

At the end of 12^{th} century the Muslims under Bakhtiyar Khilji burst down upon Bengal shaking Bihar. Bakhtiar removed the seat of government to Lakhnauti (Gaur) and from this centre Ghiasuddin Iwaz (1211-26) extended the area of Muslim control over the whole country called Gaur as well as Bihar and his rule was acknowledged by the surrounding tracts including Tirhut.

But it seems due to an impenetrable network of rivers interspersed with large patches of jungle, the area of Muslim control could not extend to the northern portion of the erstwhile Purnea district, i.e., the present Araria district. Hence the present Araria district seems still to have been held by the hill tribes of Nepal.

It was not less than the 18^{th} century that it could be gained from the northern tribes. In the year 1738, the military governor of Purnea Nawab Saif Khan, son of an Afgan Amir, recovered the area north of the Jalalgarh fort up to Jogbani (i.e., the present Araria district) from the Rajput kings of Morung. Saif Khan appointed one Raja Nandlal as the administrator of the newly annexed area, who is credited to have built the temple of Lord Shiva at Madanpur.

Saif Khan after forcing the hill tribes back to the terai, cleared the jungles and brought the area under cultivation. He also defeated the Birnagar chief and subjugated his territory. Birnagar included the area west of river Kosi, presently the entire area under Raniganj and Bhargama blocks and some portion of Narpatganj.

In the year 1765 though the area came under the Dewani of East India Company, it was continued to be ruled by the Nawabs of Purnea till 1770. In the same year a British Supervisor, later to be known as District Magistrate and Collector Mr. G.G.Ducarrel was posted and since then it has the same history as Purnea. But some special events related to the history of this area are worth mentioning.

When in 1738 Saif Khan annexed this area, i.e., the present Araria district, he gave it to the family of Purnea Raja, an old ruling family of this district. This family had its headquarters

at Pahsara near Raniganj. They belonged to the Surgan Lauam family of Shrotriya Brahmins of Mithila. Maharaja Samar Singh was the founder of the family during the regime of Shah Jahan, the Mogul king of India. After Samar Singh his son Krishnadev became the ruler, followed by Vishwanath, Veernarayan, Narnarayan, Ramchandranarayan, and Indranarayan all having the title of Maharaja. Indra died in 1784. After his death his wife Maharani Indrawati became the ruler. She ruled till her death in 1803. The contemporary British writers have described her as one of the most able rulers. The area under her administration included the purganas of Sultanpur, Sripur, Nathpur, Gorari, Katihar, Gondwara, Tira Khardah, Asja and others.

Indrawati had built a beautiful palace at Pahsara, which now stands in ruins and a number of temples. One of these temples devoted to Lord Shiva is still present in the Basaiti village of Raniganj block.

In the year 1751 Maharaja Ramchandra of the same family gave the purganas of Tira Khardah (present Kursakata and Sikti blocks) and Asja (present Amour block of Purnea) to one Devanand, who distributed the two purganas between his two sons Parmanand alias Hajari getting Tira Khardah and Maniknanadan getting Asja. The present ex zemindars of Champanagar, Garhbanaili, Sultanganj and Srinagar (all part of the old Banaili Raj) are the descendents of Parmanand .

Maharani Indrawati died without child. After the death the succession of the family became disputed. Indrawati had adopted Bhaiyajee Jha, son of her maternal uncle, as her successor. But the descendents of Maharaja Samar's second son Raja Bhagirath of Sauriya branch put their claim over the large estate of Maharani and a quarrel issued.

In the year 1815 Raja Bhaiyajee Jha died having one son named Vijaygovinda, who became the Raja. Vijaygovinda had two sons Kumar Vijay Gopal Singh and Kumar Bhav Gopal Singh . But both died without a son. The quarrel of the succession ruined the large estate of Indrawati and in 1820 the estate was purchased by Babu Pratap Singh, banker of Murshidabad and Babu Nakchhed Lal grandfather of Raja P.C.Lal of Purnea City. Pratap Singh purchased entire Sultanpur and Sripur parganas. His descendents sold the pargana of Sultanpur to Alexander John Forbes.

A. J. Forbes was a military adventurer and had taken part in the adventures of Northwest India . He was also in the team of Commissioner Yule of Bhagalpur while fighting the rebels of 73rd native infantory.A. J. Forbes founded the Sultanpur estate and a number of indigo factories situated at different places in this district. The sub divisional town of Forbesganj is named after him. Due to its proximity with the international boundary of Nepal the problems from across the borders always have been a special concern for the administrators of this district. In the time of British rule the Nepalese sardars used to the subjects of this area.125

In 1770, Ducarrel the Supervisor or Collector at Purnea reported that Budhkaran who had been the Dewan of the deceased Raja Kamdat Singh of Morung was plundering the Company's frontiers and putting the subjects to flight. Ducarrel's suggestion was to extend the influence by rendering military assistance to Regonault who was opposing Budhkaran.

Depredations of the religious mendicants (Fakirs) was also one of the troubles from the north and above all it were the Dacoits who after committing crimes in this area took refuge in Morung. All these compelled the district administration to have a serious thought in regard of the problems from the north. Again in the year 1788 the collector of Purnea wrote to the board of revenue that the conquest of Morung by the Gorkhas in defiance of Mr. Hasting's order, the assassination of the young Raja and their repeated ravages on our frontier, that nothing but a decisive step will be sufficient to restrain them within their bounds. According to O'Malley the aggression of the Nepalese continued during the next century. In 1808 the Gorkha Governor of Morung seized the whole zamindari of Bheemnagar. This flagrant encroachment could not be over looked and in June 1809 a detachment of troops was sent from Purnea to the frontiers. Climax to all these happening was the Indo Nepalese war of 1811 – 12 and after this war the present boundary between Araria (India) and Nepal was determined.

In the first war of independence of 1857 Araria also witnessed a few skirmishes between the mutineers and the commissioner Yule's forces, which took place near Nathpur. In view of the 1857 episode and other developments regarding the law & order, in the year 1864 Araria was constituted as Sub-Division by merging the small divisions of Araria, Matiari, Dimia, parts of Haveli and Bahadurganj to provide better administration and ultimately it became a district in 1990.

Geographical Location

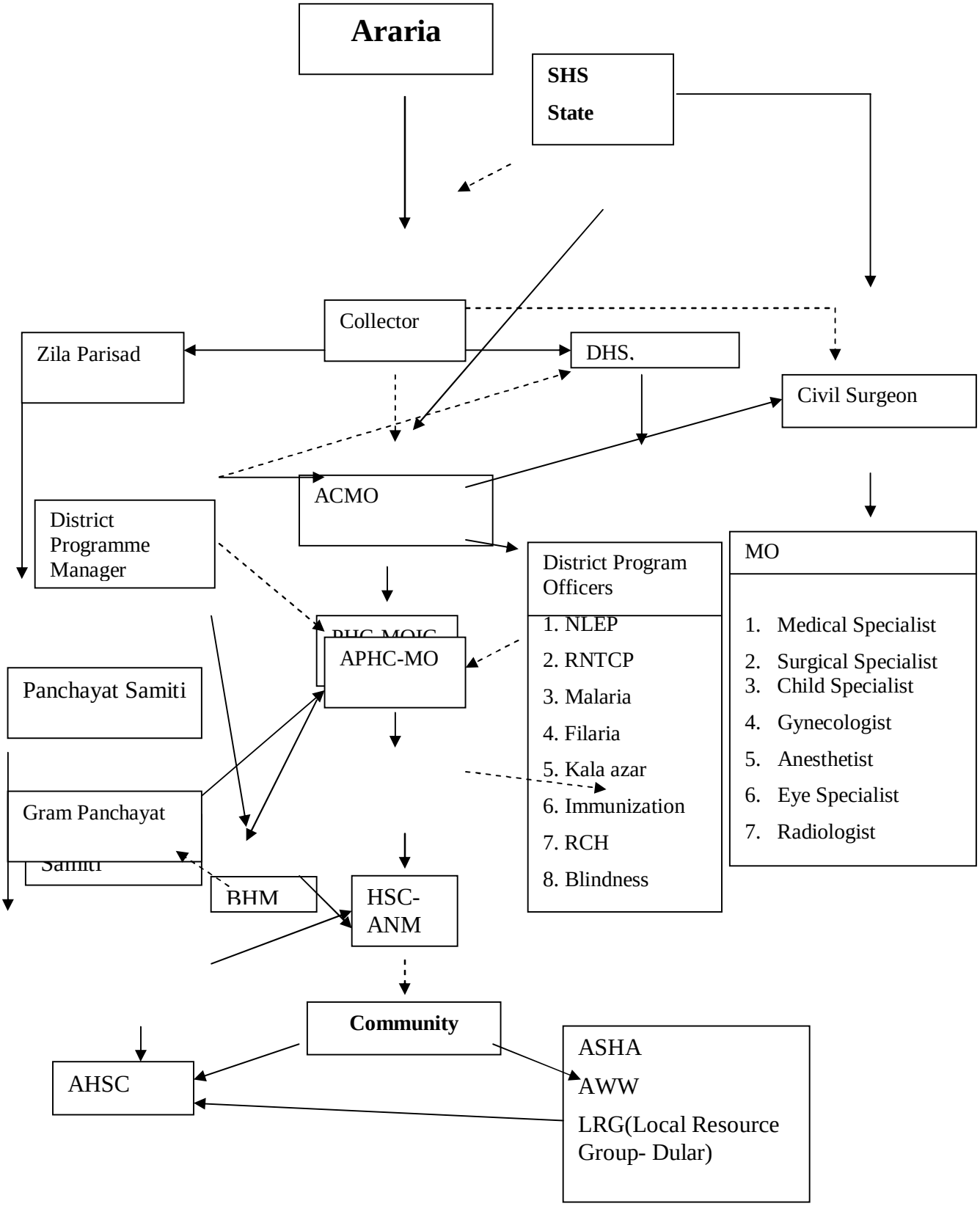
Araria District is located at 26°9' to 26°15' North latitude and 87°31' to 87°52' east longitude with attitude 47cm from sea level. The District is surrounded by Purnea District in south, Supaul & Madhepura District in west, Kishanganj is in east and International boarder with Nepal in North. The District is in semi tropical Gangetic plane. The District is spread over 2830 sq km area.

DISTRICT PROFILE

ADMINISTRATIVE SET – UP:

PARTICULARS	NUMBER
Number of Sub-Division	2
Number of Blocks	9
Number of Municipality	2, Nagar Panchayat-1
Number of Gram Panchayat	218
Number of Police Station	18
Number of Inhibited Villages	706
Number of Uninhibited Villages	36
Number of Villages	742

District Health Administrative Setup



DISTRICT DEMOGRAPHY AND DISTRICT DEVELOPMENT INDICATORS:

Population	Male	Female	Total
Rural Population (in %)	48.57%	44.89%	93.86%
Literacy Rate	19.05%	08.27%	27.32%
SC Population (in %)	7.04%	6.55%	13.59%
ST Population (in %)	0.69%	0.66%	1.36%
BPL Population	412063(Family)		
Sex Ratio	Females per 1000 males 913.48	(0 – 6 years) 962.96	
Population Growth (1991 – 2001)	2158608 -1509360=649248		
Population Density (person per sq km)			
Number of Household	Total 415563	Rural 393598	Urban 21965
Household Size			
Type of house (%)	Pucca	Kuchha	
Per Capita Income			
Total workers (number)	853445		
Main workers (number)	657446		
Marginal workers (number)	195999		
Non – workers (number)	1305163		
Total workers to total population (%)	39.53%		
Cultivators to total workers (%)	21.03%		
Agriculture laborers to total workers (%)	16.74%		
Workers in HH industries to total workers (%)	0.57%		
Main workers to total population (%)	3.05%		
Marginal workers to total population (%)	9.08%		
Non workers to total population (%)	60.46%		
Number of villages having drinking water facilities	100%		
Number of villages having safe drinking water facilities	100%		
Number of electrified villages	165 (Excluding Raniganj & Bhargama Block)		
Number of villages having primary school	1088		
Number of villages having middle schools	526		
Number of villages having secondary/sr.	44		

secondary schools	
Pupil Teacher Ratio (Primary School)	60:1
Pupil Teacher Ratio (Middle School)	58:1
Out of School children	22188
Number of villages having any health care facilities	232
Number of Health Sub Centre	199
Number of Additional Primary Health Centre	32
Number of Primary Health Centre	9
Number of Sub-divisional hospital	2
Number of hospitals/dispensaries per lakh population 2007 – 08	1.12
Number of beds in hospitals/dispensaries per lakh population 2007 – 08	1.2
Percentage of children having complete immunization 2007-08	
Percentage of women having safe delivery 2007 – 08	
Number of villages having post office facility	169
Number of villages having Paved approach road	
Number of villages having mud approach road	
Average size of operational holding	
Normal Rain Fall	1648.5mm
Actual rain Fall	1195.5mm
Percentage of cultivable land to total geographical area 2006-07	70%
Percentage of area under commercial crops to gross cropped area 2006-07	13.23%
Percentage of net area sown to geographical area 2006-07	59.69%
Cropping intensity	Rice,wheat,jute,maize,maser,khesari
Percentage of gross irrigated area to gross area sown 2006-07	32.13%
Percentage of net irrigated area to net area sown 2006 – 07	39.89%
Consumption of fertilizer in kg/hectare of gross area sown 2006-07	
Average yield of food grains 2006-07 (kg/ha)	
Percentage of area under bhadai crops	23.62%
Percentage of area under agahani crops	36.17%

Percentage of area under garma crops	
Percentage of area under rabi crops	27.19%
Length of highways and major district roads (mdrs) per lakh population (km) 31st march 2005	381.49km.
Length of highways and major district roads (mdrs) per thousand sq km in area (km) 31st march 2005	134.80km.
Length of rural roads per lakh population (km) 2004-05	
Length of rural roads per thousand sq km in area (km) 2004 – 05	
Number of branches of scheduled commercial banks 2008 – 09	57
Credit deposit ratio 2008(2009-10)	43.70
Density of livestock per sq km 2003	235
Density of poultry per sq km 2003	238.9
Average livestock population served per veterinary hospital/dispensary 2003	37002
District wise fish production 2007 – 08	2.81
Share of districts in total milk production 2007 – 08	50790960 Litrre.

RAINFALL AND FLOOD SITUATION

The district receives medium to heavy rainfall (average rainfall 1161 mm), and faces condition of severe flood. In the year 2008 flood condition was so bad that almost 71 gram panchayats and 124 villages got marooned. Narpatganj and Bhargama blocks were the worst affected blocks. According to the estimates of National Disaster Management Department, in the year 2008, 626062 people were directly affected by the floods. Crops were damaged and there was irreparable damage to property and huge loss of lives. The economic loss due to floods this year amount to Rs. 65 Crore of crope loss, Rs . 25 Crore of housing loss and Rs. 27 Crore of property loss. The district has poor drainage system and nearly 4% of the area is water logged.

The district is spread over 2830 sq. Km. area with no forest cover. 65.43% of the land is agricultural and nearly 67% of the area under cultivation is irrigated. Araria district is also affected by droughts. Cycles of flood and droughts severally affected the flood production and flood distribution system and lead to distressful situation for most people.

LAND AND SOIL:

The district has, by and large, alluvial and sandy soil with a varying nature of acetic or basis. Thought it is deficient in mineral such as Sodium, Potassium and Magnessium, it can be supplemented with suitable fertilizers. The soil is suitable for paddy, wheat, pulses, vegetable and jute

SOCIAL STRUCTURE:

Socio –Economic profile

Social

●Araria district has a strong hold of tradition with a high value placed on joint family Kinship. Religion, caste and community.

●The village of Araria have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.

●13.7% of the population belongs to SC and 1.3% to ST. There are at least 13% village where the SC population is more than 40%. Some of the most backward communities are Mushahar, Turha, Mallah and Dome.

Economy

Araria mainly depends on agriculture, with paddy, maize and jute as the major agriculture products. There are also many jute mills in Araria. This area contain many ponds, canal and rivers, fisheries is one good source. Somewhere Makhana production can be seen easily. However Araria has big name for the Plywood Industries. In recent year such industries are losing their production volume due to many factors related with timber. Almost 20% of the youth

population migrates in search of jobs to the metropolitan cities like Delhi, Punjab, Haryana etc.

FACT SHEET OF BLOCKS AND URBAN LOCAL BODIES:

Name of Sub Divisions	Name of the Blocks	Total Population	No. of GP	No. of Revenue	% of Total Literates	% of Male Literates	% of Female Literates	% of SC Population	% of ST Population	Sex Ratio
	Araria	355675	30	85	28.17%	66.5%	33.5%	8.95%	0.6%	1.1:1
	Jokihat	246043	27	99	23.35%	69.7%	30.3%	3.54%	0.16%	1.07:1
	Palasi	190241	21	107	23.54%	74.77%	25.2%	8.8%	0.6%	1.08:1
	Sikti	124203	14	57	26.16%	72%	28%	16.25%	0.23%	1.07:1
	Kursakanta	115667	13	69	29.6%	73.6%	26.4%	13.12%	0.34%	1.1:1
	Raniganj	302261	32	89	27.06%	69%	31%	21.3%	4.53%	1.08:1
	Forbisganj	373933	32	113	30.6%	67.5%	32.5%	15.62%	1.36%	1.1:1
	Narpatganj	270128	29	65	27.31%	72.2%	27.8%	16.2%	1.4%	1.1:1
	Bhargama	180457	20	67	28%	70%	30%	19%	1.43%	1.1:1

HEALTH PROFILE

General Status of health in Araria district

In a study of 513 districts of the country (Jansankhya Sthirata Kosh", www.jsk.gov.in) in terms of overall rank in health it was found that Araria district ranks 549 though on the basis of under-five mortality it ranked 507 Filaria, Malaria, Dengue, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in Araria district. Hepatitis, Diarrhea, Typhoid, Blindness and Leprosy are other high prevalence diseases. Kala-azar is an endemic problem in Bihar. As per DLHS 2002-2004 the prevalence percentage of kala-azar is 11.4 % and TB is 4.3 %. The overall prevalence of tuberculosis in India is ..... per 100,000 populations while in Araria it is reported to be close to 618 per 100,000 (RCH, Round 2).

Infant Mortality Rate (IMR) and Child Mortality Rate (CMR)										
Indicators	Rural			Urban			Total			
	M	F	T	M	F	T	M	F	T	
Infant Mortality Rate	-	-	-	-	-	-	-		71	Araria
	56	60	58	41	42	42	55	58	57	Bihar
										India
Child Mortality Rate	-	-	-	-	-	-	-	-	-	Araria
	59	69	64	42	46	44	57	66	62	Bihar India

Source: Population Foundation of India May 2008

The table gives the estimates of infant mortality rates and child mortality rates of Araria and compared with the data of Bihar. IMR in rural areas are higher than the urban areas. Also CMR in rural areas is higher than in urban areas . The differential ratio of infant mortality rate of male/female is 0.7 and rural/urban is 1.4. The differential ratio of child mortality rate of male/female is 0.8 and rural/urban is 1.5.

HEALTH STATUS AND BURDEN OF DISEASE

CASE FATALITY RATE

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

MORBIDITY DUE TO MAJOR DISEASE

Sl.No.	Disease	2007	2008
1	Kala-azar	3275	2632
2	T.B. (NSP)	724	643
3	Leprosy (PR/10000)	1.15	1.30

BASIC HEALTH STATUS INDICATORS OF ARARIA DISTRICT

Indicators	Araria	Bihar
Couple Protection Rate (CPR)	33%	
Crude Death Rate (CDR)	8.1	8.1
Crude Birth Rate	31.9	30.4
Infant Mortality Rate	61	61
Maternal Mortality Rate	371	371
Total Fertility Rate (TFR)	4.6	4
Under 5 Mortality Rate	85	85
Still Birth Rate	NA	NA
Abortion rate	NA	NA

DENOTING PRIORITY AREAS IN EACH OF THE BLOCK	
Block	Hard to Reach area
Narpatganj	Whole Narpatganj block (72 villages)
Bhargama	Village Bahlolpur
Sikti	Two villages

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

PUBLIC HEALTH CARE DELIVERY SYSTEM: ORGANISATIONAL STRUCTURE AND INFRASTRUCTURETable HEALTH CARE INSTITUTIONS IN THE DISTRICT

S.No.	Type of Institutions	Number	No. of Beds*
1	District Hospital	1	100
2	Sub.Divisional Hospital	1	32
3	Referal	3	90
4	Block PHCs	06	36
5	APHCs	32	0
6	Sub-centres	199	0
7	Ayurvedic Dispensaries	02	0
8	Anganwadi Centres	2125	-
9	Others (Pvt. Facility accredited)	NIL	NIL

DISTRIBUTION OF PUBLIC HEALTH FACILITIES IN DISTRICT				
District Hospital	Sub-Div. Hospital	Community Health Centres	Block PHC	Referral Hospital
1	01	0	06	03

SWOT analysis of Part A,B,C,D

SWOT Analysis of Part A

Strength

- Decentralized Planning and availability of Resources and Fund for program till HSC level.
- Huge pool of Human Resource working at ground level as ANM, Asha and Anganwadi workers.
- Provision of incentive money for Asha, ANM according to their performance in mobilizing community for institutional delivery ,FP etc.
- Provision of Incentive money for beneficiary under JBSY, Family Planning.
- Extension of emergency facilities in remote rural areas and posting of skilled doctors.
- Regular training program of doctors and other medical staffs for skill up gradation.
- Strong provision of IEC and BCC activity under the programs for effective program implementation and sensitizing people.
- Decentralized implementation process of the entire program.
- Involvement of people in uplifting health facilities through RKS and VHSC.

Weakness

- All PHCs are with only six bedded facility.50-60% of facilities are not adequate as per IPHS norms for providing emergency care.
- Lack of doctors and other human resource in the remote areas medical facilities
- Achievements in most of the program are far less than target.
- Slow pace of most of training like SBA and IMNCI.
- Monthly VHND is not operational as yet.
- Institutional delivery is still less than 50% in the district.
- No NRC has been made operational in the district.
- Seat for contractual medical officer and specialist, ANM and ASHA are still vacant.
- Achievements in Family Planning and IUD insertation are far less than targets.
- Insensitivity of Doctors and other health staffs for patients.
- Unavailability of doctors and staffs in hospital at the time of duty.

No timely procurement of equipments and drug in the remote health facilities.

Opportunity

- All the time support from state health society for all financial and logistics requirements for program implementation
- Scope for involving Private partner like Surya clinic for timely achievement of targets.

- Scope of getting full support from people through their participation in RKS and VHSC.
- Favourable political and administrative environment for program implementation
- Increasing literacy and awareness among public to support Family planning and institutional deliveries.

Better coordination and support from other line departments like ICDS, Municipality etc

Threat

- Large scale poverty becomes the cause of nutritional deficiency leading to health problems.
- In case of remaining without practice for long time health staff training become useless.
- Extending services in remote rural areas is still a challenge in achieving targets of MCH and FP, RI.

Traditional and religious attitude of public is hindrance for increasing Institutional deliveries, Family planning etc.

SWOT Analysis of Part B

Strength

- ASHA support system with DCM and BCM has been made functional in the district.
- Motivational program for ASHA like Umbrella distribution is completed in time.
- Formation of VHSC has been completed in most villages of the district.
- Deployment of BHM and Hospital Managers is complete at all the vacant places in the district.
- Services of advanced life saving ambulance (108) is started in the district
- Contractual AYUS doctors have been placed in APHC.

Decentralized planning at HSC level has been started from this year in the district

Weakness

- ASHA Selection is not 100% complete
- RKS is not function in any APHC.
- Utilization of untied fund in most of the health centers is very less.
- Replenishment of ASHA kit and drugs is not timely and complete.
- Construction of HSC, APHC, PHC buildings and staff quarters moving with very slow pace.
- ISO certification process of health facilities is still to start in the district.
- Pathology and Radiology services under PPP initiatives are not properly functional at most of the health facilities.

Lack of orientation among members of RKS regarding their scope of works for Health facilities.

Opportunity

- Participation of Mukhiya and Sarpanch in ASHA selection process to expedite the process and also proper and complete utilization of Untied fund for health facility development.
- Favorable administrative and political condition for program implementation.
- Availability of fund from both NRHM and State funding for development of health infrastructure.

Threat

- Corruption and ill intention in construction of buildings and selection process of employees.
- Lack of people interest and support for proper maintenance of health infrastructure and quality of services.
- Less knowledge and sensitivity for work among Asha and other contractual employees.
- Not immediately filling vacant positions Specialist Doctors of.

SWOT Analysis of Part C- Routine Immunization

Strength

- Properly and timely formation of block micro plan of RI.
- Availability and involvement of large human work force in form of ANM and ASHA.
- Functioning of one separate dept. in health sector to look after RI.
- Timely availability of vaccines.

Abundance of fund for all kind of review meeting and supervision of the program.

Weakness

- Low achievement against the fixed targets.
- Poor cold chain maintenance.
- Handling of cold chain-deep freezers by untrained persons.
- Poor public mobilization by ANM and ASHA.
- Poor or false reporting data from block and sub centers.
- Quarterly review meeting at district and blocks are not happening regularly.

Unavailability or non use of RI logistics like red/black bag, twin bucket etc

Opportunity

- Support from UNICEF and other development agencies in RI.
- Proper coordination and support from Anganwadi –ICDS dept.
- Growing awareness among people regarding immunization.

Threat

- Sudden outbreak of epidemic.
- Corruption in program implementation.

Integrated Disease Surveillance Project

Surveillance is essential for the early detection of emerging (new) or re-emerging (resurgent) infectious diseases. In the absence of surveillance, disease may spread unrecognized by those responsible for health care or public health agencies, because many individual health care workers would see sick people in small numbers. By the time the outbreak is recognized, it may be too late for intervention measures. Continuous monitoring is essential for detecting the 'early signals' of outbreak of any epidemic of a new or resurgent disease. For disease surveillance to prevent emerging epidemics, the time taken for effective action should be short.

Integrated Disease Surveillance Program (IDSP) is intended to be the backbone of public health delivery system in the state. It is expected to provide essential data to monitor progress of on- going disease control programs and help in optimizing the allocation of resources. It will be able to detect early warning signals of impending outbreaks and help initiate an effective and timely response. IDSP will also facilitate the study of disease patterns in the state and identify new emerging diseases. It will play a crucial role in obtaining political and public support for the health programs in the state.

Major Components of the project

1)Integration and Decentralization of Surveillance activities
2)Strengthening of Public Health Laboratories
3)Human Resource Development - Training of SSO, DSO, RRT, other medical and paramedical staff
4)Use of Information Technology for collection, compilation, analysis & dissemination of data

Response Mechanism

The multidisciplinary Rapid Response Team (RRT) constituted/ trained at all State and district headquarters; comprises of:

(1)One Public Health Expert - Epidemiologist/(District Surveillance Officer/ Faculty of Community Medicine), One Clinician, One Microbiologist/ Lab personnel, One Entomologist (for Vector Borne Diseases)

(2)Video Conferencing for interaction on outbreak investigations.

(3)Purposes of data analysis important

(4)Identifying outbreaks / Potential outbreaks (alert the health services system) e.g. a case of measles
should alert health care services system

(5)Identifying High-risk population groups (person/place) so that targeted intervention can be provided

(6)Identifying regional differences for improving services (e.g. measles: low vaccination in a area)

(7)Predicting changes in disease trends over time (prevention/IEC)

(8)Identifying problems in health systems so that gaps can be effectively plugged (e.g. possibility of increased vector density/poor mosquito control/migration of infected people to the region)

Importance

The importance of health in economic and social development for improving the quality of life has long been recognized. In order to energize the various components of health system, Government of India has launched the Integrated Disease Surveillance Project. This was launched in Nov 2004, to provide effective health care to the rural & urban population throughout the country with special focus on states which have weak public health indicators and/or weak infrastructure.

IDSP to support data collection, analysis and other functions at district, state and central surveillance unit under information and communication technology being implemented by the national informatics corporation.

Objectives

Specific objectives are to establish a decentralized based system of surveillance for communicable and non-communicable disease so that well-timed and effective and preventive public health care actions can be initiated in response to changes and improve the health care in the rural & urban settings.

As well as to amalgamate existing surveillance approach to avoid replication and communicate information across each & every disease control program and other stakeholders so that actual information is available for health decision making in the bottom to the top level surveillance unit.

Diseases conditions under the surveillance program

Regular Surveillance:

Vector Borne Disease:	Malaria & Kala-azar
Water Borne Disease:	Acute Diarrhoeal Disease (Cholera) & Typhoid
Respiratory Diseases:	Tuberculosis
Vaccine Preventable Diseases:	Measles
Diseases under eradication:	Polio
Other Conditions:	Road Traffic Accidents

BUDGET FOR DISTRICT ACTION PLAN FOR DISTRICT SURVEILLANCE UNIT, IDSP, ARARIA

Issues & Objectives:

EFFECTIVE IMPLEMENTATION OF DISTRICT SURVEILLANCE UNIT, IDSP AND MAKE A BETTER APPROACH OF PUBLIC HEALTH AS WELL AS DISEASE PREVENTIVE SYSTEMS & CONTROL MEASURES.

Stratagem	Approach & actions	Unit	Unit Cost	Total Cost (in Rs.)
(A)SALARY STRUCTURE OF IDSP PERSONNEL	(1) DISTRICT EPIDEMIOLOGIST	12 MONTH	40,000	4,80,000
	(2) DISTRICT DATA MANAGER	12MONTH	30,000	3,60,000
	(3)ACCOUNTANT	12MONTH	15,000	1,80,000
	(4) DATA ENTRY OPERATOR	12MONTH	12,000	1,44,000
(B) CAPACITY BUILDING FOR HEALTH CARE SERVICES PROVIDERS	WORKSHOP AT DISTRICT LEVEL	QUARTERLY-4	Rs. 30,000	1,20,000

	TA/DA FOR CAPACITY BUILDING OF THE RESOURCE PERSONS & PARTICIPANTS	QUARTERLY-4	Rs. 12,000	48,000
	WORKSHOP AT PHC/ BLOCK LEVEL	9 PHC-36	Rs. 15000	5,40,000
	TA/DA FOR CAPACITY BUILDING OF THE RESOURCE PERSONS & PARTICIPANTS	9 PHC-36	Rs. 15000	5,40,000
(C) MONITORING & SURVEILLANCE	FIELD VISITATION BY THE DSU PERSONNEL	20 DAYS	Rs. 10 PER KM/PER DAY @ 200 KM	4,80,000
	FIELD VISITATION BY THE DOIT	10 DAYS	Rs. 10 PER KM/PER DAY @ 200 KM	2,40,000
	FIELD VISITATION BY THE RAPID REPONCE TEAM	10DAYS	Rs. 10 PER KM/PER DAY @ 200 KM	2,40,000
(D)INFORMATION EDUCATION COMUNICATION (IEC MATERIALS)	WALL PAINTINGS	(9 PHC + 1 DH)* 3 = 30	Rs. 5000 EACH PANTING	1,50,000
	HOARDINGS	(9 PHC + 1 DH)* 3 = 30	Rs. 7000 EACH PANTING	2,10,000
	FLAX BANNERS	(32 APHC + 200 HSC)*1 = 232	Rs.1500 EACH BANNER	3,48,000
	FLEX POSTERS WITH HARDBOARD	(32 APHC + 200 HSC)*1 = 232	Rs.500 EACH POSTER	1,16,000
	PHEMPLET FOR OUTBREAKS & EPIDEMIC SITUATION FOR GENERAL / MASS AWARENESS	(32 APHC + 200 HSC)*1 = 232	Rs.500	1,16,000
	BOOKLETS/LEAFLETS OF ALL EPEDEMIC RELATED ISSUES FOR ALL HEALTH CARE SERVICES PROVIDERS	ALL DOCTOR, LHV, ANM, MPHW, ASHA, OTHERS. 1000 PCs	Rs.100 (BOOKLETS/ LEAFLETS)	10,000
	NUKKAD NATAK THROUGH NGO, MIKING	6 PLAY * 9 BLOCKS-54	Rs. 10000 EACH SHOW	5,40,000
(E)EXPENDITURE ON DEPARTMENT/ OFFICE	STATIONARY ITEMS FOR 12 MONTHS	12	Rs. 20000 PER MONTH	2,40,000

	JOURNALS/BULETIN /NEWS PAPER/ MAGAZINE FOR 12 MONTHS	12	Rs. 1000 PER MONTH	12,000
	TELEPHONE/ CELL CHARGES FOR 12 MONTHS	12	Rs. 5000 PER MONTH	60,000
	FUND FOR OFFICE MANAGEMENT FOR 12 MONTHS	12	Rs. 10000 PER MONTH	60,000
	GENERATOR FACILITY CHARGES	12	Rs. 15000 PER MONTH	1,80,000
	OFFICE BOY/PEON FOR 12 MONTHS	12	Rs. 4500 PER MONTH	54,000
	SWEEPER WAGES FOR 12 MONTHS	12	Rs. 3600 PER MONTH	43,200
(F)NETWORKING WITH VARIOUS INTERSECTORAL STAKEHOLDERS	RECOMMENDED MONTHLY MEETINNG OF THE DISTRICT SURVEILLANCE COMMITTEE	12	Rs. 20000 PER MEETING	2,40,000
	MEETINGS WITH MEDIA PERSONS AND PRI MEMBERS & OTHERS	12	Rs. 12000 PER MEETING	1,44,000
(G)EXPLORE THE RESEARCH ACTIVITIES	PROPOSAL FOR RESEARCH	EACH BUDGETRY YEAR	Rs. 225000 YEARLY	225000
	DESK REVIEW		DO	
	DEVELOPING TOOLS		DO	
	DATA COLLECTION		DO	
	DATA COMPILATION AND ANALYSIS		DO	
	REPORT WRITING		DO	
	PRESENTATION OF ACTUAL SCENARIO OF RESEARCH		DO	
	YEARLY DISSEMINATION OF REPORT OF ALL ACTIVITIES		DO	
(H)ENDOWMENT FOR CONTIGENCY & EMERGENCY PURPOSES	EXPECTED INCIDENTIAL EXPENDITURE	12	Rs.30000 PER MONTH	3,60,000
(I) PROCUREMENT OF ESSENTIALS GOODS	LAPTOP & ASSESSIRIES	2		1,50,000
	PHOTO COPIER/XEROX MACHINE	1		1,50,000

	FAX WITH PHONECONNECTION	1		25,000
	GRAND TOTAL:		AMOUNT Rs:=	68,05,200

Situational Analysis of district

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

Table below indicates the Health indicators of Araria district with respect to Bihar and India as a whole.

Health Indicators

Indicator	Araria	Bihar	India
CBR#	36.2	30.4	23.8 (SRS 2005)
CDR#	8.80	8.1	7.6
IMR#	71	61	58 (SRS 2005)
MMR#	-	400	301

Internal MIS data, SRS 2005

Availability of facilities and location of facilities

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

The number of gap is in the number of sectors without HSCs, without APHC, we have major gap in PHC where in practice the norm followed is one PHC per administrative block. There is no PHC in the Bihar. Amongst existing facilities there is considerable loss of utilization due to improper location and improper distribution. And this is compounded by improper choice of village within the section or sector and the choice of venue within the village. Sub centers were most affected by such poor location. The existing process of choice of venue is flawed and a specific alternative policy on this is required.

Gaps in Health Infrastructure

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

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

Block wise health infrastructure details of Araria district

Blocks	Population covered	PHC Existing (In No.)	APHC Existing (In No.)	HSCs Existing (In No.)
Araria	355675	01	05	22
Kursakanta	115667	01	03	15
Sikti	124203	01	03	16
Palasi	190241	01	03	16

Jokihat	246043	01	02	29
Narpatganj	270128	01	04	22
Forbesgaj	373933	01	02	19
Bhargama	180457	01	05	24
Raniganj	302281	01	05	36
Total	2158608	09	32	199

(census2001)

Proposed Infrastructure

Blocks	Population covered	PHC		APHC		HSCs	
		Existing (In No.)	Proposed (In No.)	Existing (In No.)	Proposed (In No.)	Existing (In No.)	Proposed (In No.)
Araria	355675	01	0	05	05	22	25
Kursakanta	115667	01	0	03	04	15	20
Sikti	124203	01	0	03	04	16	25
Palasi	190241	01	0	03	04	16	30
Jokihat	246043	01	0	02	05	29	30
Narpatganj	270128	01	0	04	05	22	20
Forbesgaj	373933	01	0	02	05	19	30
Bhargama	180457	01	0	05	04	24	20
Raniganj	302281	01	0	05	05	36	25
Total	2158608	09	0	32	41	199	225

PHC level Infrastructure details

PHC/ Block PHC	Building		Building Condition	Power Supply (in hrs)	Gen set	Water Supply	Telephone	Sanitation (Toilet / Bath)		No. of Beds	Waste Management
	Govt.	Rented						Patient	Staf		
Araria SDH	01	0	Good	24	01	01	01	01	01	32	0
Kursakanta	01	0	Good	24	01	01	01	01	01	06	0
Sikti	01	0	Good	24	01	01	01	01	01	06	0
Palasi	01	0	Bad	24	01	01	01	01	01	06	0

Jokihat	01	0	Good	24	01	01	01	01	01	30	0
Narpatganj	01	0	Good	24	01	01	01	01	01	06	0
Forbesgaj	01	0	Good	24	01	01	01	01	01	30	0
Bhargama	01	0	Good	24	01	01	01	01	01	06	0
Raniganj	01	0	Good	24	01	01	01	01	01	30	0
Total	09	0			09	09	09	09	09	152	0

1◎ implies availability
0◎ implies unavailability

Further, the current health infrastructure is supported by Sub Divisional Hospital and Referal Hospital, and PHCs. All PHCs, Referal Hospital and Sub Divisional Hospital except Araria PHC are having vehicle services with ambulance.

PHC level Vehicle details

Sl.No.	PHC/ Block	Type of Vehicle	No.	Condition
1	Araria	Ambulance	01	Good
2	Kursakanta	Ambulance	01	Good
3	Sikti	Ambulance	01	Good
4	Palasi	Ambulance	01	Good
5	Jokihat	Ambulance	02	Good
6	Narpatganj	Ambulance	01	Good
7	Forbesgaj	Ambulance	02	Good
8	Bhargama	Ambulance	01	Good
9	Raniganj	Ambulance	01	Good
Total			11	

The gaps in accommodation are huge. APHC do not have the required number of quarters for Doctors as well as nurses (Table annexed). Whatever the existing quarters are there, they are in a very sorry state. There is acute shortage of quarters for Paramedics and other staff at all the APHC. In the campus residential accommodation for all staff is required not just for few is very necessary if we really want to have our PHC working for 24 hours a day and 7 days a week.

Most of the quarters for the Doctors, Nurses, paramedics and other staff needs to be immediately renovated and quarters need to be constructed according to the minimum manpower norms for PHC.

As far as 32 APHC are concerned, all APHCs are functioning without any facilities with damaged building. Either functioning in the sub-centre building. Almost 08 APHCs

are functioning in government buildings, but building condition is very poor. All APHC are devoid of electricity, lacking of water supply because Hand pumps are not functioning properly. There are no residential facilities for staff in APHCs except Jogbani APHC in Forbesganj.

Out of 199 existing Health Sub-Centre, 49 HSCs are running in Government building, 150 HSCs are running without building. 25 HSCs building is under construction, rest are in poor condition and immediately renovation / new constructions are required. As per population norms and geographical conditions 225 new more sub-centers are required to provide better health facility to the community. The total number of new buildings is required 364 others are renovated i.e. 35 HSCs.

Manpower Availability and Gaps in Manpower

Sl. No.	Cadre	Sanctioned	In position	Vacant
	Civil Surgeon	01	01	0
	ACMO	01	01	0
	DMO	01	0	01
	DIO	01	0	01
	DPM	01	01	0
	DAM	01	01	0
	DPC	01	01	0
	DCM(Asha)	01	01	0
	M&E OFFICER	01	0	01
	DDA(ASHA)	01	01	0
	BHM	09	06	03
	Block Accountant	09	08	01
	BCM(ASHA)	09	09	0

	Medical Officer (Lep)	01	0	01
	Medical Officer	121	57	64
	Contractual Doctors(Allopath)	36	13	23
	Contractual Doctors(AYUSH)	32	29	03
	'A' Grade nurse	39	04	35
	Contractual 'A' Grade nurse	96	58	38
	LHV	45	08	37
	A.N.M.	274	161	113
	Contractual A.N.M.	290	269	21
	Sanitary Inspector	09	0	09
	Pharmacists	46	03	43
	Health Educator	30	13	17
	Dresser	42	03	39
	Lab Tech	37	03	32
	Lab Tech(Contractual)	---	12	---
	B.H.W.	48	21	27
	F.P. Worker	27	07	20
	Health Worker	27	02	25
	Block Extension Educator	09	0	09
	O.T. Assistant	03	0	03
	Opth. Assistant	09	02	07
	Statistician	02	01	01
	Contractual Kala-azar Technical Supervisor	06	05	01
	Medical Social Worker (Lep)	02	0	02
	Health Visitor	04	0	04
	B.C.G. Technician	06	0	06
	Clerk	63	51	12
	Steno			
	Store Keeper	04	04	0
	Metron	01	0	01

	Medical Record Technician	01	0	01
	Plumber	01	0	01
	Trained Dai	01	0	01
	I D O Metrician	01	0	01
	E C G Technician	01	0	01
	Driver	19	07	12
	Dispenser(T.B.)	01	0	01
	B C G Team Leader	01	01	0
	Opthalimic Assistant	09	03	06
	Computer	09	02	07
	Vaccinator	09	03	06
	Junior Team Leader	02	0	02
	Health Demonstrator (T B)	04	0	04
	4th Grade Staff	188	137	54
	ASHA	2376	2306	70

Infrastructure: Current Status and Gap

HSCs Gaps, Issues and Strategy

Health Sub Centers: Total population of the district as per 2001 census is 2158608 but 29,57774 is the expected population by the year 2010. After considering projected population in 2010, the district needs altogether 637 HSCs to cater its whole population. At present Araria has 199 established Health Sub Centers and 392 more Health sub centers are proposed to be formed. As per the IPHS norms (5000 population in plain area) the district still requires 392 new HSCs to be formed. Again, out of 199 established HSCs, only 77 have their own buildings and rest 122 having no building. All these 20 HSCs Need renovation work. All the above mentioned HSCs need equipments, drugs, furniture and stationeries.

Health Sub Centers:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	A. Out of 199 HSCs only 77 are having own building	In adequate facility in constructed building and lack of community ownership	Enhance visibility of HSC through hardware activity by the help of community participation	S**trengthening of HSCs having own buildings**
	B. In existing 77 buildings 57 are in running comparatively in good condition,			B.1.White washing of HSC buildings. B.2.Organize adolescent girls for wall painting and plantation./hire local

				painter for colure full painting of HSC walls. List out all services which is provided at HSC level. On the wall. B.3.Gardening in HSC premises by school children.
	C.No one building is having running water and electric supply.			C. Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental.
	D. Lack of equipments and ANM are reluctant to keep all equipments in HSC . E. Lack of appropriate furniture	Operational problem in availability of equipment in constructed HSC		D.1.Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/) D.2. Purchase of equipments according to services Purchase one almirah for keep all equipment safely and it could be keep in AWW / ASHA house.
	1.Non payment of Rent of HSCs	1.Non payment of rent	Regularizing rent payment	**3B. Strengthening of HSCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of

				stationeries
	1.The district still Needs392 more HSCs to be formed.	1. Land Availability for new construction 2. Constraint in transfer of constructed building		**3C. Construction of new HSCs** C1. Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local 28 PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings.
	Non participation of Community in monitoring construction work	Monitoring	Ensuring community Monitoring	1. Biannual facility survey of HSCs through local NGOs as per IPHS format 2. Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 3. Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4. Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 5. Monthly Meeting of one representative of VHSC/Mothers committees on construction work
	1. Lack of community ownership .	1.Community ownership	Strengthening of VHSCs, PRI	1.Formation and strengthening of VHSCs, Mothers committees,

				2.“Swasthya Kendra chalo abhiyan” to strengthen community ownership 3.Nukkad Nataks on Citizen’s charter of HSCs as per IPHS 4.Monthly meetings of VHSCs, Mothers Committees
Service performance	Unutilized untied fund at HSC level	Operationalization of Untied fund	Capacity building of account holder of untied fund	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts
	ANC at HSC level not done properly due to lack of infrastructure	Improvement in quality of services like ANC, NC and PNC, Immunization	Strengthening one HSC per PHC for institutional delivery in first quarter	1. Identification of the best HSC on service delivery 2.Listing of required equipments and medicines as per IPHS norms 3. Purchasing/ indenting according to 31 the list prepared 4.Honouring first delivered baby and ANM
		Improvement in quality of services like ANC, NC and PNC, Immunization and family planning	1.Phase wise strengthening of 2 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. 2. Community focused family planning	1 Gap identification of 2 HSCs through facility survey 2. Eligible Couple Survey 3. Ensuring supply of contraceptives with three month’s buffer stock at HSCs. 4. training of AWW/ASHA on family planning

			services	methods and RTI/STI/HIV/AIDS 5. Training of ANMs on IUD insertion
	Lack of counseling services	Training	Training	1.Training to ANMs on ANC, NC and PNC, Immunization, Breastfeeding and other services.
	HSC unable to implement disease control programs	Integration of disease control programs at HSC level.	Implementation of disease control programs through HSC level	1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.
			Lack of Cleaner	Recruitment of Cleaner through RKS on Contract
	80% of the HSC staffs do not reside at place of posting	Absence of staffs	Community monitoring	1. Submission of absentees through PRI
	Problem of mobility during rainy season and during flood.	Communication and safety		1.Purchasing Life saving jackets for all field staffs 2. Providing incentives to the ANMs during rainy season so that they can use local boats.
	Lack of convergence at HSC level	Convergence	Convergence	1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at

				all villages of the respective HSC. 2. Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues.
	Lack of proper timely reporting from field Lack of appropriate HMIS formats .	Reporting	Strengthening of reporting system	1.Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc 2.Printing of adequate number of reporting formats and registers 3.Hiring consultants to develop softwares for reporting. 4.Establish data centre at APHC which will monitor all HSC
Human Resource	1.100% HSC have either ANMs or Male worker, 2.Out of 45 sanctioned post of LHVs only 8 are placed	Filling up the staff shortage	Staff Recruitment	1.Selection and recruitment of ANMs 2.Selection and recruitment of male workers
	1.Out of 430(senctioned564) ANMs 148 Are trained on different services.	1.Out of 430 ANMs 148 Are trained on different services.	Capacity Building	1.Training need Assessment of HSC level staffs 2.Training of staffs on various services
	Lacks adequate number of trainers, staffs and facilities	Training	Oppening of ANM training school	2.Deployment of required staffs/trainers 3.Hiring of trainers as per need 4.Preparation of annual training calendar issue wise as per guideline of Govt

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

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

Additional PHCs Status

Additional PHCs:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	1.The district altogether need 197 APHCs but there are only 32 APHCs functioning in the district . 2. 165 more are proposed to be established. 3.Out of 32 APHCs only 11 are having own building 4.Non payment of rent of APHCs for more than few years Lack of equipments, Non availability of HMIS formats/registers and stationeries 5. PHCs doesn't have boundary walls resulting	Lack of facilities/ basic amenities in the constructed buildings Non payment of rent Land Availability for new construction Constraint in transfer of constructed building . Lack of community ownership	Strengthening of VHSCs, PRI and formation of RKS Strengthening of Infrastructure and operationalization of construction works in Three phase	1."Swasthya Kendra chalo abhiyan" to strengthen community ownership 2.Nukkad Nataks on Citizen's charter of APHCs as per IPHS 3. Registration of RKS 4.Monthly meetings of VHSCs, Mothers committees and RKS **A.Strengtheing of APHCs having own buildings** A.1 Prioritizing the equipment list according to service delivery A.2 Purchase of equipments A.3 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

	PHC Premises Safe heaven for Astray animals and Trespasser		Monitoring	B2. Streamlining the payment of rent through untied fund/ RKS from t he month of April 09. B3 Prioritizing the equipment list according to service delivery B4 Purchase of equipments as per need B5 Printing of formats and purchase of stationeries 3C. Construction of new APHC buildings as standard layout of IPHS norms. C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New APHC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed APHCs buildings. 4 Biannual facility survey of APHCs through local NGOs as per IPHS format 4.1 Regular monitoring of APHCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project.

				4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.
Human Resource	Out of 32 APHCs 5. doesn't have Doctors. Shortage of Staffs. Hospital campus, lacks adequate number of trainers, staffs and facilities Most of the APHC staffs are deputed to respective PHCS hence APHCS are defunct	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	1.Selection and recruitment of .Doctors/Grade A nurse/ANMs 2.Selection and recruitment of male workers 3. Sending back the staffs to their own APHCs. 1. Training need Assessment of APHC level staffs 2. Training of staffs on various services 3. EmoC Training to at least one doctor of each APHC 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 42 of allocated fund
Drug kit Availability	No drug kit as such for the APHCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, Only need based emergency suuply Irregular supply of drugs	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 2 and 6 Couriers for vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	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 wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the APHC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through APHC account 4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage
Service Performance	RKS has not been formed at any of the APHC. No institutional delivery at APHC level No inpatient facility available No ANC, NC, PNC No regular	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	Capacity building of account holder of untied fund Phase wise strengthening of 9 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms.	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

	Family Planning available No lab facility 5 Ayush practitioner is not posted 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	disease control programs at 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 PPP Convergence	36 APHCs through facility survey 2.strengtheing one APHC per PHC for institutional delivery in first quarter 3.Owneringfirst delivered baby and ANM 1 Review of all disease control programs APHC wise in existing Tuesday 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, cleanliness and ambulance
				1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at

				all villages of the respective HSC.

PRIMARY HEALTH CENTRE

Primary Health Centers:(30 bedded)				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	All PHCs are running with only six bed facility. At present 5 PHC are working with average 50 delivery per day, 1 inpatient Kala-azar, and 140 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms. 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 not upto expected level. area of improvement. Lack of equipments as	Available facilities are not compatible with the services supposed to be delivered at PHCs. Quality of services Community participation.	Upgradation of PHCs into 30 bedded facilities. ISO certification of selected PHCs in the district. Strengthening of BMU Ensuring community participation. Strengthening of Infrastructure and operationalizatio n of construction works	1.Need based (Service delivery)Estimation of cost for upgradation of PHCs 2.Preparation of priority list of interventions to deliver services. 1.Selection of any two PHCs for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers, Accountants in all institutions 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their

	per IPHS norms and also under utilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries Operation of RKS: Lack in uniform process of RKS operation. Lack of community participation in the functioning of RKS. Lack of facilities/ basic amenities in the PHC buildings		Monitoring	responsibilities. 1.Meeting with Community representatives on erecting boundary, beautification etc, 2. Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS. **3.Strengtheing of PHCs** 1Rennovation of PHCs 2 Purchase of Furniture 3 Prioritizing the equipment list according to service delivery and IPHS norms. 4 Purchase of equipments 5 Printing of formats and purchase of stationeries 1. Biannual facility survey of PHCs through local NGOs as per IPHS format 2. Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.
Human Resource	As per IPHS norms each PHC requires the following clinical staffs General Surgeon Physician Gynecologist	staff shortage Untrained staffs	Staff recruitment	1.Selection and recruitment of Doctors 2.Selection and recruitment of ANMs/ male

	Pediatrics Anesthetist Eye surgeon As per IPHS norms each PHC requires the following para medical support:(List attached) But the actual position is Nurse midwife (A Grade) 62/135 Dresser 3./42 Pharmacist/compounders 3/46 Lab technician 15/37 Ophthalmic assistant 2/9		Capacity building	workers 3.Selection and recruitment of paramedical/ support staffs 1.Training need Assessment of PHC level staffs 2.Training of staffs on various services 3.Trainings of BHM and accountants on their responsibilities. 4. Trainings of BHM on implementation of services/ various National program programs.
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time. . 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 Operationalizatio n	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all PHCs 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months 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, 1 inpatient Kala-azar, 10 FP operation/emergency operation and 140 OPD per day in each PHC. 2. Total 64 seats of Regular and 23 seats of contractual doctors in the district is vacant. 3. All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less(only average 20 patients per Doctor per OPD days during April08-Nov 08, however the IPHS norms says that the OPD should be 40 per Doctor.) 4. five PHCs provides 24 hrs BEmoC services. 6. None of the PHC provides 24 hour blood transfusion servic 8. No any PHC provides adolescent sexual and reproductive health services. 9.Health facility with AYUSH services is not being provided 10. Referal a. No pick up facility for PW or patients. b.BPL patients are not exempted in paying fee of ambulance. c. Lack of maintenance of	Optimum Utilization of Human Resources Epidemic outbreaks and Need based intervention in epidemic areas. Service Load centered at PHC	Quality improvement in residential facility of doctors/ staffs. Recruitment Proper and timely information of outbreaks Strengthening of equipments and services and increase in the number of ambulances.	1. Hiring of rented houses from RKS fund for the residence of doctors and key staffs. 2. Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kalaazar patients treatment. 3. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day 1.Selection and appointment of contractual doctors and staffs 1. Mapping of the areas having history of outbreaks disease wise. 2.Developing micro plans to address epidemic outbreaks 2.Assigning areas to the MOs and staffs 3.Motivating ASHA on immediate

	ambulances d. Shortage of ambulances 11. Quality of food, cleanliness (toilets,Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC. 12. In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases. 13. Several cases of theft of instruments, computers, and submersible pumps etc at PHCs. 14. No guidance to the patients on the services available at PHCs. 15.Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular. 16. Lack of inpatient facility for kala-azar patients. 17.Lack of counseling services 18.Problem of mobility during rainy season 19.Lack of convergence 20. Lack of timely reporting and delay in data collection	Availability of AYUSH pathy. Insecurity (Staff and Properties) Govts existing services like lab, x-ray, generator, fooding and cleanliness services.	Strengthening of AYUSH services at PHC level in the first level. Confidence building measures Strengthening of the Govts existing services like lab, x-ray, generator, fooding and cleanliness services. Creating friendly environment HMIS and strengthening of reporting process	information of outbreaks 4. Purchasing folding tents, beds and equipments and medicines to organize camps in epidemic areas. 1. Repairing of all defunct Ambulances 2. Repairing of PHcs gensets and initiating their use. 3. Hiring of ambulances as per need. 1. Appointment of one AYUSH practitioner and Yoga teacher in every PHC 1.Insurance of all properties and staffs of PHC 2.Placing one TOP in every PHC 1. Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate. 2.Recruitment of lab technicians as required 3. Purchase of equipments/ instruments for strengthening lab. 4. Hiring of menial workers

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

Infrastructure facilities at PHC

Araria District has 09 PHC/Referral. All the PHC function from their own building. The source of water for all PHC is overhead tank and hand pump.

All the facilities have electricity in all parts of the hospital. all PHCs, Referal Hospital and SDH Araria have operations theatres and Ambulance. Generator and Telephone is available in all PHCs.

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

There are facilities for privacy in all PHC, for sterilizing instruments is available in 09 PHC while facility for counseling is available in none of the facilities. There is blood storage cnter available in the district H.Q.

Quarters for MOs & Paramedical staff in all PHC are inadequate and required immediate new construction renovation. Accommodation facilities for relatives or attendants of patients are not available in any PHC. Personal Computers are available in all PHC Out Sources.

Specific staff training of medical officer in PHC

The post of obstetrician/ gynecologist is not filled in any PHC. The post of RTI/STI specialist is not filled in any of the facilities. The posts of laboratory technician, pharmacist and staff nurse are not full- filled and available in all PHC. The post of Health Assistant (Female) is filled and available in all PHC. There is no training on sterilization, MTP, RTI / STI since last 6 years in any PHC.

Availability of specific facilities in Additional Primary Health Centres

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

Availability of specific facilities in District H Q level.

There is a Sadar Hospital in Araria district. The Sadar hospital has electricity supply, generator and a telephone. The hospital has toilet facility and a vehicle in working condition. There are facilities like laboratory and X-ray machine. There are separate indoor or outdoor departments in the Hospital. Beds, pillows, bed sheets, delivery table and examination table are available as per norms. There is an independent 01 Sub-Divisional Hospital, 09 Primary Health Centre (PHC)/Referral and 32 APHC in the district. The all facilities cover the entire about 30 lakhs population of the district.

Physical Infrastructure

a. Hospital Building

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

b. Source of Water Supply

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

c. Electricity

Electricity is available in all parts in the facilities. The electricity supply to the DH is continuous. All the facilities have regular electricity supply. The generators available at both the SDH and 09 PHC are in working condition. It was reported that the capacity of the generators is sufficient as per the requirement at all these facilities.

d. Disposal of waste

SDH is disconnected to the municipal sewage. The other facilities surveyed do not have any sewage facility. The waste is not segregated as infectious/ non-infectious at any of the facilities. There is not any waste treatment plant in Sub. Div. Hospital compound, The biological wastes are buried in a pit need of incinerator in all the Health facilities of District.

e. Staff Quarters

It is found that quarters for both Doctors/MO and other staff are available but not sufficient. PHC of SDH and Referral Hospitals have quarters for the doctors / in-charge. None of the PHCs have staff quarters for gynecologists, /obstetricians, pediatrician, RMOs and anesthesiologists.

f. OPD Services

OPD facilities are available in the SDH, Other Referal Hospitals and PHCs. OPD facilities are found to be good in the Sadar hospital. It is observed that OPD services for gynecology /obstetric and RTI / STI are available in the SDH. OPD services are available in all Units very well.

g. Availability of Beds

The information about total number of in-patient wards is available in the SDH while the total numbers of beds are 100 but it will upgrade into 300 bedded District Hospital. All PHC have the number of beds being 6 respectively.

h. Man power and In-service Training

In the SDH, all the sanctioned posts of doctor in charge, gynecologist and obstetrician, pediatrician, pathologist, and anesthesiologist are not filled and available. There is gynecologist and obstetrician posted for few PHC.

Rationalisation Equipment – Gap, Procurement & Utilisation

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

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

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

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

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

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

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

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

Training Need Assessment /Human resource development/ Capacity Building

Though regular trainings are provided under various national programmes to doctors, paramedical staff specially lab techs and MPWs, the quality of trainings are not Upto the level expected. So far the block level trainings are concerned, these are largely done like meetings and the lower level trainings go to even poorer results. Skilled team for training is another issue. This leads largely to logistics gaps and also affects the training quality and transmission sustenance. Thus the major focus should be training logistics and personnel. No any ANM training center located in District which imparts is months trainings to ANMs so that they retain what they have been taught.

The following additional trainings for various levels need to be imparted in 2011–12.

§ Skilled birth attendant training for ANM, LHV and Grade "A" Nurse etc.

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

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

Multi-skilling for Paramedical

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

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

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

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

training in most areas and in some areas like basic laboratory services they should be capable of providing in-service training.

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

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

Trainings for Medical Officers

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

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

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

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

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

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

Health Services:

There are 199 subcentres, 32 APHC and 09 PHC/ Referal Hospitals spread in the 09 blocks of Araria District. The OPD situation, bed occupancy and hospital management related issues are not in a very good condition if compared to the potential and capacity of institutions. The quality of public health services has been described in concerned sections and here the analysis of the clinical services.

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

Creating Conducive environment: Service condition

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

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

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

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

Another basic service issue is accommodation. At no level is there adequate housing for all staff. The focus has been on developing government housing for doctors first. At the PHC level there is no accommodation available for doctors and other categories of staff. In many of these locations, availability of basic quality rental accommodation is also a problem.

Laboratory Services

Laboratory services at the sub-centre are absent. By norms four basic tests-Blood pressure, weighing of pregnant women and children, blood hemoglobin estimation and urine testing for sugar and albumen (also ESR) are expected to take place here. These above tests however should do take place infrequently in APHC but even here they are not regular. That the PHC, as per norms, has a basic laboratory which can do about 20 basic diagnostic tests has almost been forgotten within the system. Even microscope availability is low. In the last three years there has been considerable movement forward in this area through Out Sourcing.

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

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

Referral Services

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

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

Preventive services:

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

- Diagnostic services:
- Laboratory based
- Complete Blood Count
- Routine Urine examinations
- Urine examinations for sugar and Albumin
- Stool examinations.
- Peripheral smear for Malaria / Kala Azar.
- Laboratory based diagnostic and surveillance procedures for Leprosy and other endemic diseases should also be made available.
- Sputum examinations should be carried out for diagnosis and monitoring of treatment under RNTCP.
- Facilities for diagnosis/ collection centre for the investigations of HIV/AIDS infection shall be made available.
- Radiological investigations (optional, to be need based and decided locally)
- A portable X-ray machine.
- Portable Ultrasonography equipment.
- Portable ECG machine (optional, to be need based and decided locally)
- Screening for breast cancer, cervical cancer (optional, to be need based and decided locally).
- Basic facilities for diagnosis ophthalmic anomalies/deficiencies (optional, to be need based and decided locally).
- Clinical services:
- Maternal health- Outreach Gynecological health care services
- ANC services
- Minimum 3 ANC check-ups.
- Prophylaxis of iron and folic acid.
- Tetanus Toxoid immunization.
- Early detection of complicated pregnancy.
- Counseling and referrals for institutional delivery.
- Child health

- Outreach pediatric health care services.
- Management of Diarrhoea and dehydration.
- Management of malnutrition.
- Monitoring of growth of under five year olds.
- Routine immunization.
- Family planning and Reproductive health services
- Clinical FP services- Cu-T, Injectables, Sterilizations (optional).
- RTI/STI management.
- Counseling on Various family planning initiatives/ methods (Natural- LAM, Safe period etc. and Modern- Condoms, Oral pills etc)
- Adolescent health issues
- Breast feeding
- First Aid and Minor Surgical procedures.
- Drug Distribution centre for various treatment modalities available under NRHM and State health initiatives.
- Specialized health care services (optional, to be need based and decided locally)
- Pediatrics / Orthopedic / Skin and STD /Ophthalmic /Psychiatric/Cardio-thoracic
- Ear Nose Throat disorders

Pharmacy services:

Referral and Transportation services

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

Emergency Care Services

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

Telemedicine

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

Maternal Health Care

Women are the foundation of the Country's families and communities. Over the years, Complications of pregnancy and childbirth are the leading cause of death and disability for childbearing women in many parts of the country. Comprehensive, high-quality maternity care can help prevent infant and maternal death and disability. No matter where they live, women should have access to the information and care that keeps them healthy and safe. Engender Health has learned that when women have access to family planning, fewer women die from risky pregnancies or unsafe abortions. Our work safeguards women's health.

Engender Health works with partners to develop practical strategies to strengthen and integrate maternal health care services into national health systems.

In the district young girls inter the reproductive phase of their like as victims of under nourishment and anemia. Their health risks increase with early marriages, frequent pregnancies and unsafe abortions choices regarding marriage, child bearing and contraception are denied to women. There is also lack of access to functional reproductive health services and most deliveries are still carried out by untrained birth attendants especially in the rural areas where there is no effective system of referral or management in case complications arise through there has been widespread increase of infrastructure service in the district during the past years, access to these facilities is still varied.

The immediate causes of maternal mortality are well known. They are sepsis, hemorrhage, obstruction, anemia, toxemia and unsafe abortions. The larger social determinants of these are also equally well known – they include educational status of women, poverty levels, social inequities and access to quality care.

It is evident that all the health / health service indicators of Araria district are as lower as compared to that of Bihar CDR, MMR IMR , Immunization, Institutional Delivery and Safe delivery is not better than Bihar State. However efforts in terms of quality and service need to be taken for the betterment of the present indicators. Service utilization is not good in Araria district. In urban areas, there is no any Urban Health Centre in the Araria district. In this reason, the slum population is neglected for proper immunization, Institutional Delivery and Safe delivery.

Field observations show that the blocks Narpatganj, Bhargama andSikti are lagging with respect to no. of institutional deliveries due to lack of staff, proper health facilities as well as they are unreachable areas. Further the no. of maternal deaths in that block are much

more as compared to other blocks as these are non tribal belts, far-away sub-centers, unapproachable areas etc.

Constraints:

- Health workers are not able to do 100% pregnancy registration due to different reasons such as unreachable areas, personal reasons, illiteracy etc.
- No proper follow-up by workers of ANC cases and monitoring by supervisors, sector doctors etc
- No proper referral service
- Lack of awareness among rural masses / low IEC activities
- Improper access quality antenatal, natal and post natal services may be due to
- Lack of nurse (refers to female MPW or ANM) for providing quality ante-natal care at an appropriate time in vicinity of her home.
- Lack of skilled birth attendant in vicinity of home (trained midwife, nurse or doctor).
- Lack of facility providing institutional delivery on a 24 hour basis:
- The Sub-Centre is not usually a site for institutional delivery. 75% approxof sub centres the lack of buildings rules it out as an option. Equipment gaps may also contribute to poor service.
- Lack of transport facilities
- The post-partum mother and the neonate require a visit by a ASHA in the first day after birth and at least once more in the first week of the neonate's life. Given geographical constraints it is not possible for the ANM to do so. Only a trained community level care give like the ASHA can do so.
- Sometimes the nurse is there and resources are not a problem but there is a poor motivation to provide services or a reluctance to accept services even when the knowledge and attitudes are alright. These gaps are cultural gaps and represent a certain passive discrimination – of caste or creed, or of gender.

The following matrix highlights the indicators that are taken into consideration to achieve the objectives of reproductive and child health. For each indicator current status has been assessed and targets have been set that are to be achieved in the period present year plan . In order to attain the set goals certain strategies are laid out against each indicator.

ASHA

Accredited Social Activist (ASHA) is a key strategy of the NRHM to link the community with the health systems. ASHA works with the community to raise awareness about various health programmes, provide basic health knowledge, and provide information on health practices thus generating demand for health services. She also helps and supports the community to access health services. Proper selection and training of ASHAs is a crucial step for the success of NRHM. In Araria ASHAs have been selected in all the blocks. In most of the blocks ASHAs have completed two rounds of training, while in some of the blocks they have completed one round of training. Salient information related to ASHAs in the district can be found in the matrix below:

Situation analysis:

Out of a total target 2376 ASHAs for the District, 2306 have already been selected. The number of ASHAs to be selected has been determined on the basis of older population estimates. Given that the current estimate of district rural population is approx 30 lakh . The total number of ASHAs required at the norm of 1 for every 1000 population is 2900 while sanctioned number is 2376 given by SHSB.

Activities

- Submission of proposal for the sanction and selection of additional ASHAs
- Development of an IEC campaign on the role of the ASHA using print and folk media by Block Health Educators.
- Building partnerships with NGOs for conducting an IEC campaign on the ASHA programme.
- Monitoring of the IEC Campaign by Block Community mobilizer.
- Determining the community based selection and review process for ASHAs by DHS.
- Partnership with NGOs for implementing the community based selection and review process
- Monitoring of NGO partnership for community based selection and review of ASHAs by Block Health Educators.

Strategies

- Sanction of additional ASHAs
- Facilitate selection through a community process focused on creating awareness about the role of the ASHA as a community mobiliser and activist and her positioning as a representative of the community.
- Community based review of existing ASHAs for performance and replacement of non-functional ASHAs.
- Partnership with local, active voluntary organizations with a background in community health work in the community based selection and review process.

ASHA Training

Situation Analysis: Out of 2306, 2026 ASHAs have received the first round of training.

Strategies

- Conducting 12 days of camp based training for all ASHAs

Supportive Supervision Activities

- Monthly cluster level meetings of ASHAs, ANMs, AWWs, VHSC members and ASHA trainers.
- Monthly block level trainer's meeting
- Monthly district level trainer's meeting
- Development of simple monitoring formats to be filled out by ASHA trainers, and District Resource Persons to review the functionality of the programme
- Organising an ASHA mela every year at the District level to create a sense of solidarity and support amongst ASHAs
- ASHA Helpline to be managed by the ASHA helpdesks

Selecting active ASHAs with leadership qualities to be ASHA trainers

Strategies

- Timely release of monetary incentives to ASHAs

Instituting social incentives for ASHAs

Activities

- Advertising for an ASHA coordinator at the district level

Recruitment of ASHA coordinator Health educators at the block level to support in ASHA training

RKS AND UNTIED FUND

Rogi Kalyan Samitis & Untied Funds for Health Sub-Centre, APHC & PHCs

"Health Sub Centre"

Strategies

- Ensuring that HSCs receive untied funds

Activities

- Opening Bank Accounts
- Ensuring timely release of funds to HSCs

"Additional Primary Health Centre"

Strategies

- Ensuring that all APHCs receive untied funds as per the NRHM guidelines

Activities

- Ensuring that all APHCs receive untied funds as per the NRHM guidelines

"Primary Health Centre"

Strategies

- Ensuring timely release of funds to HSCs
- Ensure that RKS is registered in all PHCs.
- Ensure UCs are sent regularly.
- Utilisation of RKS funds to pay for outsourced services
- Ensuring that HSCs receive untied funds
- Opening Bank Accounts

Activities

- Training of RKS office bearers on documentation of meetings as well as of the potential of the RKS
- Training of block level accountants in preparation of the utilization certificates
- Monthly review meeting of block level accountants by District Accounts Manager to strengthen the documentation process
- Developing a check list for review

IMMUNIZATION

Objectives

- 100 % Complete Immunization of children (12-23 month of age)
- 100 % BCG vaccination of children (12-23 month of age)
- 100% DPT 3 vaccination of children (12-23 month of age)
- 100% Polio 3 vaccination of children (12-23 month of age)
- 90% Measles vaccination of children (12-23 month of age)
- 100% Vitamin A vaccination of children (12-23 month of age)

Activities

- Organising regular routine immunisation training for ANM and AWW and IPC/IEC/BCC trainings for ASHA and AWWs.
- Organising immunisation camps at every Sub centre level on every Wednesday and at the AWCs on every Saturday.
- Regular house to house visits for registration of pregnant women for ANC and children for immunisation.
- Developing tour plan schedule of ANM with the help of BHM and MOIC.
- Timely payment to MOICs to arrange transportation of vaccines from district hospital to PHCs.
- Regular disbursement of funds from the DIO to MOs for providing incentives to ANMs.
- Regular disbursement of funds for ANMs to provide incentives to AWWs and ASHA workers.
- Providing per diem for health workers, mobilisers, supervisors and vaccinators and alternative vaccinators.
- Maintaining the disbursement records.
- Visits by MOIC, CDPO, BHM, LHV and health educator to monitor the progress of immunisation schedule and prepare report.
- Ensuring the unrestricted movement of the monitoring team with fuel for vehicle and funds for hiring of the vehicle.
- Maintaining continuous power supply at PHC level for maintaining the cold chain.
- Applying for acquisition of ILR and deep freezer for the 1 PHCs which do not have ILR at present.
- Applying to State Heath society for the funding for Vaccine van to get timely stock of vaccines for the districts.
- Timely and regular requests from district to state as well as blocks to district to replenish the supply of DPT and syringe.
- Rationalisation of courier rates and making request to the SHS for increased funding for courier in order to ensure timely supply of vaccines to sub centres.
- Reviewing the contract of Voltas Cooling Company, currently responsible for repair and maintenance.
- Submitting a proposal to the state health society to acquire power of issuing maintenance and repair contract for cold chain equipment from district.
- Procure stock of hub cutters for all the PHCs for safe disposal of needles and syringe.

IEC/BCC

Situation Analysis

- 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:

- 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

- Information Dissemination through various media,
- Interpersonal Communication.
- Promoting Behaviour change.

Activity

- Awareness on Fixed MCHN days
- 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.
- Consistent and appropriate messages on electronic media – TV, radio.
- Use of the Folk media, Advertisements, hoardings on highways and at prominent sites.
- Training of ASHA/AWW/ANM on Interpersonal communication and Counselling on various issues related to maternal and Child health.
- Display of the referral centres and relevant telephone numbers in a prominent place in the village.
- Promoting inter-personal communication by health and nutrition functionaries during the Fixed health & Nutrition days.
- Orientation and training of all frontline government functionaries and elected representatives.
- Integration of these messages within the school curriculum.
- Mothers meeting to be held in each village every month to address the above mentioned issues and for community action.
- Kishore Kishori groups to be formed in each village and issues relevant to be addressed in the meetings every month
- 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.
- 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
- Developing Nirdeshika for holding Fixed Health & Nutrition days to be distributed to all MOs, ANMs, AWWS, LS, PRIs,
- Monthly Swasthya Darpan describing all the forthcoming activities and also what happened in the month along with achievements
- Bal Nutrition Melas 4 times at each Sub centre
- Wall writings.
- Pamphlets for various issues packed in an envelope.

PROGRAMME MANAGEMENT

Situation Analysis

The District Health Society have formed been registered in Jamui The Society is reconstructed and with these following members and the Deputy Commissioner as the Governing board President. The members are all the Programme Officers, Education, SDM, IMA president, ICDS, PWD. The Governing body meetings are held monthly under the chairmanship of the Deputy Commissioner. Although the DHS formed and meetings conducted regularly but still they are not focused on health issues and need proper training on planning and management.

Objective

- District Health Society to make functional and empower to plan, implement and monitor the progress of the health status and services in the district.

Strategies

- Capacity building of the members of the District Health Society regarding the programme, their role, various schemes and mechanisms for monitoring and regular reviews.
- Establishing Monitoring mechanisms.
- Regular meetings of Society.
- Bimonthly meetings of Health, ICDS and PHED (as role of water and sanitation will play an important role in providing better health)

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 DPMU, Four skilled personnel i.e. District Programme Manager, District Account Manager, District Nodal M&E Officer, District planning coordinator, District Data Assistant ASHA have being provided in the district.
- These personnel are there for providing the basic support for programme implementation and monitoring at district level under DHS.
- The District Programme Manager (DPM) 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 Health Society including grants received from the State Health 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 FMR.

- The District Nodal Monitoring and Evaluation Officer (M&E Officer) has to work in close consultation with district officials, facilitate working of District Health Society, Maintain records, Create and maintain district resource database for the health sector, Inventory management, procurement and logistics, Planning, monitoring & evaluation, HMIS, data collection and reporting at district level.

- There is a need for providing more support to the Civil Surgeon office for better implementation especially in light of the increased volume of work in NRHM, monitoring and reporting especially in the areas of Maternal and Child Health, Civil works, Behaviour change and accounting right from the level of the Sub centre.

- The Civil surgeon's office is located in the premises of the Sadar Hospital in the district. The office of all the Deputy Civil Surgeons is also in Sadar Hospital premises.

Activities

- 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.

- **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

Development of total clarity in the Orientation workshops and review meetings at the district and the block levels amongst all the district officials and Consultants about the following set of activities:

- Disease Control
- Disease Surveillance
- Maternal & Child Health
- Accounts and Finance Management
- Human Resources & Training
- Procurement, Stores & Logistics
- Administration & Planning
- Access to Technical Support
- Monitoring & MIS
- Referral, Transport and Communication Systems
- Infrastructure Development and Maintenance Division
- Gender, IEC & Community Mobilization including the cultural background of the Meows
- Block Resource Group
- Block Level Health Mission
- Coordination with Community Organizations, PRIs
- Quality of Care systems

Provision of infrastructure for officers, DPM, DAM, M&E Officer and the consultant of the District Project Management Unit. Provision of office space with furniture and computer facilities, photocopy machine, printer, Mobile phones, digital camera, fax, etc;

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. jurisdiction of the Civil Surgeon

- **Strengthening the Block Management Unit**: The Block Management units need to be established and strengthened through the provision of :
- Block Health Managers (BHM), Block Accounts Managers (BAM), Block Community Mobilizer ASHA and Data Operators (DO) for each block. These are hired on contract.
- Office setup will be given to these persons
- Accountants on contract for each PHC since under NRHM Sub centres have received Rs 10,000 also the village committees will get Rs 10,000 each, besides the funds for the PHCs.
- Provision of Computer system, printer, Digital Camera will be provided for BHM
- **Convergence of various sectors at district level**
- Provision of Convergence fund for workshops, meetings, joint outreach and monitoring with each Civil Surgeon
- **Monitoring the Physical and Financial progress** by the officials as well as independent agencies
- **Yearly Auditing** of accounts

Strategies

- Support to the Civil Surgeon for proper implementation of NRHM.
- Capacity building of the personnel
- Development of total clarity at the district and the block levels amongst all the district officials and Consultants about all activities
- Provision of infrastructure for the personnel
- Training of District Officials and MOs for management
- Use of management principles for implementation of District NRHM
- Streamlining Financial management
- Strengthening the Civil Surgeon's office
- Strengthening the Block Management Units

- Convergence of various sectors

MONITORING AND EVALUATION

Situation Analysis

Monitoring is an important aspect of the programme but it is not happening effectively and regularly. Each officer and the MOIC, MO, BHM at PHCs are supposed to make regular visits and monitor the progress and check on the activities and also the data provided by the ANMs. The reports have to be submitted and discussed in the monthly review meetings at the entire forum. The District Health Society is not monitoring the progress and neither are the committees at the Block and Gram Panchayat levels. No proper Check-lists exist for monitoring. Also analysis is not done of the visits and any data collected No Verbal Autopsies (Maternal, Neo-natal, Infant & Child Death audits) are carried out any levels. The Role & Functioning of the Sub centre level Committee, PHC level Committee, RKS at PHC and VLC need to be clearly defined. There is no system of concurrent Evaluation by independent agencies so that the district officials are aware regarding the progress and the lacunae.

Strategies

- Developing the system for visits, reporting and review
- Developing a system of Concurrent Evaluation

Activities

- Fixing the dates for visits, review meetings and reports.
- Development of Checklist for Monitoring.
- Software for the checklist and entry of the findings in the checklist.
- MOIC, MOs & BHM to make at least 5% facility visits and also of the villages.
- Quality assessment of all health institutions.
- Maternal Mortality Audit by MO and by involving ANM AWW for reporting of maternal deaths,
- Mobility for monitoring at all levels and with the use of district monitors.

BLOCK WISE SCHOOL INFRASTRUCTURE

Sl.	Block	Total No of school	% of schools without own building	% of school without Drinking	%of school without toilet facility	%of school without playground	% of school without kitchen for

								water facility										mid-day meal		
		Primary	Middle	High	Primary	Middle	High	Primary	Middle	High	Primary	Middle	High	Primary	Middle	High	Primary	Middle	High
1	Forbisganj	146	65	08	22.6%	0	0	15.75%	0	0	66.4%	63.07%	0	96.6%	81.5%	12.5%	72%	17%	N/A
2	Ranigan j	139	66	05	21.6%	0	0	5%	0	0	56.1%	40.9%	0	95%	71.2%	20%	64%	30.3%	N/A
3	Araria	165	73	07	24.8%	0	0	9%	0	0	69%	57.5%	0	96.4%	76.7%	0	66.7%	37%	N/A
4	Bharg ama	96	51	04	39.6%	0	0	22.9%	0	0	51%	50.9%	0	91.7%	64.7%	0	51%	39.2%	N/A
5	Jokiha t	149	68	04	21.5%	0	0	17.4%	0	0	51%	17.6%	0	98%	78%	0	64.4%	29.4%	N/A
6	Kursa kanta	78	44	03	14.1%	0	0	16.6%	0	0	66.7%	36.4%	0	96.2%	59%	33.3%	42.3%	45.5%	N/A
7	Palasi	105	53	06	20%	0	0	9.52%	0	0	83.8%	58.5%	0	95.2%	73.6%	16.6%	54.3%	37.7%	N/A
8	Narpa tganj	129	62	04	31.8%	0	0	6.20%	0	0	58.9%	38.7%	0	93.8%	71%	0	60.5%	32.3%	N/A
9	Sikti	81	44	03	3.7%	0	0	8.64%	0	0	12.3%	36.4%	0	95.1%	61.4%	0	44.4%	45.4%	

BLOCK WISE STATUS OF PDS BENEFICIARIES

Sl No.	Block	No. of BPL Cards	No. of AAY Cards	No. of APL Cards	No. of Annapurna Cards (coupan)
1	Forbisganj	34412	9546	29445	1832

2	Ranigan j	35790	9931	25660	1164
3	Araria	34201	9862	31032	Not distributed
4	Bharga ma	19245	5811	13912	1008
5	Jokihat	29276	8557	21641	4692
6	Kursaka nta	12711	3716	9673	372
7	Palasi	21281	6221	17713	2272
8	Narpatg anj	29337	8577	26716	996
9	Sikti	13518	3949	10709	1008

BLOCK WISE NUTRITIONAL STATUS OF CHILDREN (0-6 YEAR)

S. L	Block	Total no. of AWC	Total no. of childr en (0-6 year)	Total no. of childre n weighe d	% of childr en weig hed	Norm al grade childr en (%)	Gr ad e I chi ldr en (%)	Gra de II chil dre n (%)	Grade III childr en (num ber)	Grade IV childr en (num ber)	Total (Gra de III + Grad e IV)	% of severel y malno urished childre n
1	Forbis ganj	374	29920	Weighi ng scales supplie d recentl y trainin g of AWW is going on for Growth Monito ring								
2	Ranig anj	300	24000									
3	Araria	355	28400									
4	Bharg ama	180	14400									
5	Jokiha t	232	18560									
6	Kursa kanta	115	9200									
7	Palasi	187	14960									
8	Narpa tganj	258	20640									
9	Sikti	124	9920									

GP AND PS ROAD NETWORK OF THE DISTRICT ARARIA

Sl No.	Block	No. of GP	No. of villages	Length of total road	Black Tape Road	C.C Road	Metal ling	Earthen	Murom	Cart Track
B.A.D. P 1	Narpatganj	2	2	3.50	-----	------	------	3.50	-----	-----
2		1	1	1.50	-------			1.50		
3		3	5	4.0				4.0		
4		1	2	2.0				2.0		
5		1	2	2.0				2.0		
6		1	2	2.0				2.0		
7		1	2	3.0				3.0		
NAW ARD 1		3	6	11				11		
2		2	4	8				8		
3		3	5	7				7		
4		2	2	3	3			----		
5		2	2	3				3		
6		2	2	7				7		
7		4	6	7				7		
8		2	2	3				3		
9		2	2	3				--		3
10		1	2	4				4		
11		2	2	3				3		
12		1	2	4				4		
B.A.D, P 1	Forbesganj	1	2	2				2		
2		1	2	3				3		
3		1	1	2				2		
4		1	1	3				3		
5		1	1	1.5				1.5		
6		1	1	1				1		
7		1	2	1.2				1.2		
8		2	2	1.5				1.5		
NAW	Forbesganj	2	3	5				5		

ARD 1										
2		1	1	2	2					
3		1	2	3				3		
4		1	2	4				4		
5		2	4	7				7		
6		2	4	7				7		
7		2	2	2				2		
8		2	4	6				6		
9		2	3	3				3		
10		2	3	4				4		
11		1	2	3				3		
12		1	3	3				3		
13		1	2	3				3		
14		1	1	2				2		
15		1	1	1				1		
16		1	2	2				2		
B.A.D.P 1	KURSAKANTA	2	3	4				4		
2		1	2	2				2		
3		1	2	2.5				2.5		
4		1	2	4				4		
NAWARD 1		4	6	12				12		
2		3	6	9				9		
3		2	4	7				7		
4		2	2	3				3		
5		2	4	4				4		
6		2	4	5				5		
7		2	2	3				3		
8		2	4	10				10		
9		2	4	9				9		
10		2	2	2				2		
11		1	2	3				3		
12		2	4	5				5		
NAWARD 1	ARARIA	1	1	4				4		
2		2	2	2				2		

3		3	7	6	2			4		
4		1	2	4				4		
5		5	12	13				13		
6		2	6	4				4		
7		2	5	5				5		
8		2	4	4				4		
9		4	10	7				7		
10		2	4	4				4		
11		2	2	4				4		
12		2	2	3				3		
13		2	4	5				5		
14		1	2	4				4		
15		3	6	10				10		
16		2	5	6				6		
17		3	7	10				10		
NAWARD 1	BHARGAMA	4	13	23	7			16		
2		2	4	10				10		
NAWARD 1	RANIGANJ	3	6	16				16		
2		3	4	17				17		
3		2	5	6				6		
4		2	6	9				9		
5		1	1	3.75				3.75		
6		1	1	2.5				2.5		
7		2	4	5				5		
8		2	4	6				6		
9		2	2	3.5				3.5		
10		1	2	3				3		
NAWARD 1	JOKIHAT	1	3	2				2		
2		2	5	7				7		
3		2	4	4				4		
4		2	2	3				3		
5		1	2	1.75				1.75		
6		2	2	4				4		
7		2	3	3				3		
8		3	5	9				9		
9		2	4	6				6		

10		2	3	5				5		
11		2	2	3				3		
NAWARD 1	PALASI	3	6	8				8		
2		2	3	4				4		
3		2	3	6				6		
4		2	2	4				4		
5		2	3	7				7		
6		2	4	8				8		
7		2	3	7				7		
8		2	2	3				3		
NAWARD 1	SIKTI	4	10	23				23		
2		2	2	7				7		
3		2	2	8				8		
4		2	4	7				7		
5		2	3	6				6		
6		2	3	5				5		
7		2	5	10				10		
B.A.D.P.1	SIKTI	2	2	5				5		
2		2	3	5				5		
3		1	2	3				3		
4		1	1	3				3		
5		1	2	3				3		

Total Road length of B.A.D.P.- 64.70KM

Total Road length of NABARD- 552.5 KM

SWOT ANALYSIS OF THE DISTRICT:

To identify the strength, weakness, opportunities and threats of districts a workshop was organized during the plan preparation process and suggestions were taken from different stakeholders from different sectors. The strategic planning workshops highlight the followings as SWOT in different sectors / sub-sectors.

District:

Strength	Weakness	Opportunity	Threat
Ø Suitable climatic condition for agriculture particularly for paddy, Jute, Wheat, Maize, Banana, Groundnut, Vegetables and also for Makhana, Mango, Bamboo betel leaf, etc. Ø For most part of the soil is sandy and andy-loam with good fertility. Ø The district has sufficient water resources both surface as well as ground water. Ø A vast area available for non-agriculture economic activities and development work.	Ø It is a flood prone district and it has to suffer damages of life and properties on large scale caused by disastrous flush flood almost every year and during summer, cyclonic storms. Ø The major rivers which are notorious for brining flood and causing excessive damages have no embankments to control and regulate the excessive flow of seasonal rain	Ø Araria being a potential producer of jute fiber, groundnut and Bamboo, which are not locally consumed, need strengthening communication network for transporting them in adjoining state and flung districts of the state. Ø Development of market centres along with small sized godowns, construcation of all weather sheds, will help the local farmers for different agriculture produce. Ø It being basically an agricultural district and	Ø Flood is a recurring phenomenon in Araria. The flood menace begins to frighten the common people with the onset of monsoon every year and at the end of the monsoon we only disrupted and washed away roads, damaged crops, lost rural connectivity, mostly collapsed houses and sad faces of rural people. Ø Power scarcity is a chronic phenomenon in the district which has grossly hampered the development, thriving of factories and mills and small and cottage

Ø Large amount of wasteland and the land under water, which can be reclaimed and made fit for horticulture and cultivation. Ø The district has enough potential for small and cottage industries based on Jute, Groundnut, paddy Milling, and Bamboo etc. Ø The district abounds in cheap potential manpower for different economic activities.	water which have their catchment area in Nepal. Ø Old and poor agro related technology and lack of modern agro related technical know-how. Ø Poor rural connectivity and deplorable condition of existing roads. Ø Very low literacy rate i.e. 35 % (avg.) when compared to State and National literacy rate which are 47.53 % and 65.38 % respectively. Ø The district lacks in Technical institutes / Vocational institutes / Research institutes / Training institutes and Higher	having a large number of ponds and tanks, the formation and establishment of soil testing laboratory and fish farmer training centres would help in more producation of agricultural produce and development of pisciculture. Ø The development of rural connectivity and the roads with bridges would enhance the employment opportunities, economic activities and would help to better the livings of the people in rural areas. Surface transport is essential also to provide market facilities to the SHGS formed under SGSY. Ø The building of several schools arein bad shape, hence their construction and	industries run on electricity. Ø Araria being a border district of Nepal has to confront with several types of offences and unlawful activities committed along the border such as smuggling, abduction and immoral traficking and cattle thievery etc. So the police administration needs to be strengthened, facilitated and suitably equipped with.

	Educational institutions. Ø The district has no Minerals, power plant, Factory. Ø The district has no Developed agricultural market and marketing infra-structure. Ø The district suffers from chronic power shortage and power based industry as well as industrial infra-structure.	renovation are important and are to be considered in this development plan. Ø The district has no district hospital, having only one sub divisional hospital, so it needs up gradation and more facilities to be added to. Ø The development of forest areas will reduce the soil erosion caused by severe flood every year, and would give the district a healthy environment.	

MCH SUB PLAN

FACILITY AND HR

Name of the District: ARARIA											
Level 1 (HSC and APHC)			**Facility and HR Status Sheet**								
			Delivery Status	**Staff in Place in numbers**				**Staff required in numbers(indicate : Regular/Contractual)***			
Name of Block	**Name and place of facility**	**Type of facility (Sub-Center/ APHC/BPHC any other)**	**Average Monthly Institutional Deliveries (Based on Jan to June 2010)**	**MO***	**SN**	**ANM**	**LT**	**MO*****	**SN**	**ANM**	**LT***
ARARIA	MADANPUR	APHC	0	2	0	1	0	0	1	1	1
ARARIA	PEKTOLA	APHC	0	2	0	1	1	0	1	1	0
ARARIA	BERGACHI	HSC	0	0	0	1	0	1	0	2	1
JOKIHAT	UDAHAT	APHC	0	0	0	2	0	1	1	0	1
PALASI	SOHANDAR	APHC	0	0	1	1	0	1	0	1	1
SIKTI	BHUTHA	APHC	0	0	0	1	0	1	1	1	1
KURSAKANTA	HALDHARA	APHC	0	0	1	2	0	1	0	0	1
FORBESGANJ	SIMRAHA	HSC	0	2	0	2	0	0	0	1	1
FORBESGANJ	JOGBANI	APHC	0	2	1	1	1	0	0	1	0
NARPATGANJ	NAWABGANJ	APHC	0	1	0	2	0	0	1	0	1
RANIGANJ	MIRJAPUR	APHC	0	1	0	0	1	0	1	2	0
BHARGAMA	BIRNAGAR	APHC	0	1	0	0	0	0	1	2	1
BHARGAMA	CHARAIYA	APHC	0	1	0	1	0	0	1	1	1
Total for District				12	3	15	3	5	8	13	10

*The requirement of the LT needs to fulfilled by the redeployment of LTs in the district

**** MO's will only be providing OPD services

* It is recommended that all AYUSH doctors be given SBA and NSSK training

TRAINING

Sl. No	Name of the facility			Level 1	Training Status and Requirment									
					MO (In Numbers)				ANM/ SN (In Numbers)					
	Name of the PHC	Name and place of facility	Type of facility	Training status	Be MOC	IUCD	NSSK	Others	NSSK	SBA	F-IMNCI	IMNCI	IUCD	Other
1	ARARIA	MADANPUR	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
2	ARARIA	PEKTOLA	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
3	ARARIA	BERGACHI	HSC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	0	2	3	0
4	JOKIHAT	UDAHAT	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
5	PALASI	SOHANDAR	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
6	SIKTI	BHUTHA	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
7	KURSAKANTA	HALDHARA	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
8	FORBESGANJ	SIMRAHA	HSC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	0	3	3	0
9	FORBESGANJ	JOGBANI	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
10	NARPATGANJ	NAWABGANJ	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
11	RANIGANJ	MIRJAPUR	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
12	BHARGAMA	BIRNAGAR	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
13	BHARGAMA	CHARAIYA	APHC	Completed	0	0	0	0	0	0	0	0	0	0
				Required	0	0	1	0	3	3	1	2	3	0
TOTAL					**0**	**0**	**13**	**0**	**39**	**39**	**11**	**27**	**39**	**0**

INFRASTRUCTURE

Name of the District: ARARIA **Name of the Block:** **Infrastructure Status Level 1**

Sl. No	Name of the facility			Status (Specify numbers wherever applicable)	Staff Quarters	Number of beds	Labour Room	New Born Care Corner	Toilets	Other Infrastructures required(Water/ Electricity/others)	Equipment (Adeq/ Inadequate)	Existing refferal mechanisim (see code below A to E)
	Name of the Block	Name and place of facility	Type of facility									
1	Araria	Madanpur	APHC	Existing	1	0	0	0	0		Inadquate	
				Required: New	3	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
2	Araria	Paktola	APHC	Existing	1	0	0	0	0		Inadquate	
				Required: New	3	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
3	Araria	Bergachi	HSC	Existing	0	0	0	0	0		Inadquate	
				Required: New	4	2	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	0	0	0	0	0			
4	Jokihat	Udahat	APHC	Existing	1	0	0	0	0		Inadquate	
				Required: New	3	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
5	Palasi	Sohandar	APHC	Existing	1	0	0	0	0		Inadquate	
				Required: New	3	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
6	Sikti	Bhutha	APHC	Existing	0	0	0	0	0		Inadquate	

				Required: New	4	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	0	0	0	0	0			
7	Kursakanta	Haldhara	APHC	Existing	1	0	0	0	0	[redacted]	Inadquate	[redacted]
				Required: New	3	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
8	Forbesganj	Simraha	HSC	Existing	1	0	0	0	1	[redacted]	Inadquate	[redacted]
				Required: New	3	2	1	1	1	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
9	Forbesganj	Jogbani	APHC	Existing	1	0	0	0	0	[redacted]	Inadquate	[redacted]
				Required: New	3	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
10	Narpatganj	Nawabganj	APHC	Existing	1	0	0	0	0	[redacted]	Inadquate	[redacted]
				Required: New	3	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
11	Raniganj	Mirjapur	APHC	Existing	1	0	0	0	0	[redacted]	Inadquate	[redacted]
				Required: New	3	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
12	Bhargama	Birnagar	APHC	Existing	1	0	0	0	0	[redacted]	Inadquate	[redacted]
				Required: New	3	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
13	Bhargama	Charaiya	APHC	Existing	1	0	0	0	0	[redacted]	Inadquate	[redacted]
				Required: New	3	6	1	1	2	Outsourced generator / water Boundary Wall		Hiring on Out Sourced
				or Rennovation	1	0	0	0	0			
Total Required New					41	70	13	13	25			
Total Required Rennovation					11	0	0	0	0			

Refferal Mechanisim			
A	Own Ambulance		
B	EMRI Model		
C	Other PP model		
D	Hiring Private Vehicle		
E	Private Vehicle but difficult to manage		

Annual Budget: Level - I

Budget Head	Additional Requirement	Unit Cost (in Rs.)	Amount in Rs.	Amount by State	Additional amount from Centre	Remarks
Human Resource						
Medical Officer	Redeployment					
Staff Nurse	8	12000	1152000			Calculated @ 12000 per month
LT	Redeployment		0			
ANM	Redeployment		0			
Supportive Supervision [Clinical supervisor + Nonmedical supervisor]						Supervised by Block MOIc. & BHM weekly one days each
Mobility support for supervision	13	96000.00	1248000.00			Hiring Private Vehicle maxium @ Rs. 800/- per Day for 5-6 blocks to minimun 10 Days for 12 months
One Fourth grade & one Sweeper	26	36000.00	936000.00			one fourth grade & one Sweeper for each Facility Centre @ Rs. 3000/ Month to 12 Month
Security Guard	39	36000.00	1404000.00			3 guards per facility X 12 months @3000 per month

Sub-total 1:	86		**4740000**			
Training						
SBA	39	28000.00	1092000			28000/ nurse
BEmOC (MO)	0	15000.00	0			15000/ doctor
NSSK	52	117050.00	234100			For 32 participants
F-IMNCI	11	288250.00	288250.00			288250 for a batch of 16 people
IMNCI	27	100800.00	100800.00			100800/ for a batch of 24 people
IUCD	39	63102.00	126204			211550 for 20 participants
Any Other (Please Specify)		0.00	0			
Sub-total 2:	168	612202	**1841354**			
Infrastructure						
Staff Quarters : New	41	750000.00	30750000			
Repair /Rennovation	11	200000.00	2200000			
Beds for patient: New	70	8200.00	574000			
Repair /Rennovation	0	0.00	0			
Labour Room: New	13	400000.00	5200000			
Repair /Rennovation	0	200000.00	0			
New Born Corner: New	to be supplied by state	0.00	0			
Repair /Rennovation	0	0.00	0			
Toilets: New	25	40000.00	1000000			
Repair /Rennovation	0	20000.00	0			
Equipments	to be supplied by state		0			
Boundary Wall	13	500000.00	6500000			
Delivery Drug + Delivery Kit	13	87000.00	339300000.00			Delivery Kit + Dilivery Drug for per Benificiaries @ Rs. 290 X 25 Benificiaries X 12 Month
Outsourcing of Generator for Electricity	13	180000.00	2340000.00			It is @ 15000 per mnth for 1 year
Any Other (Please Specify)			0			

Subtotal 3:	199	2385200	**39724000**			
Grand Total	453	2997402	**46305354**			

MCH LEVEL-2

Name of the Disctrict: ARARIA **Name of the Block:** **Training Status and Requirment (MCH Level 2 (27x7))**

Name of Block	Name and place of facility	Type of facility (24x7 PHC/CHC/Pvt./Others	Training status	MO(In Numbers)									LHV/ANM/SN (In Numbers)					
				BeMOC	MTP/MVA	NSV	NSSK	F-IMNCI	Mini-Lap	Laparoscopy	IUCD	Others	NSSK	SBA	F-IMNCI	IMNCI	IUCD	Other
Jokihat	Jokihat	24x7 PHC	Completed	0	0	0	1	0	0	0	0	0	0	3	0	0	0	0
			Required	2+3	2	2	4	5	2	1	0	0	5	2	3	2	5	0
Palasi	Palasi	24x7 PHC	Completed	0	0	0	1	0	0	0	0	0	0	2	0	0	0	0
			Required	2+3	2	2	4	5	2	1	0	0	5	3	3	2	5	0
Sikti	Sikti	24x7 PHC	Completed	0	0	0	1	0	0	0	0	0	0	3	0	0	0	0
			Required	2+3	2	2	4	5	2	1	0	0	5	2	3	2	5	0
Kursakanta	Kursakanta	24x7 PHC	Completed	0	0	0	1	0	0	0	0	0	0	3	0	0	0	0
			Required	2+3	2	2	4	5	2	1	0	0	5	2	3	2	5	0
Raniganj	Raniganj	24x7 PHC	Completed	0	0	0	1	0	0	0	0	0	0	2	0	0	0	0
			Required	2+3	2	2	4	5	2	1	0	0	5	3	3	2	5	0
Bhargama	Bhargama	24x7 PHC	Completed	0	0	0	1	0	0	0	0	0	0	2	0	0	0	0
			Required	2+3	2	2	4	5	2	1	0	0	5	3	3	2	5	0
Narpatganj	Narpatganj	24x7 PHC	Completed	0	0	0	1	0	0	0	0	0	0	3	0	0	0	0
			Required	2+3	2	2	4	5	2	1	0	0	7	4	3	4	7	0
		Total Required-		40	14	14	28	35	14	7	0	0	37	19	21	16	37	0

INFRASTRUCTURE

Name of the District: ARARIA **Name of the Block:** **Infrastructure Status Level II**

Sl. No.	Name of the facility			Status (Specify numbers wherever applicable)	Staff Quarters	Number of beds	Labour Room	Child stablization Unit	New Born Care Corner	Toilets	Other Infrastructures required(Water/ Electricity /others)*	Equipment(Adeq/Inadequate)	Equipments for Maintanence of Cold Chain (ILR/DF)	Existing refferal mechanisim* (see code below A to E)
	Name of the Block	Name and place of facility	Type of facility											
1	Jokihat	Jokihat	PHC	Existing	2	6	1	0	1	2		Inadequate	Each ILR & DF Exists	D
				Required : New	6	24	1	1	0	2	not required			
				or Rennovation	2	0	0	0	0	2				
2	Palasi	Palasi	PHC	Existing	0	6	1	0	1	2		Inadequate	Each ILR & DF Exists	D
				Required : New	8	24	0	1	0	2	not required			
				or Rennovation	0	0	0	0	0	0				
3	Sikti	Sikti	PHC	Existing	3	6	1	0	1	2		Inadequate	Each ILR & DF Exists	D
				Required : New	5	24	0	1	0	2	not required			
				or Rennovation	3	0	0	0	0	2				
4	Kursakanta	Kursakanta	PHC	Existing	2	6	1	0	0	2		Inadequate	Each ILR & DF Exists	D
				Required : New	6	24	0	1	1	2	not required			
				or Rennovation	2	0	0	0	0	2				

5	Raniganj	Raniganj	PHC	Existing	3	6	1	0	0	2		Inadequate	Each ILR & DF Exists	D
				Required : New	5	24	1	1	1	2	not required			
				or Rennovation	3	0	1	0	0	2				
6	Bhargama	Bhargama	PHC	Existing	3	6	1	0	0	2		Inadequate	Each ILR & DF Exists	D
				Required : New	5	24	1	1	1	2	not required			
				or Rennovation	3	0	1	0	0	2				
7	Narpatganj	Narpatganj	PHC	Existing	2	6	1	0	0	2		Inadequate	Each ILR & DF Exists	D
				Required : New	6	24	0	1	1	2	not required			
				or Rennovation	2	0	1	0	0	2				
Total Required New					**41**	**168**	**3**	**7**	**4**	**14**				
Total Required Rennovation					**15**	**0**	**3**	**0**	**0**	**12**				

*Refferal Mechanisim			
A	Own Ambulance		
B	EMRI Model		
C	Other PP model		
D	Hiring Private Vehicle		
E	Private Vehicle but difficult to manage		

* A requirement for 24 beds has been calculated for all facilities that have been sactioned to be converted into a CHC

Annual Budget at a Glance Level II

Budget Head	Additional Requirement	Unit Cost (in Rs.)	Amount in Rs.	Amount by state	Extra from Centre	Remarks
Human Resource						
Medical Officer	Redeployment		0			
ANM	Redeployment		0			
Staff Nurse	15	12000	2160000			
LHV / PHN	0		0			
LT	Redeployment		0			
Supportive Supervision [Clinical supervisor + Nonmedical supervisor]	1	480000	480000			Clinical Supervision by Mobile Trainer one each for 5- 6 blocks @ 40000 per month & Non-Clinical Supervision by DPC for 10 days a month
Mobility support for supervision	1	180000(additional requirement)+ 96000	276000			Hiring Private Vehicle maxium @ Rs. 800/- per Day for minimun 10 Days in Month and 15000 per month for mobile trainer
Any Other (Please Specify)	0	0				
Sub-total 1:	17	492000	**2916000**			
Training						
SBA	19	28000	532000			
BEmOC (MO)	40	15000	600000			For Particeipent @15000/-
MTP	14	95795	383180			Rate 95795 for 4 doctors
NSSK	65	117050	234100			117050 for 32 people
F-IMNCI	56	288250	1153000			288250 for a batch of 16 people
IMNCI	16	100800	100800			100800/ for a batch of 24 people
Mini-Lap	14	71240	284960			71240 for 4 participants
Laparoscopy	7	71240	142480			71240 for 4 participants
NSV	14	32600	130400			32600 for 4 participants
IUCD	37	211550	423100			211550 for 20 participants
Any Other (Please Specify)	0	0	0			

Sub-total 2:	282	1031525	**3984020**			
Infrastructure						
Staff Quarters : New	41	750000	30750000			
Repair /Rennovation	15	200000	3000000			
Beds for patient: New	168	8200	1377600			
Repair /Rennovation	0	0	0			
Toilets: New	14	40000	560000			
Repair /Rennovation	12	20000	240000			
Labour Room: New	3	400000	1200000			
Repair /Rennovation	3	130000	390000			
Stabilisation Unit: New	to be supplied by state	0	0			
Repair /Rennovation	0	0	0			
New Born Corner: New	to be supplied by state	0	0			
Repair /Rennovation	0	0	0			
Cold chain equipments- ILR/ DF	**to be supplied by state**	**0**	0			
Equipments	to be supplied by state	0	0			
Any Other (Please Specify)		0	0			
Subtotal 3:	256	1548200	**37517600**			
Grand Total	555	3071725	44417620			

EQUIPMENT

Sl. No.		Nos.	Unit Coast	Budget
A	**Delivery Services**			
2	Transfer Trolley	3	15500.00	46500.00
3	Small Sterilizer	3	6300.00	18900.00
4	Flash Light	2	1500.00	3000.00
5	Instrument Trolley For Delivery	2	5200.00	10400.00
6	IV Stand	6	1250.00	7500.00
7	BP Apparatus and Stethoscope	2	1500.00	3000.00
8	Beds with Mattress	8	11000.00	88000.00
9	Dressing Drum	4	1500.00	6000.00
10	Stainless Steel Basin	2	1000.00	2000.00
11	Foetoscope	2	250.00	500.00
12	Stainless Steel Bowls	4	125.00	500.00
13	Emergency Light	2	1500.00	3000.00
	Total		**46625.00**	**189300.00**
B	**Instruments**			
1	Cheatels Forcep	6		
2	Jars	2		
3	Artery Forcep	8		
4	Stainless Steel Tray	4		
5	Tooth Forcep	2		
6	Scissors	6		
7	Buckets (Plastic)	2		
8	Kidney trays	4		
9	Weighing Scale	4		
10	Oxygen Cylinder with Mask	1		
11	Sterilizer, Streem	2		
12	Hemoglobinmeter	1		

13	Haemocytometer	1		
14	Albuminometer	1		
15	Stop Watch	1		
16	Wall Clock	1		
17	Measuring Tape Steel	2		
18	Adult Weighing Scale	1		
19	Partograph Chart			
20	LPG Stove			
21	LPG Cylinder			
20	Syriges(5ml and 10 ml)			
	Total		**50000.00**	**50000.00**
C	**Linen**			
1	Bed Sheets	72	2000.00	144000.00
2	Mackintosh	20	200.00	4000.00
3	Draw Sheets	10	1000.00	10000.00
4	Blanket	18	3000.00	54000.00
5	Pillow with cover	18	1000.00	18000.00
6	Towels	4(Large), 8(Small)	500.00	500.00
7	Mosquito net	12	400.00	4800.00
	Total		**8100.00**	**235300.00**
D	**IUCD Kit**	**3**	**15000.00**	**326600.00**
E	**New Born Corner**			
1	Radiant Warmer/200 Watt Bulb	1	500.00	500.00
2	Neonatal Ambu Bag with Face Mask	1	1000.00	1000.00
3	Mucus Sucker	1	300.00	300.00
4	Baby crip	3	2000.00	6000.00
5	Baby Blanket	18	250.00	4500.00
6	Baby Sheet	18	50.00	900.00
7	Mosquito Net	12	100.00	1200.00

8	Baby Weighing Scale	2	1000.00	2000.00
Total			**5700.00**	**16400.00**
F	**Furniture/Sundry Article**			
1	Writing Table	3	1000.00	3000.00
2	Armless Chair	4	1000.00	4000.00
3	Medicine Chest	2	1500.00	3000.00
4	Examination Table Wooden	1	3000.00	3000.00
5	Foot Step	1	200.00	200.00
6	Stool	2	500.00	1000.00
7	Almirahs	2	4000.00	8000.00
9	Battery with UPS	1	15000.00	15000.00
10	CFL 20 Wat	5	150.00	750.00
11	Fan	2	1500.00	3000.00
12	Buckets 15 ltr.	2	150.00	300.00
13	Mugs	2	50.00	100.00
15	Ruber/Plastic Sheet	50 mtr.	1000.00	5000.00
16	Curtain	30 mtr.	1500.00	5000.00
Total			**30550.00**	**51350.00**
Grand Total (A+B+C+D+E+F)			**155975.00**	**868950.00**

LEVEL-III

HUMAN RESOURCE

Name of the District: ARARIA							Name of t
Level III				Facility and HR Status Sheet			
		Delivery Status		Staff in Place in r			
Name and place of facility	Type of facility DH/SDH/AH/FRU/CHC/Pvt./Others	Average Monthly Institutional Deliveries (Based on Jan to June 2010)	C-Section	Specialist/PG MO /MO-Multiskilled (OBG,PAED, ANAESTH)	MO	SN	Al
ARARIA	Sadar (SDH)	938	5	Gynec-1, Aneth.-1, Paed.-2	6	1	
FORBESGANJ	SDH	675	5	Gynec-1, Aneth.-1, GS-1	6	1	
Total			10	7	12	2	

There should be only 4 MO's at a level 3 facility and the remaining should be reallocated. The specialists may be provided as per norms

TRAINNING

Training Status and Requirment (MCH Level III)				**Name of the District:**										**Name of t**
Name and place of facility	Type of facility DH/SDH/AH/FRU/CHC/Pvt./Others	Training status		MO (In Numbers)										
			LSAS	EMOC	MTP	NSSK	F-IMNCI	Mini-Lap	Lapro Scopy	NSV	IUCD	MVA	NSSK
ARARIA	Sadar SDH	Completed	0	0	0	2	2	0	0	1	0	0	0
		Required	1	1	2	8	8	2	1	1	0		25
FORBESGANJ	SDH	Completed	0	0	0	2	0	0	0	0	0	0	0
		Required	1	1	2	7	9	2	1	2	0		11
Total Required			**2**	**2**	**4**	**15**	**17**	**4**	**2**	**3**	**0**	**0**	**36**

INFRASTRUCTURE

Name of the District: ARARIA						Name of the Block:			Infrastructure Status Level III				
Name and place of facility	**Type of facility DH/SDH /AH/FRU /CHC/Pvt ./Others**	**Status (Specify numbers wherever applicable)**	**Staff Quarters**	**Number of beds**	**OT**	**Labour Room**	**SNCU/Child stablization Unit**	**New Born Care Corner**	**Blood Storage/Blood Bank**	**Toilets(M/F)**	**Other Infrastructures required (Water/ Electricity /others)***	**Equipment (Adeq/ Inadequate)**	Equipments for Maintanence of Cold Chain (ILR/DF)
ARARIA	Sadar SDH	**Existing**	4	100	0	1	1	0	1	10		Inadequate	Each ILR & DF Exists
		Required: New	12	0	1	0	0	1	0	0	not required		
		or Rennovation	4	0	0	0	0	0	0	0			
FORBESGANJ	SDH	**Existing**	2	30	1	1	0	0	0	2		Inadequate	Each ILR & DF Exists
		Required: New	10	0	0	0	1	1	1	4	not required		
		or Rennovation	2	0	1	1	0	0	0	2			
Total Required			22	0	1	1	1	2	0	4			
	Total Rennovation		6	0	1	1	0	0	0	2			

Annual Budget at a Glance Level III						
Budget Head	**Additional Requirement**	**Unit Cost (in Rs.)**	**Amount in Rs.**	**Amount by state**	**Extra from Centre**	**Remarks**
Human Resource						
Specialists:						

Obs. / Gynaec.	0	35000.00	0			
Anaesthetist	0	35000.00	0			
Paediatrician	1	35000.00	35000			
Medical Officer	redeployment	0.00				
ANM	redeployment	0.00				
Staff Nurse	24	12000.00	3456000			
LHV / PHN	0		0			
LT	redeployment					
Supportive Supervision [Clinical supervisor + Nonmedical supervisor]	0	0.00	0			Supervised by Supritendent. Hospital manager
Mobility support for supervision	0	0.00	0			not required
Trainer for skill lab	1	480000.00	480000			nurse @ 40000 per month
Sub-total 1:			**3971000**			
Training						
SBA	32	28000.00	896000			
LSAS	2	136000.00	272000			
CEmOC	2	138000.00	276000			
MTP	4	95795.00	95795.00			Rate 95795 for 4 doctors
NSSK	51	117050.00	234100.00			117050 for 32 people
F-IMNCI	43	288250.00	864750.00			288250 for a batch of 16 people
IMNCI	8	100800.00	100800.00			100800/ for a batch of 24 people
Mini-Lap	4	71240.00	71240.00			71240 for 4 participants
Laparoscopy	2	71240.00	71240.00			71240 for 4 participants
NSV	3	32600.00	32600.00			32600 for 4 participants
IUCD	34	63102.00	126204			211550 for 20 participants
Any Other (Please Specify)	0		0			
Sub-total 2:		1142077.00	**3040729**			
Infrastructure						
Staff Quarters : New	22	750000.00	16500000			
Repair /Rennovation	6	200000.00	1200000			
Beds for patient: New	0	8200.00	0			

Repair /Rennovation	0	0.00	0			
Toilets: New	4	40000.00	160000			
Repair /Rennovation	2	20000.00	40000			
OT: New	1	3000000.00	3000000			
Repair /Rennovation	1	500000.00	500000			
Labour Room: New	1	400000.00	400000			
Repair /Rennovation	1	130000.00	130000			
Child Stabilisation Unit: New	To be supplied by state	0.00	0			
Repair /Rennovation	0	0.00	0			
New Born Corner: New	To be supplied by state	0	0			
Repair /Rennovation	0	0				
SNCU: New	1	5700000	5700000			
Repair /Rennovation	0	0				
Blood Bank: New	1	294000	294000			
Repair /Rennovation	0	0	0			
Blood Storage (BSU): New	0	To be supplied by state				
Repair /Rennovation	0	0	0			
Cold chain equipments- ILR/ DF	To be supplied by state		0			
Equipments	To be supplied by state		0			
Skill Lab to be established at the District Hospital	1	1500000.00	1500000.00			
Subtotal 3:			**29424000**			
Grand Total			**36435729**			

STRATEGIES		Component Code (only at state level)	Output 2012	Activity Plan										Budget Plan								
				2010-2011FY				2011-2012 FY						2010-2011 FY					2011-2012 FY			
	Activities			Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised {Y x (A)} = D	under or over-utilised Budget {(B~D} =E	Tentative Unit Cost (2010-11)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
										Q1	Q2	Q3	Q 4									
	RCH			-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-	-	-
	1. Mater-nal Health																					
A.1.1	1.1Operationalise facilities (dissemination, monitoring & quality) (details of infrastructure & human resources, training, IEC / BCC, equipment, drug and supplies in relevant sections)			2	2			2		0	0	0	0	492000	684000	684000	390000	294000	492000	6.9		
A.1.1.1	1.1.1 Operationalise Block PHCs/ CHCs/ SDHs/ DHs as FRUs			2	0		Lack of manpower & infrastructure	2				1	1	2.94	5.88	0	0	5.88	2.94	5.88		

A.1.1.1.1	**1.1.1 Operationalise FRUs (Diesel, Service Maintenance Charge, Misc. & Other costs) 1.1.1.1 Operationalise Blood Storage units in FRU**			2	1			1			1			3.6	7.2		3.9	3.3	3.6	6.9		
A.1.1.2	**1.1.2 Operationalise 24x7 PHCs (Organise workshops on various aspects of operationalisation of 24x7 services at the facilities @ Rs. 25,000 / year / district)**			0	0	0	No budgetary provision was planned for FY 10-11	9	Workshop at all PHCs has been planned during FY 2011-12	9				0.25	0.25	0	0	0.25	0.25	2.5	NRHM	
A.1.1.3	**MTP services at health facilities**														0	0		0		0		
A.1.1.4	**RTI/STI srvices at health facilities**			10	0	0		1	To open an OPD at Sadar Hospital for providing RTI/STI Services	5	5			4.2	42	0	42	0	4.2	4.2	NRHM	A Medical officer (Skin Specialist) shall be appointed on contractual basis @Rs.35,000 /- per month
A.1.1.5	**Operationalise Sub-centres**														0	0		0		0		
A.1.2	**1.2 Referral Transport**														0			0		0		
A.1.2.1	**1.2.1. To develop guidelines regarding referral transport of the pregnant women and sick new born / children and dissemination of the same @ Rs. 50,000 for the state**														0	0		0		0		
A.1.2.2	**1.2.2. Payment to Ambulances for all PHCs @ Rs. 200 / case of pregnancy for Jehanabad district (Pilot basis)**														0	0		0		0		
A.1.3.	**1.3. Integrated outreach RCH services**														0	0		0		0		
A.1.3.1	**1.3.1. RCH Outreach Camps in un-served/ under-served areas**			72	0	72		80		18	18	18	18	833	59976	59976		59976	833	6664		
A.1.3.2.	**1.3.2. Monthly Village Health and Nutrition Days at AWW Centres**			0	0	0		0		0	0	0	0		251160	251160		251160		-251160		

A.1.4	1.4. Janani Evam Bal Suraksha Yojana/JBSY														0	0		0		0			
A.1.4.1	1.4.1 Home deliveries (500/-)			296	0	296		500		74	74	74	74	500	148000	148000	0	148000	500	102000			
A.1.4.2	1.4.2 Institutional Deliveries					0									0	0		0		0			
A.1.4.2.1	1.4.2.1 Rural (A) Institutional deliveries (Rural) @ Rs.2000/- per delivery for 10.00 lakh deliveries			36781	22890	13891		50672		10000	10000	15336	1533 6	2000	73562000	73562000	4578000	27782000	2000	73562000			
A.1.4.2.2	1.4.2.2 Urban (B) Institutional deliveries (Urban) @ Rs.1200/- per delivery for 2.00 lakh deliveries			625	372	253		878		200	200	239	239	1200	750000	750000	0	750000	1200	303600			
A.1.4.2.3	1.4.2.3 Caesarean Deliveries (Facility Gynec, Anesth & paramedic) 10.3.1 Incentive for C-section(@1500/- (facility Gynec. Anesth. & paramedic)			200	0	200		300		75	75	75	75	1500	300000	300000	0	300000	1500	150000			
A.1.4.3	1.4.3 Other Activities(JSY) 1.4.3. Monitor quality and utilisation of services and Mobile Data Centre at HSC and APHC Level and State Supervisory Committee for Blood Storage Unit			3000	0	3000		3000		750	750	750	750	1741	5223000	5223000	0	5223000	2000	777000			
	Total (JSY)					0									0	0		0		0			
A.1.5	1.5 Other strategies/activities					0									0	0		0		0			
A.1.5.1	1.5.1 Maternal Death Audit 1.1.3 Survey on maternal and perinatal deaths by verbal autopsy method (in two districts) @ 850 per death					0									0	0		0		0			
	2. Child Health					0									0	0		0		0			
A.2.1	2.1. Integrated Management of Neonatal & Childhood Illness/IMNCI (Monitor progress against plan; follow up with training, procurement, review meetings etc) 2.1.					0									0	0		0		0			

	IMNCI (details of training, drugs and supplies, under relevant sections) 2.1.1. Monitor progress against plan; follow up with training, procurement, review meetings etc																					
A.2.2	**2.2 Facility Based Newborn Care/FBNC in districts (Monitor progress against plan; follow up with training, procurement, view meeting etc.) 2.2.1. Implementation of FBNC activities in districts. (Monitor progress against plan; follow up with training, procurement, etc.)**			0	0	0		0		57000	57000	0	0		114000	114000	0	114000	1000	-114000		
A.2.3.	**2.3 Home Based New born care/HBNC**					0									0	0		0		0		
A.2.4	**2.4 School Health Programme (Details annexed)**			1546	516	1030		2576		500	500	788	788	3000	4638000	4638000	0	4638000	2199	1026624		
A.2.5.	**2.5 Infant and Young Child Feeding/IYCF**					0									0	0		0		0		
A.2.6.	**2.6 Care of sick children & severe malnutrition**					0									0	0		0		0		
A.2.7.	**2.7 Management of Diarrhoea, ARI and Micro nutrient**					0									0	0		0		0		
	3.Family Planning					0									0	0		0		0		
A.3.1.	**3.1.Terminal/Limiting Methods**					0									0	0		0		0		
A.3.1.1.	**3.1.1. Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services**			1	0	1		1		1				22000	22000	22000	0	22000	22000	0		
A.3.1.2	**3.1.2 Female Sterilisationcamps**			45		45								1000	45000	45000		45000	1000	-45000		
A.3.1.3 3.1.2.2.	**3.1.3 3.1.2.2. NSV camps (Organise NSV camps in districts @Rs.10,000 x 500 camps)**			10	0	10		14		2	2	2	4	10000	100000	100000	0	100000	10000	40000		

A.3.1.4	3.1.4 Compensation for female sterilisation 3.1.2.3. Compensation for female sterilisation at PHC level in camp mode 3.1.2.1. Provide female sterilisation services on fixed days at health facilities in districts (Mini Lap)			12183	4909	7274		17074		2000	2000	6537	6537	1000	12183000	12183000	4909615	7273385	1000	9800615		
A.3.1.5 3.1.2.4	3.1.5 Compensation for male slerilisation 3.1.2.4. Compensation for NSV Acceptance @50000 cases x1500			641	32	609		742		120	120	251	251	1500	961500	961500	48000	913500	1500	199500		
A.3.1.6 3.1.3.1	3.1.6 Accreditation of private providers for sterilisation services 3.1.3.1 Compensation for sterilization done in Pvt.Accredited Hospitals (1.50 lakh cases)			4087	2287	1800		5887		1000	1000	1943	1943	1500	1777500	1777500	0	1777500	1500	7053000		
A.3.2	3.2. Spacing Methods					0									0	0		0		0		
A.3.2.1	3.2.1. IUD Camps			190	0	190		190		45	45	50	50	1500	285000	285000	0	285000	24000	4275000		
A.3.2.2	3.2.2 IUD services at health facilites/compensation			5065		5065		5065		1000	1000	1532	1533	50	253250	253250		253250		-253250		
A.3.2.3	Accreditation of private providers for IUD insertion services					0									0	0		0		0		
A.3.2.4	Social Marketing of contraceptives					0									0	0		0		0		
A.3.2.5 3.2.2.	3.2.5 3.2.2. Contraceptive Update Seminars (Organise Contraceptive Update seminars for health providers (one at state level & 38 at district level) (Anticipated Participants-50-70)			9	0	9		9		2	2	2	3	7135	64215	64215		64215		-64215		
A.3.3	3.3 POL for Family Planning for 500 below sub-district facilities			10	0	10		10		0	0	5	5	16200	162000	162000	65000	97000	800	-89000		
A.3.4	3.4 Repair of Laproscopes (Rs. 5000 x 40 nos.)														0	0		0		0		

A.3.5	**3.5 Other strategies/activities 3.1.4. Monitor progress, quality and utilisation of services 3.5. Establishing Community Based Condom and OCP Distribution Centres (pilot in one district/1 PHC)**					0									0	0		0		0		
	4. Adolescent Reproductive and Sexual Health (ARSH)					0									0	0		0		0		
	(Details of training, IEC/BCC in relevant sections)					0									0	0		0		0		
A.4.1	**Adolescent services at health facilites. 4.1.1. Disseminate ARSH guidelines.4.1.2. Establishing ARSH Cells in Facilities 4.1.2.1. Developing a Model ARSH Cell for the facilities 4.1.2.2. Establishing ARSH Cell at Patna District Hospital 4.1.2.3. Establishing ARSH Cell is 50% PHCs of Patna District 4.2 Conducting ARSH Camps at all PHCs for a week (as ARSH Week) 4.2.2 Establishing Youth friendly health clinics in Urban Area/ Universities Campus / Market Place**			1	0	1		2		y	y	0	0	25000	25000	25000	0	25000	25000	25000		
A.4.2	**4.2 Other strategies/activities**					0									0	0		0		0		
	5. Urban RCH					0									0	0		0		0		
A.5.1	**5.1. Urban RCH Services (Development of Micro-plans for each urban area already mapped for delivery of RCH services, both outreach and facility based through private agencies/institutions/organisations-50lakhs & Operationalising 20 UHCs through private clinics @540000/- pm**					0									0	0		0		0		

	6 Tribal Health					0									0	0		0		0		
A.6.1	Tribal RCH services					0									0	0		0		0		
A.6.2	Other strategies/activities					0									0	0		0		0		
	7. Vulnerable Groups					0									0	0		0		0		
A.7.1	7.1 Services for Vulnerable groups					0									0	0		0		0		
A.7.1	7.1 Services for Vulnerable groups					0									0	0		0		0		
A.7.2	7.2 Other strategies/activities					0									0	0		0		0		
	8. Innovations/PPP/NGO					0									0	0		0		0		
A.8.1	8.1.PNDT and Sex Ratio 8.1.1. Orientation programme of PNDT activities, Workshop at State, District and Block Level (1+38+533) (amount Rs.50 Lakhs) 8.1.2 Monitoring at District level and Meetings of District level Committee (100 Lakhs)			8	0	8		18		y	y	y	y	55910	447280	447280	0	447280	25000	2720		
A.8.2.	Public Private Partnerships					0									0	0		0		0		
A.8.3	NGO Programme					0									0	0		0		0		
A.8.4	Other innovations (if any)					0									0	0		0		0		
	INFRASTRUCTURE & HR					0									0	0		0		0		
A.9.1	Contracutal Staff & Services					0									0	0		0		0		
A.9.1.1	9.1.1 ANMs 10.1.1.2. Hiring of 1000 Retired ANMs or ANMs from other states for out reach services @ Rs. 5000 / month / ANM			90	0	90		90		20	20	25	25	5000	450000	450000	0	450000	5000	0		
A.9.1.2	9.1.2 Laboratory Technicians			6	6	0		0		0	0	0	0	126000	756000	756000	0	756000	126000	-756000		
A.9.1.3	Staff Nurses			52	43	9		49		20	20	9	0	144000	7488000	7488000		7488000	144000	-432000		

A.9.1.4	**9.1.4 Doctors and Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians) Hiring Specialists 1.1.1.1 Operationalise Blood Storage units in FRU - Salary of Medical Officer - 1,82,40,000/-; 10.1.2.1. Empeanelling Gynaecologists for gynaecology OPD in under or un served areas @ Rs. 1000/- week x 52 weeks ; 10.1.2.3. Empanelling Gyaneocologists for PHCstoprovide OPD services @ Rs. 300/- weekx 52 weeks; 10.1.2.4 Hiring Anaesthetist positions @ Rs.1000 per case x 120000; 10.1.2.5. Hiring Paediatrician for facilities where there are vacant Paediatricians positions @ Rs. 35,000/- month (2 per district); 10.1.2.6 Hiring Gynaecologists for facilities that have vacant positions @ Rs. 650 per case x 75000 cases**			2	2	0		2		2	0	0	0	3487300	3487300	3487300	0	3487300	3487300	3487300		
A.9.1.5	**Other contractual Staff 9.1 Fast-Track Training Cell in SIHFW 9.2 Filling Vacant Position at SIHFW/Hiring Consultant at SIHFW 10.1.1 Honorarium of Voluntary Workers @ of 1200/- PA x 3106 No.**					0								0	0		0		0			
A.9.1.6	**Incentive/Awards etc. 8.2.1 Incentive for ASHA per AWW center (80000x200 per month) and Incentive toANMs per Aganwari Centre under Muskan Programme (@80000 x Rs.150 Per Month**			1	1	0		1		0	0	0	0	9331300	9331300	9331300	5185860	4145440	5185860	1040420		

A.9.2	9.2. Major civil works (new construction/extension /addition)					0								0	0		0		0			
A.9.2.1	9.2.1 Major Civil works for operationalisation of FRUS					0								0	0	0	0		0			
A.9.2.2	9.2.2 Major Civil works for operationalisation of 24 hour services at PHCs			9	0	9		9						100000	900000	900000		900000		-900000		
A.9.3	9.3 Minor Civil Works					0									0	0		0		0		
A.9.3.1	9.3.1 Minor civil works for operationalisation of FRUs 10.4.1 Facility improvement for establishing New Born Centres at 76 FRUs across the state - @ Rs. 50,000 / per FRU			2	0	2		2		1	1	0	0	50000	100000	100000	0	100000	100000	100000		
A.9.3.2	9.3.2 Minor civil works for operationalisation of 24 hour services at PHCs 10.4.2. Facility improvement for establishing New Born Centres at PHCs across the state - @ Rs. 25,000 / per PHC			9	0	9		9		2	2	2	3	25000	225000	225000	0	225000	25000	0		
A.9.4	9.4 Operationalise IMEPat health facilites														0	0		0		0		
A.9.5	9.5 Other Activities					0									0	0		0		0		
	10. Institutional Strengthening					0									0	0		0		0		
A.10.1	10.1 Human Resource Development					0									0	0		0		0		
A.10.2	10.2 Logistics management/improvement					0									0	0		0		0		
A.10.3	10.3 Monitoring Evaluation/HMIS 11.3 Monitoring & evaluation through monitoring cell at SIHFW			0		0									0	0		0		0		
A.10.4	10.4 11.4 Sub-centre rent and contingencies @ 1770 no. x Rs.500/- x 60 months			40	8	32		50		10	10	15	15	6000	240000	240000	0	240000	60000	2760000		
A.10.5.	10.5. Other strategies/activities TA & DA for the 30 days contact programme					0									0	0		0		0		
	11 Training					0									0	0		0		0		

A.11.1	11.1 Strengthening of Training Institutions					0									0	0		0		0		
A.11.2	11.2 Development of training packages					0									0	0		0		0		
A.11.3	11.3 Maternal Health Training					0		5		1	1	1	2	88110	440550	440550		440550	88110	0		
A.11.3.1	11.3.1 Skilled Birth Attendance /SBA 12.1.2 Skilled Attendance at Birth / SBA--Two days Reorientation of the existing trainers in Batches 12.1.3 Strengthening of existing SBA Training Centres 12.1.4 Setting up of additional SBA Training Centre- one per district 12.1.5 Training of Staff Nurses in SBA (batches of four) 12.1.6 Training of ANMs / LHVs in SBA (Batch size of four) 20 batches x 38 districts x Rs.59,000/-			2	2	0		15		3	3	4	5	42504	85008	85008	425040	-340032	42504	977592		
A.11.3.2	EmOC Training 12.1.3 EmOc Training of (Medical Officers in EmOC (batchsize is 8)					0		15		5	5	5			0	0		0		0		
A.11.3.3	11.3.3 Life Saving Anaesthesia Skills training 12.1.5 Training of Medical Officers in Life Saving Anaesthesia Skills (LSAS)					0									0	0		0		0		
A.11.3.4	11.3.4 MTP Training 12.1.6.1 Training of nurses/ ANMs in safe abortion 12.1.8 Training of Medical Officers in safe abortion			1	0	1		2		0	y	0	y	25000	50000	50000	0	50000	25000	0		
A.11.3.5	11.3.5 RTI/STI Training			0	0	0		10		0	1	0	1	75000	275000	275000	0	275000	96900	694000		
A.11.3.6	Dai Training					0									0	0		0		0		
A.11.3.7	Other MH Training					0									0	0		0		0		
A.11.4	IMEP Training					0									0	0		0		0		
A.11.	11.5 Child Health					0									0	0		0		0		

5	**Training**																					
A.11.5.1	**11.5.1 IMNCI 12.2.1.1. TOT on IMNCI for Health and ICDS worker 12.2.1.2. IMNCI Training for Medical Officers (Physician) 12.2.1.3. IMNCI Training for all health workers 12.2.1.4. IMNCI Training for ANMs / LHVs/ AWWs 12.2.1.6 Followup training (HEs,LHVs)**			0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0		
A.11.5.2	**11.5.2 Facility Based Newborn Care 12.2.2.1 SNCU Training 12.2.2.2.NSU (TOT)**			0	0	0		0		0	0	0	0	0	0	0	0	0	0	0		
A.11.5.3	**11.5.3 Home Based Newborn Care**					0									0	0		0		0		
A.11.5.4	**11.5.4 Care of Sick Children and severe malnutrition**					0									0	0		0		0		
A.11.5.5	**11.5.5 Other CH Training (Pl. Specify)**					0									0	0		0		0		
A.11.6	**11.6 Family Planning Training**					0									0	0		0		0		
A.11.6.1	**12.6.1 Laproscopic Sterilisation Training**					0									0	0		0		0		
A.11.6.2	**11.6.2 Minilap Training12.3.2.1. Minilap training for medical officers/staff nurses (batch size of 4)**			1	0	1		1		1	0	0	0	70240	70240	70240	0	70240	70240	0		
A.11.6.3	**11.6.3 NSV Training 12.3.3 Non-Scalpel Vasectomy (NSV) Training**			1	0	1		1		1	0	0	0	33900	33900	33900		33900	33900	0		
A.11.6.4	**11.6.4 IUD InsertionTraining 12.3.4 IUD Insertion (details in Annexure) 12.3.4.1 State level (TOT for the districts) 12.3.4.2 District level training (one district total) 12.3.4.3 PHC level training (for one district only)**			2	0	2		2		1	1	0	0	29425	58850	58850		58850	29425	0		
A.11.6.5	**Contraceptive Update Training**					0									0	0		0		0		
A.11.6.6	**Other FP Training**					0									0	0		0		0		

A.11.7	**11.7 ARSH Training 12.4.1 ARSH training for medical officers 12.4.3 One Day ARSH Orientation by the MOs of 25% ANMs 12.4.4 One Day ARSH Orientation of PRI by the MOs of50% ANMs**			0	0	0		0		0	0	0	0	0	0	0	0	0	0	0		
A.11.8	**11.8 Programme Management Training**			10	0	10		10		0	0	0	0	4000	68000	68000		68000	68000	612000		
A.11.8.1	**11.8.1 SPMU Training 12.5.4 State PMU to be trained/attend workshops in various areas like HR, Procurement & Logistics, PPP, FRU review and/or undertake study of various programmes in one good and one poor performing districts**					0									0	0		0		0		
A.11.8.2	**11.8.2 DPMU Training 12.5.1 Training of DPMU staff @ 38 x Rs.10,00012.5.2. Training of SHSB/DAM/BHM on accounts at Head Quarter level @ 6x1500x12=1,08,000/- + DAM=38x1500x4 + BHM=538x1500x4 12.5.3 Training for ASHA Help Desk to DPMs (38), Block level organisers (533) and MOICs (533), @ 1104 x 1000/-**			8	0	8		16		y	y	y	y	8750	70000	70000	0	70000	8750	70000		
A.11.9	**Other Training**					0									0	0		0		0		
A.11.9.1	**11.9.1 Continuing Medical & Nursing Education 11.2 Training of 20 (for total state) regular Government doctors in Public Health at Public Health Institute, Gujarat or at Wardha institute or Vellore institute to increase their administrative skills @ Rs.50,000/-**					0									0	0		0		0		
	12. BCC/IEC (for NRHM					0									0	0		0		0		

	Part A, B & C)																					
A.12.1	**12.1 Strengthening of BCC/IEC Bureaus (State and District Levels)**					0								0	0		0		0			
A.12.2	**12.2 Development of State BCC/IEC strategy 13.3 Concept and material development workshops by State BCC/IEC Cell 13.8 Establishment cost of the State BCC/IEC Cell 13.10 Technical support at District level**			1	0	1		2		y	0	0	0	12500	12500	12500	0	12500	25000	37500		
A.12.3	**12.3 Implementation of BCC/IEC stretegy**					0								0	0		0		0			
A.12.3.1	**12.3.1 BCC/IEC activities for MH**			0	0	0		1		1	0	0	0	25000	25000	25000	0	25000	25000	0		
A.12.3.2	**BCC/IEC activities for CH**			0	0	0		1		1	0	0	0	25000	25000	25000	0	25000	25000	0		
A.12.3.3	**12.3.3 BCC/IEC activities for FP**			0	0	0		1		1	0	0	0	25000	25000	25000	0	25000	25000	0		
A.12.3.4	**12.3.4 BCC/IEC activities for ARSH**			0	0	0		1		1	0	0	0	25000	25000	25000	0	25000	25000	0		
A.12.4	**12.4 Other activities 13.4 State Level events 13.5 District Level events (Radio, TV, AV, Human Media as per IEC strategy dissemination) 13.6 Printed material (posters, bulletin, success story reports, health calendar,Quarterly magazines & diaries etc) 13.7 Block level BCC interventions (Radio, kalajattha and for IEC strategy dissemination) 13.11 Media Advertisements on various health related days 13.12 Various advertisements/tender advertisements/EOIs in print media at State level 13.13 Developing Mobile Hoarding Vans and A V Van for State and District 13.14 Hiring an IEC**			10	10	0		25		10	15	0	0	15000	225000	225000	0	225000	15000	150000		

	Consultancy at state level for operationation of BCC Strategy. (@ Rs. 50000 x 1 x 12) 13.16 Implementation of specific interventions including innovations of BCC strategy/plans block level 13.17 Implementation of specific interventions including innovations of BCC strategy/plans District level (Rs. 5000 x 38 x 12) 13.18 Implementing need based IEC Activities in Urban Areas (Support for Organization of need based IEC Activities in Urban Areas) (Rs.50000 x 9 x 2) 13.19 Capacity building of frontline functionaries (ANM, ASHA) in IPC skills building 13.20 Research, M&E, IEC prototypes etc																					
	Sub-total IEC/BCC					0									0	0		0		0		
	Procurement					0									0	0		0		0		
A.13.1	**13.1 Procurement of Equipment**					0									0	0		0		0		
A.13.1.1	**13.1.1 Procurement of equipment 14.2. Equipments for EmOC services for identified facilities (PHCs, CHCs) @ Rs 1 Lac / facility / year (in two districts - kishanganj and jehanabad) 14.4. Equipments / instruments for Blood Storage Facility / Bank at facilities 14.6. Equipments / instruments, reagents for STI / RTI services @ Rs. 1 Lac per district per year**			2	0	2		2		2	0	0	0	37200	74400	74400	0	74400	37200	0		
A.13.1.2	**13.1.2 Procurement of equipment : CH**					0									0	0		0		0		
A.13.1.3	**13.1.3 Procurement of equipment : FP**			8	0	8		8		8	0	0	0	25000	200000	200000	0	200000	25000	0		

A.13.1.4	**13.1.4 Procurement of equipment : IMEP**					0									0	0		0		0		
A.13.2	**13.2 Procurement of Drugs & supplies**					0									0	0		0		0		
A.13.2.1	**13.2.1 Drugs & Supplies for MH**					0									0	0		0		0		
A.13.2.2	**13.2.2 Drugs & Supplies for CH**					0									0	0		0		0		
A.13.2.3	**13.2.3 Drugs Supplies for FP**					0									0	0		0		0		
A.13.2.4	**13.2.4 Supplies for IMEP**					0									0	0		0		0		
A.13.2.5	**General drugs & supplies for health facilities**					0									0	0		0		0		
	14. Prog. Manag-ement					0									0	0		0		0		
A.14.1	**Strengthening of State Society/SPMU** **16.1. Strengthening of State society/State Programme Management Support Unit** **16.1.1. Contractual Staff for SPMU recruited and in position 16.5.1. Last pay drawn – Pension = Approx exp of Rs.20,000/-PM @ 20,000x6x12**					0									0	0		0		0		
A.14.2	**14.2 Strengthening of District Society/DPMU** **16.2.1. Contractual Staff for DPMSU recruited and in position**			0	0	0		1		1	0	0	0	61598	1961120	1961120	1252383	708737	83090	997080		DPM@35420x1x12M=425040/- DAM@27720x1x12M=332640/- DNM&EO@23100x1x12M=277200/- x3x12M=306000/- Peon@4000x2x12=96000/- Office Assistant@10000x2x12=240000/-

A.14.3	**14.3 Strengtheningof Financial Management Systems 16.3.1.Training in accounting procedures 16.3.2. Audits 16.3.2.1. Audit of SHSB/ DHS by CA for 2009-10 16.4 Appointment of CA 16.4.1 At State level 16.4.2 At District level 16.5 Constitution of Internal Audit wing at SHSB**			1	1	0		1		0	0	0	0	20000	240000	240000	82500	157500	20000	240000		Mobility support to DPMU staff@20000x2x12M=480000/- Office Rent@6000x1x12M=72000/- Telephone @6000x1x12M=72000/- Generator@20000x1x12M=240000/- Stationary@20000x1x12M=240000/- Contigency for TA/DA etc. @10000x1x12M=120000/-
A.14.4	**14.4 Other activities (Programme management expenses,mobility support to state,district, block) 16.1.2. Provision of mobility support for SPMU staff @ 12 months x Rs.10.00 lakhs Updgration of SHSB Office 16.2.2.Provision of mobility support for DPMU staff @ 12 months x 38 districts x Rs.69945.17/-**			12	12	0		12		0	0	0	0	69945	1961120	1961120	839340	1121780	69945	-282440		
	Total Prog. Mgt.					0									0			0		0		
	Others/Untied Funds					0									0			0		0		
	Total RCH II Base Flexi Pool					0									0			0		0		
	Total JSY, Sterilisation and IUD Compensation, and NSV Camps					0									0			0		0		

	Grand Total RCH II					0									130959224.3	130959169	58977783.9	71981440.4		10530 2576.4		
																21780	10890	32670				
																25300	10120	35420				
																15000		15000				
																		83090				

	Activities	Component Code (only at state level)	Output 2012	Activity Plan										Budget Plan								
				2010-2011 FY				2011-2012 FY						2011-2012FY						2011-2012FY		
				Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised {Y x (A)} = D	under or over-utilised Budget{(B~D} =E	Tentative Unit Cost (F)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
										Q1	Q2	Q3	Q4									
Decentrlisation																						
B.1.11	ASHA Support system at State level																					
B.1.12	ASHA Support System at District Level			2	0	2		2		0	0	0	0	97389	876507	876507	42810	833697	97389	1168668		
B.1.13	ASHA Support System at Block Level			9	0	9		9		0	0	0	0	108000	864000	864000	0	864000	108000	972000		
B.1.14	ASHA Support System at Village Level			0	0	0		0		0	0	0	0	0	0	0	0	0	0	0		
B.1.15	ASHA Trainings			350	0	350		350		350	0	0	0	1400	490000	490000	0	490000	1400	490000		
B.1.16	ASHA Drug Kit & Replenishment			2376	2306	70		2376		2376	0	0	0	1895	4502520	4502520	0	4502520	1895	4502520		
B.1.17	Emergency Services of ASHA			0	0	0		1412		y	y	y	y	0	0	0	0	0	100	141200		
B.1.18	Motivation of ASHA			2376	2306	70		2376		2376	0	0	0	710	1686960	1686960	0	1686960	725	35640		
B.1.19	Capacity Building/Academic Support programme			0	0	0		26		0	y	y	0	0	0	0	0	0	1000	26000		

B.1.2	ASHA Divas			2376	2306	70		2376		70	0	0	0	1032	2452032	2452032	200000	2252032	1032	2452032		
B.1.21	Untied Fund for Health Sub Center,Additional Primary Health Center and Primary Health Center			241	241	0		241		0	0	0	0	12680	3055880	3055880	2189824	866056	12680	3055880		
B.1.22	Village Health and Sanitation Committee			7160	7160	0		7160		0	0	0	0	10000	71600000	7152500	2430000	69170000	10000	71600000		
B.1.23	Rogi Kalyan Samiti			10	10	0		10		0	0	0	0	250000	2500000	2500000	1300000	1200000	250000	2500000		
	Infrastrure Strengthening					0									0	0		0		0		
B.2.1	Construction of HSCs (315 No.)			0	0	0		5		5	0	0	0	1557000	7785000	0	0	0	1557000	7785000		
B.2.2	Construction of residential quarters of old APHCs for staff nurse			2	0	2		2		2	0	0	0	3000000	6000000	0	0	0	3000000	6000000		
B.2.2	Construction of building of APHCs where land is available (5315000/APHCs)			2	0	2		2		2	0	0	0	5315000	10630000	10630000	0	10630000	5315000	0		
B.2.3	2.3 Up gradation of CHCs as per IPHS standards			0	0	0		0		0	0	0	0	0	0	0	0	0	0	0		
B.2.4	Infrastructure and service improvement as per IPHS in 48 (DH & SDH) hospitals for accreditation or ISO : 9000 certification			1	0	1		1		0	0	0	1	0	0	0	0	0	0	0		
B.2.5	Upgradation of ANM Training Schools																					
B.2.6	Annual Maintenance Grant			11	11	0		11		0	0	0	0	200000	1639000	1639000	450000	1189000	200000	2200000		
	TOTAL INFRASTRUCTURE strengthening					0									0	0		0		0		
B.3	Contractual Manpower					0									0	0		0		0		
B.3.1 A	Incentive for PHC doctors & staffs			91	0	91		91		0	0	0	0	50000	4550000	4550000	0	4550000	50000	4550000		
B.3.1 B	Salaries for contractual Staff Nurses			290	180	110		210		60	60	60	30	96000	27840000	27840000	5443393	22396607	12000	-19876607		
B.3.1.C	Contract Salaries for ANMs			390	180	210		390		60	60	60	30	96000	37440000	37440000	7920000	29520000	96000	37440000		
B.3.1. D	Mobile facility for all health functionaries			750	0	750		800		y	y	0	0	1500	1125000	1125000	0	1125000	2000	475000		

B.3.2.	Block Programme Management Unit			18	18	0		18		0	0	0	0	487782	4612060	4612060	1245800	3366260	487782	8780076		HM@18480x8x12=1774080/- BA@12320x8x12=1182720/- D E O@6500x7x12=546000/- Mobility@20000x7x12=1680000/- Office Exp.@10000x7x12=840000/- Contigency for TA/DA etc@10000x7x12=840000/-
B.3.4.	Addl. Manpower for NRHM			2	0	2		2		0	0	0	0	330000	450000	450000	198300	251700	330000	660000		
	PPP Initiativs					0									0	0		0		0		
B.4.1	102-Ambulance service (state-806400) @537600 X 6 Distrrict			0	0	0		384		y	y	y	y	0	0	0	0	0	11042	4240128		
B.4.2	1911- Doctor on Call & Samadhan					0									0	0		0		0		
B.4.3	Addl. PHC management by NGOs			0	0	0		2		y	y	y	y	0	0	0	0	0	75500	151000		
B.4.5	SHRC					0									0	0		0		0		
B.4.6	Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP)			8	0	8		9		y	y	y	y	194537	1556296	1556296	0	1556296	200000	243704		
B.4.7	Dialysis unit in various Government Hospitals of Bihar					0									0	0		0		0		
B.4.8	Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar					0									0	0		0		0		
B.4.9	Providing Telemedicine Services in Government Health Facilities					0									0	0		0		0		
B.4.10	Outsourcing of Pathology and Radiology Services from PHCs to DHs			0	0	0		8		y	y	y	y	0	0	0	0	0	375000	3000000		
B.4.11	Operationalising MMU			9	9	0		12		y	y	y	y	468000	4212000	4212000	2808000	1404000	468000	4212000		
B.4.14	Monitoring and Evaluation (State , District & Block Data Centre)			8	0	8		8		y	y	y	y	101250	810000	810000	0	810000	150000	390000		
B.4.15	Generic Drug Shop					0									0	0		0		0		
B.4.16	Nutritional Rehabilitation Centre			0	0	0		12		y	y	y	y		0	0	0	0	205600	2467200		

B.4.17	Hospital Maintenance					0									0	0		0		0		
B.4.18	Providing Ward Management Services in Government Hospitals 3000000/-					0									0	0		0		0		
B.4.19	Provision for HR Consultancy services					0									0	0		0		0		
B.4.2	Advanced Life Saving Ambulance			0	0	0		12		y	y	y	y	0	0	0	0	0	989000	11868000		
	TOTAL PPP INITIATIVES					0									0	0		0		0		
B.5	Prourement of supplies					0									0	0		0		0		
B.5.1	Delivery kits at the HSC/ANM/ASHA (no.200000 x Rs.25/-)			5360	0	5360		7132		y	0	y	0	25	134000	134000	0	134000	25	44300		
B.5.2	SBA Drug kits with SBA-ANMs/ Nurses etc (no.50000 /38x Rs.245/-)			386	0	386		386		0	y	0	0	245	94570	94570	0	94570	245	0		
B.5.3	Availability of Sanitary Napkins at Govt. Health Facilities @25000/district/year			1	0	1		4		y	y	y	y	25000	25000	25000	0	25000	25000	75000		
B.5.4	Procurement of beds for PHCs to DHs			72	72	0		72		y	y	0	0	7590	546480	546480	546480	0	8000	576000		
	TOTAL PROCUREMENT OF SUPPLIES					0									0	0		0		0		
	Procurement of Drugs					0									0	0		0		0		
B.6.1	Cost of IFA for Pregnant & Lactating mothers (Details annexed)			3359	3359	0		30000		y	y	0	0	110	369490	369490	369490	0	110	3300000		
B.6.2	Cost of IFA for (1-5) years children (Details annexed)			12632	12632	0		15000		y	y	0	0	50	631600	631600	631600	0	50	750000		
B.6.3	Cost of IFA for adolescent girls (Details annexed)			5267	5267	0		20000		y	y	0	0	110	579370	579370	579370	0	110	2200000		
	TOTAL PROCUREMENT OF DRUGS					0									0	0		0		0		
	Mobilisation & Management support for Disaster Management					0									0	0		0		0		
	Health Management Information System			0	0	0		4		y	y	y	y	0	0	0	0	0	7500	30000		
	Strenthening of Cold Chain (infrastrcure strengthening)					0									0	0		0		0		
B.9.1	Refurbishment of existing Warehouse for R.I. as well as provision for hiring external storage space for (during Immunization Campaigns) Logistics at State HQ @Rs 1500000/-			8	8	0		8		y	y	y	y	87500	700000	700000	700000	0	87500	700000		

B.9.2	Refurbishment of existing Cold chain room for district stores in all districts with proper electrification,Earthing for electrical cold chain equipment and shelves and dry space for non elecrtical cold chain equipment and logistics @Rs 300000 Lakhs per district x 38 districts			0	0	0		1		y	y	0	0	0	0	0	0	0	300000	300000		
B.9.3	Earthing and wiring of existing Cold chain rooms in all PHCs @Rs 10000/- per PHC x 533 PHCs			10	7	3		8		y	y	y	y	10000	100000	100000	70000	30000	10000	50000		
	Preparation of Action Plan					0									0	0		0		0		
B.10.1	Preparation of District Health Action Plan (Rs. 2 lakhs per district x 38)			1	1	0		1		0	0	y	y	100000	100000	100000	50000	50000	100000	50000		
B.10.2	Preparation of State Health Action Plan @ 5 lakhs					0									0	0		0		0		
	Mainstreaming Ayush under NRHM			24	0	24		24		y	y	y	y	456000	10944000	10944000	0	10944000	456000	0		
	Continuing Medical & Nursing Education					0									0	0		0		0		
	RCH Procurement of Equipments					0									0	0		0		0		
B.13.1	Procurement of Equipments/instruments for Anesthesia			0	0	0		1		y	y	0	0	0	0	0	0	0	244000	244000		
B.13.2	Equipment for ICU			1	0	1		1		y	y	0	0	1705263	1705263	1705263	0	1705263	1705263	0		
B.13.3	Equipments/instruments for ANC at Health Facility (Other than SubCentre) @ 50,000 per district per year			0	0	0		8		y	y	0	0	0	0	0	0	0	50000	400000		
B.13.4	Equipments for the Labour Room			8	8	0		9		y	y	0	0	255530	2044240	2044240	2044240	0	255530	2299770		
B.13.5	Equipments for SNCU &NSU																					
B.13.5.A	SNCU for 23districts unit cost of Rs. 2377258			8	1	7		1		y	y	0	0	419213	3353704	3353704	3353704	0	2377258	2377258		
B.13.5.B	NSU for 530 PHCs unit cost of Rs. 139492			0	0	0		7		y	y	0	0	0	0	0	0	0	139492	976444		
B.13.6	NSV Kits			18	0	18		32		y	y	0	0	1100	19800	19800	0	19800	1100	15400		
B.13.7	IUD insertion kit			1	0	1		32		y	y	0	0	15000	15000	15000	15000	0	15000	480000		
B.13.8	Minilap sets			13	0	13		32		y	y	0	0	3000	39000	39000	0	39000	3000	57000		
	Additionalitiesfor NVBDCP under NRHM					0									0	0		0		0		
	Total for Equipment Procurement					0									0	0		0		0		

B.14	Drugs Procurement																								
B.14.1	Drugs			0	0	0		1		y	y	y	y	0	0	0	0	0	20000000	20000000		
B.14.2	Manpower/logistics for drugs procurement @ 10000x 2x12M=240000/-			0	0	0		2		2	0	0	0	120000	0	0	0	0	120000	240000		
B.14.3	Rent for drug store@10000x12M=120000/-			0	0	0		1		1	0	0	0	120000	1200000	0	0	0	10000	120000		
	Muskaan ek Abhiyaan			2125	2125	0		2125		0	0	0	0	2400	5100000	2550000	1872000		2400	5100000		
	Grand Total NRHM-B																			200745945		

8																	C.1Mobility Support	C.2Cold chain maintenance	C.3Alternative vaccine delivery to Session Sites		C.4Focus on slum & underserved areas in urban areas:			C. 6. Computer Assistants support		C. 8 Review Meetings		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
SL No.	Name of District	ANM	Alternate Vaccinator	Number of immunisation Site	AWC	ASHA	HSC	APHC	Slums	Under served Areas	PHC	WIC/WIF	No of Sessions per month	No. of Session in per R.I.Day as per Microplan	H to R	Alternate vaccinator for Urban	No. of Urban AWCs	Mobility Support for Supervision & Monitoring at District level (Rs. 50000 per year per district	Maintenance of Cold Chain equipments ILR & DFs Rs. 12000/- per districts & Rs. 3000/- per PHCs	C.3.1-Alternative vaccine delivery in NE States, Hilly terrains & geograhically from vaccine delivery point, river crossing etc.hard to reach areas in per month @ Rs. 100 per session for 12 months	C.3.2-Alternative Vaccine Delivery in other areas @ Rs. 50 per session sites for Approx 14000 Session sites in a month & AVD for Urban Areas	C.4.1-for 3645 slums @ Rs. 200 per month per Mobilizer per session	C.4.2 Alternate vaccinators honorarium for urban @ Rs 1400 per month for 12 months for under served areas	25	C. 6.1 Computer Assistants support at State Level	C. 6.2 Computer Assistants support for District level @ Rs.10000 per person per month for one computer assistant in each 38 districts	C.8. 1 State Level Review meetings	C.8.2 Quarterly review meetings exclusive for RI at district level with one Block Mos, CDPO, and other stake holders @ Rs. 100 per participants for 5 participants per per PHCs 533	C. 8.3 Quarterly review meetings exclusive for RI at block level @ Rs. 50/- PP as honorarium for ASHAs and Rs. 25 per persons for meeting expenses for 73629 ASHAs
1	Araria																	62500	48750.00	142500	1306000	180000	4452000	570000		150000		22500	75960

C.9 Trainings (separate annexure attached with details)					C.10 Microplanning		C.11 POL for vaccine delivery	C.12 Consumables	C. 13 Injection safety	C. 14	C. 16	
31	32	33	34	35	36	37	38	39	40	41	42	43
C. 9. 1 District level orientation for 2 days for ANMs MPHW, LHV Health Assistants Nurse, Mid wife Bees and other specialist as per traning norm of RCH for 9000 persons in 600 batches	8	C.9.3 One day training for Computer Assistant on RIMS/HMIS	C.9.4 One day cold chain handlers training for block level cold chain hadlers for 542 + 38 Sadar Hosp. cold chain handlers	C.9.5 One day training of block level data handlers for 533 person.	C.10.1 To develop microplan at sub-centre level @ Rs 100/- per sub - centre	C.10.2 For consolidation of microplans at block level @ Rs. 1000 per block/ PHC(533) and at district level @ Rs. 2000 per district for38 districts.	C.11 POL for vaccine delivery from State to district and from district to PHC/CHCs (@ Rs. 20000/- per WIC/WIF point & Rs. 20000/- per Districts + Rs. 5500/- for each PHC per year),	C.12 Consumables for computer including provision for internet access for RIMs Rs. 400 per month per district for 38districts.	C.13 1- Red & 1-Black plastic bags etc. @ 90 paise per session for 12 months	C.14 Catch-up Campaign	C. 16 For major AEFI cases investigation for every district in a year. @Rs 1000/- for mobility in the field and @ 5000/- for specimen shipment to lab including travel cost, lodging & fooding etc.	Grand Total
470125			13369	12148	50375	13750	86875	6000	23598		18750	7705200.00

Sum of Sum of Grand Total Amount (A-Team+B-Team)	Quarter	1st_Qtr			1st_Qtr Total	2nd_Qtr							2nd_Qtr Total	3rd_Qtr			3rd_Qtr Total	4th_Qtr			4th_Qtr Total	Grand Total				
	Round					Jul_10	Jul_10_Flood	Aug_10	Aug_10_Flood	Shrawani Mela	Sep_10	Sep_10_Flood		Chhath_Special	Nov_10	Sonepur Mela		Feb_11	Jan_11	Mar_11			Round	Chhat	Sonepur Mela	Shrawani Mela
District		Apr_10	May_10	Jun_10																						
ARARIA		2926891	2926891	2926891	8780673	2926891	65250	2926891	65250		2926891	65250	8976423	126062	2926891		3052953	2926891	2926891	2926891	8780673	29590722	10	1	0	0
Grand		292689	292689	292689	878067	292689	65250	292689	65250	0	292689	65250	8976423	126062	292689	0	305295	2926891	292689	292689	878067	295907	10	1	0	0

Total	1	1	1	3	1		1			1				1		3		1	1	3	22				

	Fund for manpower	Amount for MP	Total
1st_Qtr	8780673	5257726	14038399
2nd-Qtr	8976423	5189000	14165423
3rd_Qtr	3052953	2464349	5517302
4th_Qtr	8780673	6065325	14845998
Year-10-11	29590722	18976400	48567122

	Pen Req
1st_Qtr	352868
2nd_Qtr	348255
3rd_Qtr	165392
4th_Qtr	407068

Sum of Sum of Grand Total Amount (A-Team+B-Team)	Quarter	1st_Qtr			1st_Qtr Total	2nd_Qtr							2nd_Qtr Total	3rd_Qtr			3rd_Qtr Total	4th_Qtr			4th_Qtr Total	Grand Total				
	Round						Jul_10_Flood		Aug_10_Flood	Shrawani Mela		Sep_10_Flood			Chhath_Special	Nov_10	Sonepur Mela		Feb_11	Jan_11	Mar_11			Round	Chhat	Sonepur Mela	Shrawani Mela
District		Apr_10	May_10	Jun_10		Jul_10		Aug_10			Sep_10															
ARARIA		2926891	2926891	2926891	8780673	2926891	65250	2926891	65250		2926891	65250	8976423	126062	2926891		3052953	2926891	2926891	2926891	8780673	29590722	10	1	0	0
Grand Total		2926891	2926891	2926891	8780673	2926891	65250	2926891	65250	0	2926891	65250	8976423	126062	2926891	0	3052953	2926891	2926891	2926891	8780673	29590722	10	1	0	0

	Fund for manpower	Amount for MP	Total
1st_Qtr	8780673	5257726	14038399
2nd-Qtr	8976423	5189000	14165423
3rd_Qtr	3052953	2464349	5517302
4th_Qtr	8780673	6065325	14845998
Year-10-11	29590722	18976400	48567122

	Pen Req
1st_Qtr	352868
2nd_Qtr	348255
3rd_Qtr	165392
4th_Qtr	407068

PART D

	BUDGET 2010-11	BUDGET 2011-12
IDSP	673000	841250
IDD	30394	37992
KALAZAR	9212350	11515437
MALARIA	54100	67625
J.E.	----------	----------
DENGUE/CHICKENGUNIA	----------	----------
FILARIA	1236110	1545137
LEPROSY	404415	505519
T.B.	5080000	6350000
BLINDNESS	1160947	1451184